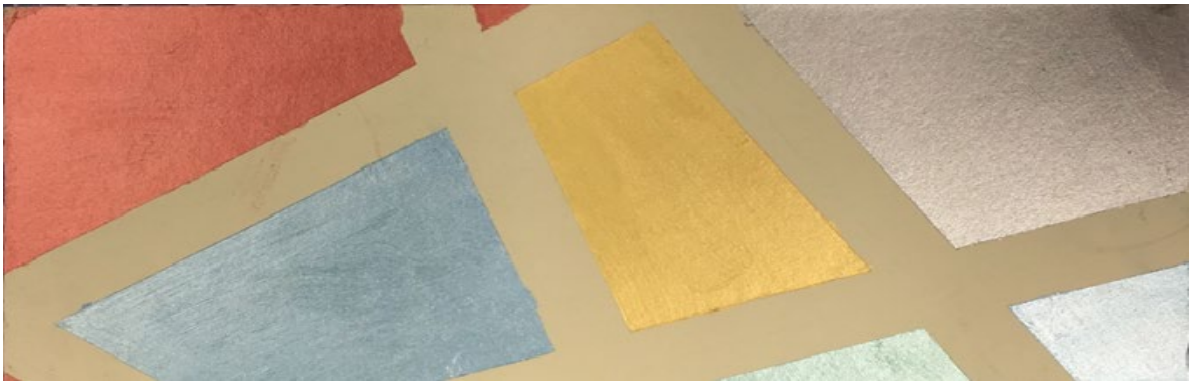
# MENTAL CAPACITY ACT / DOLS CODES OF PRACTICE UPDATE

November 2025



## A: Introduction

1. There are two Codes of Practice to the Mental Capacity Act 2005, one for the main body of the Act, and one for the Deprivation of Liberty Safeguards. They are statutory Codes: they have been approved by Parliament, and the MCA 2005 requires certain people to have regard to them. Those people include anyone acting in a professional capacity.

2. Neither Code of Practice has ever been updated since they were published, the main Code in 2007, and the DoLS Code in 2009. They are both out of date in significant ways. A draft Code (consolidating both parts) was consulted on in 2022, but was never taken forward. The Government announced in October 2025 that there would be a consultation on the Liberty Protection Safeguards, and that consultation responses would inform a final Code. It is unclear: (1) what the scope of that Code will be, and (2) what the timeline is for the Code.

3. Whilst professionals have to have regard to the Codes, they can – and should – depart from them where they have been superseded by case-law which makes clear what the Act itself, the source of the law,[1] means.

4. We have therefore prepared this **entirely unofficial** guide to those parts of the two Codes which are most obviously out of date. There are many other places (for instance scenarios in the main Codes) which might jar with practical experience gained since the MCA 2005 came into force, but we do not cover these here.

[1] See *SBC v PBA and Others* [2011] EWHC 2580 (Fam) at paragraph 67, and also *NHS Trust v Y* [2018] UKSC 46 at paragraph 97.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

## B: The main MCA Code

4. References to paragraphs in this section are to paragraphs in the main Code of Practice.

5. Paragraph 1.2. The discussion of the assumption of capacity needs to be read subject to this important judicial statement:

> *The presumption of capacity is important; it ensures proper respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence. Yet the section 1(2) presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity* [to make the relevant decision]*, the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way.* [2]

6. Paragraph 2.1. The statutory principles first aim to empower the person to decide the matter for themselves (not, as currently stated, to protect people who lack capacity).

7. Paragraph 2.3. The discussion of the assumption of capacity needs to be read subject to the observation above in relation to paragraph 1.2.

