
Mental Capacity Law Guidance Note

A brief guide to carrying out capacity assessments



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A: Introduction

1. This purpose of this document is to provide health and social care practitioners with a brief overview of the law and principles relating to the assessment of capacity. Its focus is on (a) how to apply the MCA 2005 principles when assessing capacity; and (b) how to record your assessment, primarily in the context of health and welfare decisions.¹ It can be read together with our brief guide to carrying out best interests assessments, available [here](#).
2. This document cannot take the place of legal advice. In any case of doubt as to the principles or procedures to apply, it is always necessary to consult your legal department. In particular, if it appears that the person in question is subject to undue influence or coercion, it is always vital to consult your legal department as soon as possible to consider whether and how their interests are to be secured.
3. The courts have now considered questions of capacity on many occasions, sometimes giving guidance as to how the Act should be applied in general terms, and sometimes applying

¹Useful guidance in relation to the questions that arise in the context of the management of property and affairs (called *Making Financial Decisions - Guidance for assessing, supporting and empowering specific decision-making*) can be downloaded for free at www.empowermentmatters.co.uk.

Disclaimer: This document is based upon the law as it stands as at August 2016; it is intended as a guide to good practice, and is not a substitute for legal advice upon the facts of any specific case. No liability is accepted for any adverse consequences of reliance upon it.

the Act to particular factual scenarios. We give in this guide references to the key cases throughout, with hyperlinks to the case comments in the database maintained by the editors of the 39 Essex Chambers Mental Capacity Law [Newsletter](#). We also give these references in footnotes for those who want to read further: the key information is contained in the body of the Guide, in language which is hopefully not as legalistic as that sometimes adopted by the courts.

4. Further useful resources are in Section G, and we also include an annex to this guide summarising the information that judges have held to be relevant (or irrelevant) to some of the key decisions that come up most frequently in health and social care practice.
5. Those who have previously used our guide should note that there is a substantial change to the July 2015 edition in that we have altered the order in which we suggest that the two elements of the test are applied. We explain our thinking below.

B: Key principles

6. Mental capacity is decision-specific. The statement ‘P lacks capacity’ is, in law, meaningless. You must ask yourself “what is the actual decision in hand”²? If you do not define this question with specific precision before you start undertaking the assessment, the exercise will be pointless.
7. The core principles of the MCA 2005 are set out in s.1. They are:
 - s.1(2): a person (P³) must be assumed to have capacity unless it is established that he lacks capacity;
 - s.1(3): P is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success;
 - s.1(4): P is not to be treated as unable to make a decision merely because he makes an unwise decision;
 - s.1(5): an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests; and

² See [PC and NC v City of York Council](#) [2013] EWCA Civ 478 at paragraph 40.

³ Strictly, of course, P is not ‘P’ unless they are the subject of proceedings before the Court of Protection who is alleged to lack capacity to take one or more decisions (Court of Protection Rules 2007, r6), but it is a convenient shorthand.

- s.1(6): before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
8. The presumption that P has capacity is fundamental to the Act. It is important to remember that P has to 'prove' nothing. The burden of proving a lack of capacity to take a specific decision (or decisions) always lies upon the person who considers that it may be necessary to take a decision on their behalf (or will invite a court to take such a decision). The standard of proof which must be achieved is on the balance of probabilities (s.2(4)). Accordingly, it will always be for the decision-maker to prove that it is more likely than not that P lacks capacity to make the decision in question.
9. Common phrases which suggest that this approach is not being adopted include:
- *"One needs to be certain of her capacity."*
 - *"[P] is unable to fully understand, retain and weigh information."*⁴

Who should determine mental capacity?

10. It is also important to remember that it is the decision-maker who needs to be satisfied that P lacks capacity. In a court setting, the decision-maker is the judge; outside the court setting, it is the person who is proposing to take the step in question on the basis that it is said to be in P's best interests. That does not mean that expert assistance cannot be sought (for instance as to whether the person has an impairment or disturbance of the mind or brain). But it does mean that the person relying on the defence cannot delegate the capacity issue to that expert. To give an example which occurs frequently in the clinical setting, if you are a doctor proposing to carry out a particular operation, you cannot delegate to a psychiatrist colleague the decision whether or not the person has capacity to consent to that operation. You may – and in some complex cases may need to – get expert input from that psychiatric colleague, but it is ultimately you, as the treating doctor, to determine capacity. If you do not reasonably believe that P lacks capacity to consent to the operation, but go ahead with the operation, you will have no defence under s.5 MCA 2005 even if you reasonably believed that you were acting in your patient's best interests.
11. It is important to understand that it is not only medical professionals – and in particular psychiatrists – who can carry out a capacity assessment. Much depends upon (a) the nature of the decision, and (b) who knows the person best. There will be some circumstances under which the particular expertise of a medical professional will be required, but that is because of their expertise, not because of the position that they hold. A capacity assessment is, in

⁴ These are both taken from the judgment of Peter Jackson J in [Heart of England NHS Foundation Trust v JB](#) [2014] EWHC 342 (COP), with the key words emphasised.

many ways, an attempt to have a real conversation with the person on their own terms, and applying their own value system.⁵ This means that it is frequently the case that professionals or others who know the person better, and in particular who have seen the person over time, will be able to do a more robust capacity assessment than a person (of whatever discipline) ‘parachuted’ in for a snapshot assessment.⁶