8. Paragraph 2.6. The discussion of the support principle needs to be read subject to the observations of Cobb J (as he then was) about its limits in *Calderdale Metropolitan Borough Council v LS & Anor* [2025] EWCOP 10 (T3) in which he noted (at paragraph 95) that:

> *decision-making which could be 'capacitous' only if the decision is made in the environment in which P is 'contained' by a continuous and (materially) 'compulsory' framework of protections, supports and restrictions, in my judgment lacks the quality of autonomy or self-determination which are important characteristics of capacitous decision-making, where the decisions are made "for [oneself]" (section 2(1) MCA 2005 and §9(d) above).*

9. Paragraph 2.12. The statement that "a person's best interests must be the basis for all decisions made and actions carried out on their behalf in situations where they lack capacity to make those particular decisions for themselves" is wrong. The principle only applies where the decision is being made under the MCA 2005. There are many decisions which are made in relation to those with impaired decision-making capacity which are not governed by the MCA 2005. For instance, as Lady Hale made clear in *N v ACCG* [2017] UKSC 22 at paragraph 37:

> *Other service-providing powers and duties also have their own principles and criteria, which do not depend upon what is best for the service user, although that will no doubt be a relevant consideration. The Care Act 2014, which is not relevant in this particular case but will be relevant in many which come before the Court of Protection, creates a scheme of individual entitlement to care and support for people in need of social care. But it has its own scheme for assessing those needs (section 9) and its own scheme for determining eligibility (section 13) and then deciding how those eligible needs should be met (section 24). The Act even provides for the possibility of introducing appeals to a tribunal (section 72), although this has*

[2] *Royal Bank of Scotland Plc v AB* [2020] UKEAT 0266_18_2702. The judgment relates to capacity to conduct proceedings before the Employment Tribunal, but the principles are of broader application.

> *not yet been done. The National Health Service also has its own processes for assessing need and eligibility, albeit not in a legislative context which recognises individual legal entitlement. Decisions can, of course, be challenged on the usual judicial review principles. Decisions on health or social care services may also engage the right to respect for private (or family) life under article 8 of the European Convention on Human Rights, but decisions about the allocation of limited resources may well be justified as necessary in the interests of the economic well-being of the country (see McDonald v United Kingdom [2015] 60 EHRR 1). Here again, therefore, the legal considerations, both for the public authority and for the court, are different from those under the 2005 Act.*

10. This means, in turn, that best interests decision-making is decision-making which is limited to the available options. As Lady Hale put it (at paragraph 35 of *N v ACCG*, in the context of decision-making by the Court of Protection):

> *So how is the court's duty to decide what is in the best interests of P to be reconciled with the fact that the court only has power to take a decision that P himself could have taken? It has no greater power to oblige others to do what is best than P would have himself. This must mean that, just like P, the court can only choose between the "available options".*

11. In relation to clinical decision-making, what is available will depend upon what is considered to be clinically appropriate (and, where relevant, what is actually available within the resource constraints applying to the NHS). As the Court of Appeal put it in *AVS v A NHS Foundation Trust & Anor* [2011] EWCA Civ 7 (at paragraph 38):

> *A declaration of the kind sought [i.e. that treatment was in the person's best interests] will not force the respondent hospital to provide treatment against their clinicians' clinical judgment. To use a declaration of the court to twist the arm of some other clinician, as yet unidentified, to carry out these procedures or to put pressure upon the Secretary of State to provide a hospital where these procedures may be undertaken is an abuse of the process of the court and should not be tolerated.*

12. Chapter 3. The discussion of the support principle needs to be read subject to the observations of Cobb J (as he then was) about its limits in *Calderdale Metropolitan Borough Council v LS & Anor* [2025] EWCOP 10 (T3) in which he noted (at paragraph 95) that:

> *decision-making which could be 'capacitous' only if the decision is made in the environment in which P is 'contained' by a continuous and (materially) 'compulsory' framework of protections, supports and restrictions, in my judgment lacks the quality of autonomy or self-determination which are important characteristics of capacitous decision-making, where the decisions are made "for [oneself]" (section 2(1) MCA 2005 and §9(d) above).*

13. Paragraph 4.3: the order of "This means that" needs to be reversed as per below.

14. Paragraphs 4.10-4.15 (and cross-references such as 4.46). The Code is wrong when it says that there is a two-stage test for determining capacity, starting with the question of whether the person has an impairment or, or disturbance, in the functioning of their mind or brain. The Supreme Court in *A Local Authority v JB* confirmed, however, that it is necessary to start with the second stage in

the Code: i.e. whether the person is functionally able to make the decision.[3] In *MacPherson v Sunderland City Council* [2024] EWCA Civ 1579, the Court of Appeal noted (at paragraph 36) that:

> *It should be noted that the MCA 2005 Code of Practice at para. 4.11 is in direct contradiction to the judgment in Re JB and stipulates the two-stage test of capacity should be approached with the first stage being to establish whether someone has an impairment (i.e. the diagnostic test) and only then to move onto the functional test. A new draft Code dated June 2022 but yet to be implemented, adopts the Re JB approach.* ***Regardless of the fact that the new Code has not yet been implemented, all assessments should comply with the Supreme Court approach*** *(see Hemachandran v University Hospitals Birmingham NHS Foundation Trust [2024] EWCA Civ 896 para.[140] (iii)).* (emphasis added)

15. Paragraph 4.19. The Code only refers to the foreseeable consequences that the person must be able to understand, retain, use and weigh by reference to consequences for the person. The Supreme Court in *A Local Authority v JB* confirmed, however, that those reasonably foreseeable consequences can include not just the consequences for the person but also, where relevant, the consequences for others.[4]

16. Paragraph 4.23. The Code suggests that the 'communication' limb of the capacity test should only be used for the situation where the person who cannot communicate their decision at all. This remains its primary purpose, and the communication limb should not be relied upon if the assessor identifies that the person is unable to understand, retain, use or weigh the relevant information, as at that point the person has made no decision to communicate. However, research shows that the courts have broadened the criterion also to include the situation where the person is unable to express a stable preference:[5] in such a situation, the assessor does not have access to the person's real choice.

17. Paragraphs 4.26-4.27. The discussion of fluctuating capacity conflates temporary incapacity which can be resolved by taking steps to support the person and genuinely fluctuating capacity. Our capacity guide addresses how the courts have approached the situation of genuinely fluctuating capacity.

18. Paragraphs 4.36-4.37. The discussion here conflates operation of the support principle and the consideration of capacity where there is good reason to doubt capacity: see the observation in relation to paragraph 1.2 above.[6] Wherever there is good reason to doubt capacity, the person's capacity needs to be considered – i.e. it is necessary to consider whether they can understand, retain, use and weigh the relevant information, and to communicate their decision (and, if they cannot, why not).

19. Paragraphs 4.57 to 4.59. The discussion about the situation where it is difficult to engage the person (nb, it is not good practice to talk about a person 'refusing to be assessed,' as it loads the problem onto the person, when it might well be with the assessor) needs to be read subject to the

[3] See *A Local Authority v JB* [2021] UKSC 52 at paragraph 79. See also our capacity guide.
[4] See *A Local Authority v JB* [2021] UKSC 52 at paragraph 73.
[5] Note, **inability** to express a stable preference is different to being **able** to, but **unwilling**. See our capacity guide.
[6] See also our capacity guide.

observations of Poole J in *AMDC v AG* [2020] EWCOP 58 at paragraph 28(h).

> *h. If on assessment P does not engage with the expert, then the expert is not required mechanically to ask P about each and every piece of relevant information if to do so would be obviously futile or even aggravating. However, the report should record what attempts were made to assist P to engage and what alternative strategies were used. If an expert hits a "brick wall" with P then they might want to liaise with others to formulate alternative strategies to engage P. The expert might consider what further bespoke education or support can be given to P to promote P's capacity or P's engagement in the decisions which may have to be taken on their behalf. Failure to take steps to assist P to engage and to support her in her decision-making would be contrary to the fundamental principles of the Mental Capacity Act 2005 ss 1(3) and 3(2).*

20. Further, to the extent that paragraph 4.59 appears to suggest that the only recourse where it is not possible to persuade a person to open the door to their house to undergo a capacity assessment is to consider an application for admission under the MHA 1983, it is wrong. The threshold for approaching the Court of Protection under s.48 MCA 2005 is whether there is reason to believe that the person lacks capacity to make the relevant decisions.[7] Depending on the situation, it may well be that there is sufficient circumstantial evidence to be able to bring an application to the Court of Protection to enable further steps to be considered.

21. Chapter 5. The approach to best interests in this chapter must be read subject to the observations in relation to paragraph 2.12 of the Code above about the situations in which best interests are truly in play.