12. The Court of Protection can make interim declarations and decisions about P’s best interests where it has evidence before it “*to justify a reasonable belief that [the individual] may lack capacity in the relevant regard.*”⁷ This means that it is possible to make an application where those concerned with P’s circumstances have been unable to complete a COP3 form to the level of detail usually required. This could, for example, be because they have been prevented by a third party or because P refuses to be assessed. In such circumstances, it will always be necessary to make clear in a supporting witness statement why the person or body bringing the application has reasonable grounds to believe that P may lack the relevant capacity. One of the first steps that the Court will then take is to bring about a proper capacity assessment; that capacity assessment will then determine whether or not it has jurisdiction to take further steps in relation to P.
13. Finally, the very act of deciding to carry out a capacity assessment is not, itself, neutral, and the assessment process can, itself, often be (and be seen to be) intrusive. After all, to assess someone’s mental capacity is to interfere with their right to respect for private life for Article 8 ECHR purposes. So you must always have grounds to consider that one is necessary. Conversely, you must also be prepared to justify a decision not to carry out an assessment where, on its face, there appeared to be a reason to consider that the person could not take the relevant decision. Whilst the presumption of capacity is a foundational principle, you should not hide behind it to avoid responsibility for a vulnerable individual.⁸ In our experience, this can happen most often in the context of self-neglect where it is unclear whether or not the person has capacity to make decisions.⁹

⁵ See [Kings College NHS Foundation Trust v C](#) [2015] EWCOP 18, in particular at paragraph 38.

⁶ See in this regard both [A Local Authority v SY](#) [2013] EWHC 3485 (COP) at paragraph 22 (emphasising that “appropriately qualified social worker is eminently suited to undertake [...] capacity assessments” for completing a COP3 form”) and [PH v A Local Authority v Z Limited](#) [2011] EWHC 1704 (COP) at paragraph 56. By “appropriately qualified” social worker is meant a social worker who can properly claim to have the necessary expertise (and be able to explain why they do). It does not imply a requirement for any specific medical expertise above and beyond the skills of a properly trained social worker.

⁷ *Re F* [2010] 2 FLR 28.

⁸ As the House of Lords Select Committee looking at the MCA 2005 reported, this unfortunately happens all too frequently. House of Lords Select Committee on the MCA 2005 (2014) *Mental Capacity Act 2005: Post-legislative scrutiny*, HL Paper 139, at paragraph 105.

⁹ See the joint report of the Parliamentary Health Service and Local Government Ombudsmen into the complaint against South Essex Partnership University Trust and Bedford Borough Council (JW 111510 and 11010604 (June 2014)), in which the Ombudsmen found a man with paraphrenoid schizophrenia suffered from malnutrition and poor dental health because professionals did not properly assess whether he had the capacity to make decisions for himself.

Promoting autonomy

14. To comply with s.1(3) MCA 2005, you must take all reasonable steps to help P to decide for themselves before concluding that they are nevertheless unable to make a decision. This will include asking yourself – and being in a position to record – the answers to questions such as:

- What is the method of communication with which P is most familiar (is it, for instance, a pointing board, Makaton or visual aids)?
- What is the best time of day to discuss the decision in question with P?
- What is the best location to discuss the decision in question with P?
- If you do not know P, would it assist to have another person present who does (and, if they do, what role should they play)? Or an independent advocate under the Care Act 2014?
- What help does P require to learn about and understand the information relevant to the decision? For instance, does P need to be taken to see different residential options? Have you explained to P all the pieces of information that you have identified as being relevant to the decision?
- And, perhaps above all, is there something that you can do which might mean that P would be able to make the decision? Depending upon the circumstances, this could range from simply waiting for the decision to be taken, to undergoing work with P to assist them: see for a good example, [Re DE](#),¹⁰ in which (whilst Court of Protection proceedings were ongoing), an intensive programme of education was provided to a learning disabled man, in consequence of which he gained the capacity to consent to sexual relations.

15. It may well be the case that taking practicable steps will be the end of the matter because the person has been enabled to decide for themselves.

C: Defining a lack of capacity

16. The law gives a very specific definition of what it means to lack capacity for purposes of the MCA 2005. Section 2(1) of the MCA 2005 provides that:

¹⁰ [2013] EWHC 2562 (Fam)

‘a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain.’

17. Section 2(1) is the key section.¹¹ The rest of s.2 and the whole of s.3 flesh out what are traditionally called the two limbs of the capacity ‘test’, i.e. asking:

- whether P is ‘unable to make a decision for himself’ (functional); and
- whether that inability is because of temporary or permanent ‘impairment of, or a disturbance in the functioning of, the mind or brain’ (diagnostic).

18. It is very important to understand that the terms ‘functional’ and ‘diagnostic’ do not appear in the MCA 2005, although they are used in the Code of Practice. We use them here because they are very often used in every day practice. However, we must caution that use of the term ‘diagnostic’ perpetuates a very medical model of capacity assessment and the ‘myth’ that only medical professionals are capable of conducting capacity assessments. As set out above, this is not the case. Moreover, no formal diagnosis is in fact required, particularly in emergency situations.

19. It is also important to understand that there are actually three elements to the test for capacity:

(1) Is the person unable to make a decision? If so:

(2) Is there an impairment or disturbance in the functioning of the person’s mind or brain? If so:

(3) Is the person’s inability to make the decision because of the identified impairment or disturbance?

20. The ordering of the first and second questions set out above is the opposite to that set out in the Code of Practice to the MCA 2005. However, we consider that the case-law is now clear that the ordering set out in the Act itself must be followed.¹² There are also two sound ‘policy’ reasons why this order should be followed:

(1) There is a danger that you will mentally ‘tick off’ the presence of an impairment or

¹¹ Referred to as the “core determinative provision” in [PC and NC v City of York Council](#) [2013] EWCA Civ 478 at paragraph 56.