22. Paragraphs 5.5-5.7 and 5.13. The discussion of best interests has to be read subject to the decision of the Supreme Court in *Aintree v James* [2013] UKSC 67, in particular Lady Hale's emphasis (at paragraph 45) that the "*purpose of the best interests test is to consider matters from the* [person's *point of view*." See also our best interests guide, which sets out how the courts approach questions of best interests.

23. Paragraph 6.4. A misconception that s.5 MCA 2005 could only be used in the case of emergencies was comprehensively put to bed by the Vice-President of the Court of Protection, Theis J, in *Leicestershire County Council v P & Anor (Capacity: Anticipatory declaration)* [2024] EWCOP 53 (T3) (see paragraph 137(6)(a).

24. Paragraphs 6.8-6.14. The Code's discussion of the operation of s.5 MCA 2005 in the context of moves of residence needs to be read subject to (1) subsequent case-law about the limits of s.5 in this context (discussed here); and (2) the operation of the Deprivation of Liberty Safeguards where these apply.

25. Paragraphs 6.18-6.19. The discussion of when applications are required in the context of medical treatment is no longer accurate. The position is now summarised in the Serious Medical

[7] *Barnet Enfield And Haringey Mental Health NHS Trust & Anor v Mr K & Ors* [2023] EWCOP 35 at paragraph 57, where the court emphasised that "*the language of section 48 needs no gloss and that the court need not be satisfied, on the evidence available to it, that the person lacks capacity on the balance of probabilities, but rather a lower test is applied. Belief is different from proof*."

Treatment Guidance issued by the then-Vice-President of the Court of Protection, Hayden J, on an interim basis pending the production of a revised Code. See also *Cardiff and Vale UHB v NN* [2024] EWCOP 61 (T3) at paragraph 43.

> *A final observation: the application in this case was to authorise a possible future deprivation of liberty which did not, in fact, materialise. It would be reasonable for NN or her mother to ask what purpose was served by the proceedings and what benefit they had for NN. It is incumbent on those concerned with obstetric* [and other] *cases to give the most careful scrutiny at the earliest possible stage to whether orders are actually required from the Court of Protection, and if so, the substance of those orders. In this case, the minutes of various professionals meetings held in June and July 2024 suggest that there was a mistaken belief that any best interests decision about termination of pregnancy for a person without capacity required court authorisation. If there is a professional consensus about the treatment proposed, no intention to impose treatment on P against her wishes, and no disagreement from those concerned with P's welfare such as close family members, the provisions of s.5 and s.6 MCA 2005 permit medical best interests decisions to be taken without court involvement, having followed the requirements of the MCA and any associated professional guidance: An NHS Trust v Y [2018] UKSC 46.*

26. Paragraphs 6.49-6.53. The discussion of deprivation of liberty is now significantly out of date. A summary of the current position can be found here.

27. Paragraph 6.58. Note that the Court of Appeal confirmed in *Aster Healthcare Ltd v The Estate of Mr Mohammed Shafi, Deceased* [2014] EWCA Civ 1350 that s.7 MCA 2005 does not come into play where it is not intended by the supplier that the recipient should pay for the goods and services.

28. Paragraph 7.7. Note that the suggestion that the certificate provider is simply confirming that the donor understands the purpose of the LPA is insufficient. Poole J confirmed the relevant information that a person has to have in order to be able to make an LPA in *The Public Guardian v RI & Ors* [2022] EWCOP 22 (see paragraph 27), and Lieven J confirmed in *TA v The Public Guardian* [2023] EWCOP 63 that the certificate provider must actually show that they have considered the donor's capacity (see paragraphs 29 to 33)

29. Paragraphs 8.24. The discussion of when applications are required in the context of medical treatment is no longer accurate. The position is now summarised in the Serious Medical Treatment Guidance issued by the then-Vice-President of the Court of Protection, Hayden J, on an interim basis pending the production of a revised Code.