¹² See [PC and NC v City of York Council](#) [2013] EWCA Civ 478 at paragraph 58 and [Kings College NHS Foundation Trust v C and V](#) [2015] EWCOP 80 at paragraph 35.

disturbance and then will not sufficiently question whether that impairment or disturbance is actually **causing** the inability to make the decision;¹³

(2) Linked to this, there is also a risk that a different order would perpetuate the discriminatory approach to those with mental disorders, as it essentially loads the capacity assessment against them by ‘pre-filling’ the first element of the test. In other words, it makes it – subconsciously – easier for you to move from thinking ‘this person has schizophrenia’ to concluding ‘this person lacks capacity to make [X] decision.’

21. In all cases, though, all three elements of the single test must be satisfied in order for a person properly to be said to lack capacity for purposes of the MCA 2005.

22. We now look at these elements in turn.

(1): The Functional Test

23. The elements of the functional test are found in s.3(1) MCA 2005, which states that P is unable to make a decision for himself if he is unable:

- to understand the information relevant to the decision; or
- to retain that information; or
- to use or weigh that information as part of the process of making the decision; or
- to communicate his decision (whether by talking, using sign language or any other means).

24. As obvious as it may sound, it is vitally important to ensure that, having framed the question with sufficient precision to yourself, you actually then need to ask P the question (in whatever manner is appropriate) during the assessment (and record the answer). If, unusually, it is not appropriate to ask the precise question, the reasons why it was not asked should be spelled out carefully.

Is P unable to understand the relevant information?

25. It is not necessary that P understands every element of what is being explained to him. What is important is that P can understand the ‘salient factors’¹⁴: the information relevant to the

¹³ This risk was identified by the Court of Appeal in *PC* at paragraph 58.

¹⁴ [LBJ v RYJ](#) [2010] EWHC 2664 (Fam).

decision. The level of understanding required must not be set too high.¹⁵ This means that the onus is on you not just to identify the specific decision (as discussed above) but also what the information is that is relevant to that decision, and what the options are that P is to choose between. We give examples of the kind of information that has been held by the courts to be relevant (and irrelevant) to some of the more common health and welfare decisions in the annex to this Guide.

26. Further, you must not start with a ‘blank canvas.’ In other words, you must present the person you are assessing with detailed options so that their capacity to weigh up those options can be fairly assessed.¹⁶ This is particularly important where a person’s particular impairment may make it more difficult for them to envisage abstract concepts. But it is also important to give the person sufficient information about the options that they are being asked to choose between so that they are given the opportunity to understand (if they are capable of doing so) the reality of those options. In other words, and to take a common example, you should not simply seek to assess a person’s ability to decide between living at home and living in a care home in the abstract, but rather by reference to what continuing to live at home would be like (for instance, what care package would the relevant local authority provide) and what living in an actual care home would be like.¹⁷
27. The ability to understand also extends to understanding the reasonably foreseeable consequences of reaching a decision or failing to do so (s.3(4)).

Is P unable to retain the relevant information?

28. We repeat the need to be precise about the information in question.
29. The issue is whether P is unable to retain enough information for a sufficient amount of time to make the decision. The Act specifies at s.3(3), however, that ‘the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.’
30. This is an important consideration, particularly when dealing with the elderly or those with deteriorating memories. Capacity is the assessment of the ability to make a decision ‘at the material time’: at the time of assessment. If information can be retained long enough for P to be able to make the relevant decision at the material time, that is sufficient, even if P cannot then retain that information for any longer period.

¹⁵ [PH and A Local Authority v Z Limited & R](#) [2011] EWHC 1704 (Fam).

¹⁶ [CC v KK & STCC](#) [2012] EWHC 2136 (COP).

¹⁷ [CC v KK & STCC](#) [2012] EWHC 2136 (COP).

Is P unable to use or weigh the relevant information?¹⁸

31. Again, it is necessary to be clear what the information is (and how it is said to be relevant to the decision). This aspect of the test has been described as *‘the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another.’*¹⁹ As with understanding, it is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient factors. Therefore, even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision.²⁰
32. It is particularly important here to be aware of the dangers of equating an unwise decision with the inability to make one – P may not agree with the advice of professionals, but that does not mean that P lacks capacity to make a decision.²¹
33. Further, if a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for that person.²² This means you need to be very careful when assessing a person’s capacity to make sure – as far as possible – that you are not conflating the way in which they apply their own values and outlook (which may be very different to yours) with a functional inability to use and weigh information. This means that, as much as possible, you need as part of your assessment – your conversation – with P, to glean an idea of their values and their life story as it relates to the decision in question.
34. In some cases, it may be difficult to identify whether P is using a piece of relevant information but according it no weight, or failing to use the piece of information at all. For example, agreeing or refusing to take medication for a condition that P does not think P has. Psychiatric expertise may be of assistance in such cases, as it may explain whether P’s ability to process information is impaired and if so, to what extent.
35. Another common area of difficulty is where a person with an acquired brain injury gives superficially coherent answers to questions, but it is clear from their actions that they are unable to carry into effect the intentions expressed in those answers (in other words, their so-

¹⁸ Note that the statutory requirement is that P must be unable to use or weigh the relevant information. In practice, the two terms are usually used together, so we also refer here to “use and weigh.” However, we think that it is clear that P should be considered to lack capacity if they are able to use the information, but not able to weigh it.

¹⁹ [The PCT v P, AH & the Local Authority](#) [2009] EW Misc 10 (COP).

²⁰ [Kings College NHS Foundation Trust v C and V](#) [2015] EWCOP 80 at paragraph 37.

²¹ “there is a space between an unwise decision and one which an individual does not have the mental capacity to take and ... it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual’s autonomy operates”: PC at paragraph 54.

²² [Kings College NHS Foundation Trust v C and V](#) [2015] EWCOP 80 at paragraph 38.

called executive function is impaired). It can be very difficult in such cases to identify whether the person in fact lacks capacity within the meaning of the MCA 2005, but a key question can be whether they are aware of their own deficits – in other words, whether they are able to use and weigh (or understand) the fact that there is a mismatch between their ability to respond to questions in the abstract and to act when faced by concrete situations. Failing to carry out a sufficiently detailed capacity assessment in such situations can expose the person to substantial risks.

Is P unable to communicate their decision?

36. Any residual ability to communicate is enough, so long as P can make themselves understood. This will be an area where it is particularly important to identify (and to demonstrate you have identified) what steps you should be taking to facilitate communication: for instance, reproducing as best as possible the manner by which they usually communicate, providing all necessary tools and aids, and enlisting the support of any relevant carers or friends who may assist with communication.

(2): The Diagnostic Test

37. In many cases, and especially if you are not medically qualified, you will be relying upon a clinician to provide an opinion as to whether P has an impairment or disturbance in the functioning of the mind or brain, and, if so, what precisely it is. As this is primarily a clinical question, we do not therefore address this aspect of the test in great detail here.

38. It is, though, important to make the following points:

- (1) The impairment or disturbance in the functioning of the mind or brain can be temporary or permanent (s.2(2)): if temporary, be careful to explain why it is that the decision cannot wait until the circumstances have changed before the decision is taken.
- (2) It is important to remember that it is not necessary for the impairment or disturbance to fit into one of the diagnoses in the ICD-10 or DSM-V.²³ It can include medical conditions causing confusion, drowsiness, concussion, and the symptoms of drug or alcohol abuse. To this extent, therefore, the term “diagnostic” test is misleading – the important thing is that there is a proper basis upon which to consider that there is an impairment or disturbance.

²³ The revised COP3 form recognises this in section 7, where it requires the identification of the material impairment of or disturbance in the functioning of the mind or brain, and the identification of the specific diagnosis (or diagnoses) “[w]here this impairment or disturbance arises out of a specific diagnosis.”

- (3) Finally, particular care needs to be exercised if you are considering a person who appears to have a very mild learning disability – this may well not be enough to constitute an impairment or disturbance of the mind or brain for these purposes.²⁴

(3): The Causative Nexus

39. In all cases, it is vital to consider whether this third requirement – the ‘causative nexus’ – is established. In other words, are you satisfied that the inability to make a decision is because of the impairment of the mind or brain? Any pro forma form for the assessment of capacity that does not include a final box asking precisely this question is likely to lead you astray. In *PC and NC v City of York Council* this issue made all the difference: that her inability “*significantly relate[d] to*” PC’s mild learning disability was insufficient: the MCA requires the inability to be “because of” of the impairment, which is evidentially more stringent.
40. To reiterate, there has to be (and you have to show that you are satisfied why and how there is) a causal link between the disturbance or impairment and the inability to make the decision(s) in question. *JB’s* case, again, shows how easy it is to assume that merely because a person has schizophrenia, they are then unable to take decisions regarding surgical procedures – this is entirely incorrect. The disturbance or impairment in the functioning of the mind or brain must also not merely impair the person’s ability to make the decision, but render them unable to make the decision.²⁵
41. There will be situations in which it is not entirely easy to identify whether a person is unable to make what professionals consider to be their own decisions because of:
- (1) An impairment or disturbance in the functioning of their mind or brain (for instance the effect of dementia);
 - (2) The influence of a third party (for instance an over-bearing family member); or
 - (3) A combination of the two.
42. Examples of such cases include:
- (1) The elderly patient on the hospital ward who looks to their child for affirmation of the ‘correctness’ of the answers that they give to hospital staff;
 - (2) A person with mild learning disability in a relationship with an individual who (even when that individual is next door) is clearly still cautious about expressing any opinions that may go against what they think may be the wishes of that individual.

²⁴ See [WBC v Z](#) [2016] EWCOP 4.

²⁵ [Kings College NHS Foundation Trust v C and V](#) [2015] EWCOP 80 at paragraph 31.

43. In such cases, there will sometimes a difficult judgment call to make as to whether the involvement of the third party actually represents support for the person in question, or whether it represents the exercise of coercion or undue influence. We strongly suggest that in any case where you have grounds for concern that you seek legal advice as soon as possible as to what (if any) steps should be taken. In particular, there are some cases in which the right route is not to go to the Court of Protection but rather to make an application to the High Court for declarations and orders under its inherent jurisdiction.²⁶

D: Recording your assessment

44. A “good” capacity assessment would include the following considerations:

- (1) Be clear about the capacity decision that is being assessed;
- (2) Ensure P (and you) have the concrete details of the choices available (e.g. between living in a care home and living at home with a realistic package of care);
- (3) Identify the salient and relevant details P needs to understand/comprehend (ignoring the peripheral and minor details);
- (4) Avoid the protection imperative;
- (5) Demonstrate the efforts taken to promote P’s ability to decide;
- (6) Evidence each element of your assessment:
 - i. Why could P not understand, or retain, or use/weigh, the information relevant to the decision, or communicate the decision, in spite of the assistance given?
 - ii. What is the impairment/disturbance? Is it temporary or permanent?
 - iii. How is the inability to decide caused by the impairment/disturbance (as opposed to something else)?
- (7) Why is this an incapacitated decision as opposed to an unwise one?