30. Paragraph 8.38. The Code is wrong when it says that personal welfare deputies will only be appointed in the most difficult cases. The correct position was set out in *Re Lawson, Mottram and Hopton, Re (appointment of personal welfare deputies)* [2019] EWCOP 22, namely that (1) each case falls to be decided on its merits, and by reference to whether an appointment is in the best interests of P; (2) P's wishes and feelings will form an aspect of that decision (for instance if it is clear that P would wish a family member to be appointed to be their personal welfare deputy); and (3) the proper operation of s.4 and s.5 MCA 2005 means that, in practice, personal welfare deputies will not often be appointed, in particular because the appointment should not be seen, in and of itself, as less restrictive of P's rights and freedoms.

31. Paragraph 9.40. The case of *Re PW (Jehovah's Witness: Validity of Advance Decision)* [2021] EWCOP 52 makes clear that a person can 'do something clearly inconsistent' with an ADRT remaining their fixed decision even after they have lost capacity to make the relevant decision about medical treatment.

32. Paragraphs 9.67 to 9.70. The discussion about the role of the Court of Protection in the case of ADRTs needs to be read subject to the decision of Poole J in *Re AB (ADRT: Validity and Applicability)* [2025] EWCOP 20 (T3).

33. Chapter 13. The chapter relating to the interface between the MCA 2005 and the MHA 1983 pre-dates the introduction of the Deprivation of Liberty Safeguards and Schedule 1A to the MCA 2005 and is therefore of only limited use. More recent statutory guidance in relation to the interface can be found in Chapter 13 of both the English Code of Practice to the MHA 1983 and the Welsh Code of Practice to the MHA 1983. An overview of the interface can be found here, with the most recent case being *Manchester University Hospitals NHS Foundation Trust v JS & Anor (Schedule 1A Mental Capacity Act 2005)* [2023] EWCOP 33.

## C: The DoLS Code of Practice

34. References to paragraphs in this section are to paragraphs in the DoLS Code of Practice.

35. Paragraphs 2.1-2.24. The discussion of deprivation of liberty is now significantly out of date. A summary of the current position can be found here.

36. Paragraphs 3.2-3.3 (and cross-references). The discussion of authorising deprivation of liberty is out of date in terms of the identity of supervisory bodies in England in respect of hospital DoLS, and also does not take account of the situations where authority cannot be provided by DoLS but needs to be sought from the Court of Protection (as to which, see this guidance here).

37. Paragraph 4.9. Case-law has made clear that the information that the person must be able to understand, retain, use and weigh for purposes of the capacity assessment includes the key elements of the arrangements for them which give rise to a confinement. This is not the same decision as a decision on residence: *Wareham v Betsi Cadwaladar University Health Board & Ors* [2024] EWCOP 15 at paragraph 69.

38. Paragraphs 4.40-4.51. The discussion of the interface between the MCA 2005 and the MHA 1983 needs to be read subject to the significant body of case-law decided subsequently. An overview of the case-law and the interface can be found here, with the most recent case being *Manchester University Hospitals NHS Foundation Trust v JS & Anor (Schedule 1A Mental Capacity Act 2005)* [2023] EWCOP 33.

39. Paragraph 7.12. The discussion of the selection of the Relevant Person's Representative needs to be read subject to the analysis of their role in *Re AJ* [2015] EWCOP 5.

40. Paragraph 7.25. The discussion of supporting and monitoring the Relevant Person's Representative needs to be read subject to *Re AJ* [2015] EWCOP 5, which clarifies the role of the supervisory body in terms of ensuring that the RPR is doing their job in terms of enabling the person

to challenge their deprivation of liberty.

41. Paragraph 10.2. The discussion of applications to the Court of Protection needs to be read subject to *Re RD & Ors (Duties and Powers of Relevant Person's Representatives and Section 39D IMCAS)* [2016] EWCOP 49, which sets out a clear template for (1) identifying whether the person has capacity to make an application; and (2) what to do if they do not.

## D: Useful resources

42. Useful free websites include:

- www.39essex.com/resources-and-training/mental-capacity-law – database of guidance notes (including as to capacity assessment) case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Report, 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.capacityguide.org.uk – a website which draws upon both this guidance and research conducted by the Mental Health and Justice project to give further assistance to those thinking about capacity, especially in more difficult situations.
- www.lpslaw.co.uk – a website set up by Neil which includes videos, papers and other materials relating both to the Liberty Protection Safeguards and the MCA 2005 more widely;
- 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.

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