45. In addition to the specific points mentioned above, as with all documentation, the key general points to remember are:

²⁶ For an example of such case, see [LB Redbridge v G, C and F](#) [2014] EWHC 485 (COP), in which the judge ultimately found that, in fact, G fell within the scope of the MCA 2005.

- (1) Contemporaneous documentation is infinitely preferable to retrospective recollection, and verbatim notes of the key questions and answers can be particularly valuable;
- (2) Do not assert an opinion unless it is supported by a fact;
- (3) “Yes/No” answers are, in most cases, unlikely to be of assistance unless they are supported by a reason for the answer;
- (4) What is reasonable to expect by way of documentation will depend upon the circumstances under which the assessment is conducted. An emergency assessment in an A&E setting of whether an apparently brain-injured patient has the capacity to run out of the ward into a busy road will not demand the same level of detail in the assessment or the recording as an assessment of whether a 90 year old woman has the capacity to decide to continue living in her home of 50 years where the concerns relate to her declining abilities to self-care.

E: Fluctuating and temporary capacity

46. Fluctuating capacity is not a concept expressly addressed or provided for in the MCA 2005, although it is referred to in the Code of Practice.²⁷
47. It is important to distinguish between two different potential situations:
 - (1) A person with genuinely fluctuating capacity, such as a person with bi-polar disorder whose condition may lessen or become more severe over time. This fluctuation can take place either over a matter of days or weeks, or over the course of each day: there are many, especially elderly individuals, whose cognitive abilities are significantly less impaired at the start of the day than they are towards the end;
 - (2) A person who has a temporary impairment of their ability to make decisions, a very clear example being a person suffering from a severe urinary tract infection and in consequence of the infection suffering from confusion and/or delirium.
48. The second of these situations is in some ways the easier: the first and key question is whether the decision that you need the person to take is one that can wait. If it can, and you can treat or otherwise alleviate the cause of the temporary impairment, then do so as part of supporting the person to take their own decisions. If it genuinely cannot wait and it is necessary to assess the person’s capacity (and, usually, to act there and then in their best interests), then it is vitally important to take as few irreversible steps as possible in the name

²⁷ [MCA Code of Practice](#), paragraph 4.26.

of the person's best interests whilst at the same time doing whatever is necessary to assist them recover the ability to take their own decisions.

49. How to approach the first situation will depend both upon the 'cycle' of fluctuation (both its length and gravity) and upon the nature of the decision.

(1) If it is a one-off decision, and it is possible to wait, then it is clearly appropriate to wait until the person's cognitive abilities are at their least impaired. It is also then extremely important to document the assessment of capacity fully, and also – wherever possible – their wishes in relation to the relevant decision. This means that, if decisions then need to be taken for or on behalf of the person when they lack capacity in the material respect, it will be possible to do so secure in the basis that you know what the right decision for that person is (see in this regard further our best interest assessment guide). Again, if it is not possible to wait, then the same maxim as in relation to temporary incapacity applies: take the minimum action necessary to “hold the ring” pending a return at a point when the person has the capacity to take their own decision.

(2) Some decisions are not one-off, however, and/or require taking repeatedly over a period of time (for example, the management of property and affairs or the conduct of litigation).²⁸ We suggest legal advice is sought wherever it appears that a person appears to have fluctuating capacity to take such decisions, because the consequences for the person may be very grave if they are assessed as having capacity in this regard when, in reality, this is only true for a very short part of the time.

F: Conclusion

50. As the court memorably put it in *JB*, “do not allow the tail of welfare to wag the dog of capacity”. An extremely foolish or irrational capacitous decision is still a decision and one that P is entitled to make. A decision can only be taken either in reliance on the general defence in s.5 MCA 2005 or by the court if and when it is proved on the balance of probabilities that (1) P is in fact unable to take the decision in question, (2) there is an impairment or disturbance in the functioning of their mind/brain and (3) the inability is because of that impairment/disturbance.

51. And finally: it is possible to overcomplicate capacity assessments. Especially in the context of those with learning disability and dementia, the key to a successful assessment is patience and empathy. Those are not skills that are the province of particular professionals, but they are ones that can be taught, and need to be nurtured in settings in which it is understood that assessment of capacity to take complex decisions necessarily takes time. Remember,

²⁸ [A, B and C v X and Z](#) [2012] EWHC 2400 (COP) at paragraph 32.

conversations determine capacity.

G: Useful resources

52. Useful free websites include:

www.39essex.com/resources-and-training/mental-capacity-law – database of case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Newsletter, to which a free subscription can be obtained by emailing marketing@39essex.com.

www.mclap.org.uk – website set up by Alex with forums, papers and other resources with a view to enabling professionals of all hues to ‘do’ the MCA 2005 better.

www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.

www.scie.org.uk/mca-directory/ - the Social Care Institute of Excellence database of materials relating to the MCA

www.gmc-uk.org/learningdisabilities/ - extremely useful resource designed in the first instance for doctors, but of much wider application, with particularly useful practical guidance upon communication techniques

www.assessright.co.uk/ - a website developed in conjunction between NHS Aylesbury CCG and NHS Chiltern CCG to help health and social care professionals assess capacity for purposes of the MCA 2005.

Annex: relevant (and irrelevant information)

Introduction

1. As noted in the body of this Guidance Note, the courts have now applied the MCA 2005 in respect of very many types of decision. In the course of doing so, they have given indications as to what they consider to be relevant (and sometimes irrelevant) information for purposes of those decisions. This Annex²⁹ pulls together the guidance given in relation to some of the most common decisions that are encountered in practice in the context of health and welfare matters.

Medical treatment

2. The information that is relevant to the assessment of whether a person has the capacity to consent to a medical procedure is the information going to the nature, purpose and effects of the proposed treatment, the last of these entailing information as to the benefits and risks of deciding to have or not to have the operation, or of not making a decision at all.³⁰ It is important that the information as to risks is tailored to the risks specific to that particular individual.³¹
3. The courts have emphasised that what is required is “*a broad, general understanding of the kind that is expected from the population at large,*” and that the person “*is not required to understand every last piece of information about her situation and her options: even her doctors would not make that claim. It must also be remembered that common strategies for dealing with unpalatable dilemmas – for example indecision, avoidance or vacillation – are not to be confused with incapacity. We should not ask more of people whose capacity is questioned than of those whose capacity is undoubted.*”³²

Sex

4. The assessment of whether a person has the capacity to consent to sexual relations is an assessment that looks at their general capacity to consent to sex, rather than being specific to any particular person or any particular occasion.³³

²⁹ Primarily prepared by Shereen Akhtar.

³⁰ [Heart of England NHS Foundation Trust v JB](#) [2014] EWHC 342 (COP) at paragraph 25.

³¹ [Montgomery v Lanarkshire Health Board](#) [2015] UKSC 11 at paragraph 87.

³² [Heart of England NHS Foundation Trust v JB](#) [2014] EWHC 342 (COP) at paragraph 26.

³³ [IM v LM, AB and Liverpool City Council](#) [2014] EWCA Civ 37.

5. When judging that general capacity to enter into sexual relations, the relevant information for the purposes of making an assessment is whether the person can understand.³⁴

(a) **The mechanics and nature of the sexual act;**

(b) **The risk of sexually transmitted infections.** The knowledge required is fairly rudimentary. *“In my view it should suffice if a person understands that sexual relations may lead to significant ill-health and that those risks can be reduced by precautions like a condom.”*³⁵ Nothing more than this is required. There is thus no need to be able to name and describe each, or indeed any, potential infection, nor must a person specifically be able to understand condom use (this is an example of a precaution);³⁶

(c) **The potential that sexual activity between a man and a woman can give rise to pregnancy,** although note that where it is clearly established that the person is homosexual, it is *it is ordinarily unnecessary* to consider this since pregnancy is not a consequence of homosexual sex.³⁷

(d) **A basic understanding of contraception;**

(e) **That one has a choice whether to have sex and can refuse.** The person must understand that they can change their mind in relation to consent to sex at any time leading up to and during the sexual act.³⁸

6. The assessment must not however entail consideration of the following elements, should they be present in any particular case:

(a) **The identity of the sexual or marriage partner.** In other words, capacity to consent to sexual relations is act-specific, rather than person-specific.³⁹

³⁴ The majority of these come originally from the judgment of Munby J in *X City Council v MB, NB and MAB* [2006] EWHC 168 (Fam), applied by Court of Protection judges subsequent to the passage of the MCA 2005.

³⁵ *A Local Authority v H* [2012] EWHC 49 (COP) at paragraph 23.

³⁶ *LB Southwark v KA (Capacity to Marry)* [2016] EWCOP 20 at paragraph 72.

³⁷ *Re TZ* [2013] EWHC 2322 (COP) at paragraphs 31-3.

³⁸ *A Local Authority v H* [2012] EWHC 49 (COP) at paragraph 25; *LB Tower Hamlets v TB & Ors* [2014] EWCOP 53 at paragraph 41; *LB Southwark v KA (Capacity to Marry)* [2016] EWCOP 20 at paragraph 54.

³⁹ *IM* at paragraph 77.

- (b) **An understanding of what is involved in caring for a child (should a protected person become pregnant).** This comes close to crossing the line into a paternalist approach that would find incapacity on the basis that a decision is simply unwise.⁴⁰
 - (c) **The risk that may be caused to herself through pregnancy, or the risk to future children.** The social, emotional and psychiatric consequences of falling pregnant or those attaching to the children arising from such a pregnancy cannot be part of the relevant information informing the decision of whether a protected party has the capacity to consent to sex or marriage.
 - (d) **The fact that the opportunity for sexual relations with a specific partner will be limited for some time to come into the future.**⁴¹
 - (e) **The ability to understand or evaluate the characteristics of some particular partner or intended partner.**⁴²
7. Finally, the courts have emphasised that, when it comes to making decisions to consent to sexual relations with another person, a person of full capacity may act from a more intuitive than cerebral set of factors. *IM* reminds us that “*the notional process of using and weighing information attributed to the protected person should not involve a refined analysis of the sort which does not typically inform the decision to consent to sexual relations made by a person of full capacity.*”⁴³ In other words, there should not be a higher threshold for a person with allegedly impaired capacity to consent to sexual relations than exists for an “ordinary” person (whoever they might be).

Marriage

8. The test for capacity to marry is a simple one, and the issue is act- (or status-), rather than person-specific. The wisdom of the marriage is irrelevant,⁴⁴ and the courts have emphasised that the bar must not be set high so as to avoid discrimination.⁴⁵ The information relevant to

⁴⁰ Bodey J in *Re A (Capacity: Refusal of Contraception)* [2010] EWHC 1549, (Fam) [2011] Fam 61 at paragraph 61.

⁴¹ *IM* at paragraph 89

⁴² Munby J in *X City Council v MB, NB and MAB* [2006] EWHC 168 (Fam) at paragraph 86.

⁴³ *IM* at paragraph 36.

⁴⁴ Hedley J in *A, B and C v X and Z* [2012] EWHC 2400 (COP) at paragraph 32.

⁴⁵ *Sheffield City Council v E* [2004] EWHC 2808 (Fam) at paragraph 144.

the test is:⁴⁶

- (a) **The broad nature of the marriage contract;**
- (b) **The duties and responsibilities that normally attach to marriage**, including that there may be financial consequences and that spouses have a particular status and connection with regard to each other;
- (c) **That the essence of marriage is for two people to live together and to love one another.**

9. It has also been held that the person must not lack capacity to enter into sexual relations.⁴⁷

10. Information that has been held to be irrelevant includes:⁴⁸

- (a) **that in a family which facilitates arranged marriage the person is much more likely to find a spouse than if they were unaided;**
- (b) **How financial remedy law and procedure works and the principles are applied.** A person who lacks capacity to conduct proceedings in relation to any financial aspects of divorce proceedings does not necessarily lack capacity to marry.
- (c) **That (at least in the context of entry clearance) a spouse may require entry clearance.**

Contraception

11. In deciding whether a person has capacity to make decisions about their own contraceptive regime, the information that will be seen as relevant is as follows:⁴⁹

- (a) **A rudimentary understanding of the reproductive process.** This would involve an understanding that pregnancy is a result of sexual intercourse and not other (non-sexual) activity such as eating or ingesting unfamiliar substances.⁵⁰

⁴⁶ This comes originally from the judgment of Munby J in *Sheffield City Council v E* [2004] EWHC 2808 (Fam), as applied subsequently by Court of Protection judges, most recently by Parker J in *LB Southwark v KA (Capacity to Marry)* [2016] EWCOP 20.

⁴⁷ See most recently *LB Southwark v KA (Capacity to Marry)* [2016] EWCOP 20 at paragraph 76.

⁴⁸ All of these come from *LB Southwark v KA (Capacity to Marry)* [2016] EWCOP 20 at paragraphs 78-79.

⁴⁹ Save where otherwise indicated, these come from the decision of Bodey J in *A Local Authority v A* [2010] EWHC 1549 (Fam),

⁵⁰ Cobb J in *The Mental Health Trust, The Acute Trust & The Council v DD & Ors* [2015] EWCOP 4 at paragraph 67.

- (b) **A basic understanding of the purpose of contraception.** This understanding would encompass both the reason for contraception and what it does. This would primarily include understanding that there is a likelihood of pregnancy if it is not in use during sexual intercourse;
- (c) **The types of contraception available and how each is used;**
- (d) **The advantages and disadvantages of each type;**
- (e) **The possible side-effects of each and how they can be dealt with;**
- (f) **How easily each type can be changed;**
- (g) **The generally accepted effectiveness of each;**
- (h) **If medically necessary, the important medical information associated with a pregnancy, delivery or future pregnancy.** This is highly specific to the person involved but could include the risk of development of specific medical conditions or complications due to pregnancy or childbirth. For those who suggest a preference for a home birth, the additional risk of a person of home birth must also be understood. The risk of premature birth, where it exists, must be understood, as well as the effects it may have on the child. This is all contingent on there being present one party for whom a further pregnancy could lead to serious health risks, whether physical or mental.⁵¹

12. The following factors are not relevant to this assessment:⁵²

- (a) **The woman's understanding of what bringing up a child would be like in practice;**
- (b) **Any opinion of the woman or other expert or authority as to how she would be likely to get on with child rearing;**
- (c) **Whether any child would be likely to be removed from her care.**

Residence

13. The information relevant to an assessment as to a person's capacity to make a decision as to their

⁵¹ *The Mental Health Trust, The Acute Trust & The Council v DD (By her litigation friend, the Official Solicitor)*, BC [2015] EW COP 4 (Fam)

⁵² Again, all of these come from *A Local Authority v A* [2010] EWHC 1549 (Fam).

place of residence is:⁵³

- (a) **The two (or more) options for living.** This must include the type and nature of the living option, such as whether it amounts to supported living or not, and if so, in what way the protected person will be supported. The person being assessed must also understand what sort of property it is, and the facilities that would be available to them there;
- (b) **Broad information about the area.** This would cover the notional 'sort' of area in which the property is located, and any known specific risks of living in that area beyond the usual risks faced by people living in any other given area;
- (c) **The difference between living somewhere and just visiting it.** Pictorial methods of conducting this assessment may be useful. The courts have approved of a social worker's methodology of asking a person to describe what they understood to be the meaning of living, the meaning of visiting, and to draw the difference between the two, which happened to be a picture of a bed and which held the meaning of overnight stays. This could also include a discussion of what it means to sleep somewhere, and an understanding of the days of the week;
- (d) **The activities that the person being assessed would be able to do if he lived in each place;**
- (e) **Whether and how the person being assessed would be able to see friends and family if he lived in each place;**
- (f) **The payment of rent and bills.** This is not required to be understood in any detail beyond the fact that there will have to be a payment made on their behalf, as for most cases concerning protected persons, the payments will be made by an appointee;
- (g) **Any rules of compliance and/or the general obligations of a tenancy.** Again, the rules are not required to be known in any great detail by the person under assessment but a basic understanding of the fact that there are restrictions, and the areas in which they would operate, will be necessary.
- (h) **Who they would be living with at each placement;**
- (i) **The sort of care they would receive in each placement;**
- (j) **The risk that a family member or other contact may not wish to see the person being assessed should they choose a particular placement against their family's wishes.** This is subject to the caveat below that this should not be presented as a long term and permanent risk with severe consequences on the longer term relationship between the person and the contact involved. To do so would veer

⁵³ This comes from the judgment of Theis J in [LBX v K, L and M](#) [2013] EWHC 3230 (Fam).

towards both emotional manipulation and predicting the future. However, it is perfectly appropriate to warn the protected person of the risk that they may not get many, or any, visits from their contacts where this is born of impracticality, especially if there are long distances or restricted visiting hours involved with any particular residence.

14. The following information will not be relevant to a decision as to capacity concerning residence arrangements of the person being assessed:⁵⁴

- (a) **The cost of the placement and/or the value of money.** The details of the precise financial arrangements are not important to the question of capacity beyond a basic understanding of whether payment is required, as laid out above;
- (b) **The legal nature of the tenancy agreement or licence;**
- (c) **The consequences on the nature of the relationship of the person under assessment with a contact or family member in the long term (10 to 20 years) should the former choose to live independently.** Any long lasting social rejection or breakdown in relations would not count as a “reasonably foreseeable consequence” as required by s.3(4) MCA 2005.

Contact

15. In the delicate task of assessing whether a protected person has the capacity to decide whether to maintain, reduce or eliminate entirely their contact with another person, the factors which constitute relevant information are:⁵⁵

- (a) **Whom the contact will be.** Unlike in sex and marriage cases, the identity of the person in regards to whom the decision would be made is crucial. The decision must always be specific to a particular person.⁵⁶ We are aware that this view is not shared by the Official Solicitor, but in our view the case-law is clear upon the matter;
- (b) **In broad terms, the nature of the relationship between the person under assessment and the contact in question;**
- (c) **What sort of contact the person under assessment could have with each of the individuals with whom they may have contact.** This must include an exploration of different locations in which contact

⁵⁴ These come from [LBX v K, L and M](#) [2013] EWHC 3230 (Fam).

⁵⁵ Save where otherwise stated, these come from the judgment of Theis J in [LBX v K, L and M](#) [2013] EWHC 3230 (Fam).

⁵⁶ MacFarlane LJ in *PC (by her litigation friend the Official Solicitor), NC v City of York Council* [2013] EWCA Civ 478 at [38]

could occur, including within a private home or in a community setting such as a cafe. It must also include an exploration of the duration of contact available to the person under assessment, from an hour to overnight stays. There should also be discussion and understanding of the arrangements regarding the presence of a support worker;

- (d) **The positive or negative aspects of having contact with each person.** This will require a broad discussion which must be kept structured in the assessor's mind. Evaluations must only be disregarded as irrelevant if they are based on "demonstrably false beliefs".⁵⁷ Furthermore, the discussion should include not only current experiences but also a discussion of past pleasant experiences with the contact, of which, in appropriate circumstances, the person under assessment should be reminded.
- (e) **What a family relationship is and that it is in a different category to other categories of contact.** However the assessor must take care not to impose their own values in this assessment;
- (f) **Whether the person with whom contact is being considered has previous criminal convictions or poses a risk to the protected party.** If so, there must be a discussion of the potential risk that the person poses to the protected party, and if such a risk exists, whether the risk should be run. This may entail looking closely at the reasons for conviction and the protected party's ability to understand the danger posed to themselves or others around them.⁵⁸

16. The following are not relevant to the assessment:⁵⁹

- (a) **The nature of friendship and the importance of family ties.** Beyond the idea of a separate category for family relationships, any further exploration of this idea is irrelevant, especially where it may tend to become value laden or parochial;
- (b) **The long term possible effects of contact decisions.** As with residence decisions above, consideration of these would fall into assessment of consequences that are not "reasonably foreseeable" for purposes of the MCA 2005;
- (c) **Risks which are not clearly in issue in the case.** Therefore a consideration of financial abuse or assault when there is no indication of its likelihood would be irrelevant.

17. It is important to recognise that a person may have capacity to consent to sex or marriage, but simultaneously lack capacity to maintain contact with a particular person.⁶⁰ The former involves an

⁵⁷ Theis J in *LBX v K, L and M* [2013] EWHC 3230 (Fam) at paragraph 45.

⁵⁸ Hedley J, approved in *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 13.

⁵⁹ These come from *LBX v K, L and M* [2013] EWHC 3230 (Fam).

⁶⁰ *A Local Authority v TZ (No. 2)* [2014] EWCOP 973.

understanding of “*matters of status, obligation and rights*” whilst the latter “*may well be grounded in a specific factual context.*” The process of evaluating these capacities must be the same but the factors to be taken in to account will differ. Indeed, it is not uncommon for the court to be asked (for example in dementia cases) to regulate the contact that one spouse may have with the other.⁶¹

Care

18. In the context of decisions relating to care, each decision will be specific instead of general, and will have to be revisited should circumstances or the question posed to the person under assessment change. The following constitute relevant information to an assessment of whether a person has capacity to decide their own care:⁶²

- (a) **With what areas the person under assessment needs support;**
- (b) **What sort of support they need;**
- (c) **Who will provide such support;**
- (d) **What would happen without support, or if support was refused.**
- (e) **That carers may not always treat the person being cared for properly, and the possibility and mechanics of making a complaint if they are not happy.**

19. The following are not relevant to any assessment of capacity as to care:⁶³

- (a) **How care is funded;**
- (b) **How overarching arrangements for monitoring and appointing care staff work.**

⁶¹ McFarlane LJ in in [PC and NC v City of York Council](#) [2013] EWCA Civ 478 at paragraph 38.

⁶² Save where otherwise stated, these come from the judgment of Theis J in [LBX v K, L and M](#) [2013] EWHC 3230 (Fam).

⁶³ Save where otherwise stated, these come from the judgment of Theis J in [LBX v K, L and M](#) [2013] EWHC 3230 (Fam).