



A: Introduction

1. This purpose of this document is to provide for social workers and those working in front-line clinical settings a brief overview of the law and principles relating to the assessment of best interests. Its focus is on: (a) how to apply the MCA 2005 principles when assessing best interests; and (b) how to record your assessment, primarily in the context of health and welfare decisions.¹ It is a companion to our brief guide to carrying out capacity assessments.²
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. Nor does it take the place of the MCA Code of Practice, to which professionals must have regard; it does, however, summarise case-law that has been determined since that Code of Practice was written which has made clear how the MCA 2005 is to be applied.

B: Key principles

3. The core principles of the MCA 2005 are set out in s.1.

¹ Useful 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.

² See Section G.

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Disclaimer: This document is based upon the law as it stands as at November 2017; 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 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.

The core principles are:

- s.1(2): a person (P) must be assumed to have capacity unless it is established that he lacks capacity (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, r7), but it is a convenient shorthand);
 - 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): a person 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 the MCA for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
 - 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.
4. We set out the principles relating to capacity because it cannot be emphasised enough that all practicable steps must be taken to support a person to take their own decisions before any question of best interests assessment arise. In other words, the better the application of the MCA, the fewer best interests decisions will be required.

C: Best interests assessment as a process

5. 'Best interests' is – deliberately – not defined in the MCA 2005. However, s.4 sets out a series of matters that must be considered whenever a person is determining what is P's best interests. It is extremely important to understand that the MCA does not specify what is in the person's best interests – it sets down the process to apply. In other words, it is possible for two individuals conscientiously to apply the s.4 'checklist' and to come to different views as to where P's best interests lie; so long as both views were reasonable, both could act upon their beliefs to carry out routine acts of care and treatment safe in the knowledge that they were protected from liability under s.5 MCA 2005.³
6. Assessing best interests is therefore a process. It is a process that recognises that a conclusion

³ So long as, if those acts amounted to restraint, they also satisfied the additional requirements that are imposed by s.6 MCA 2005 – i.e. that the act is necessary and proportionate to the likelihood of P suffering harm and the seriousness of that harm.

that a person lacks decision-making capacity is not an “off-switch” for their rights and freedoms.⁴ It might perhaps best be considered as a process of constructing a decision on behalf of the person who cannot make that decision themselves.⁵ As the Supreme Court emphasised in *Aintree University NHS Hospitals Trust v James*⁶ (a medical treatment case) “[t]he purpose of the best interests test is to consider matters from the patient’s point of view.”⁷ It is critically important to understand that the purpose of the process is to arrive at the decision that health and social professionals reasonably believe is the right decision for the person themselves, as an individual human being⁸ – not the decision that best fits with the outcome that the professionals desire.

7. In practice, the process of assessing best interests can be made more difficult by confusion (1) as to whose task it is to determine where a person’s best interests lie; and (2) between best interests decision-making on behalf of that person and decision-making by public bodies as to the health or social care services to deliver to that person. We address both of these matters in Section F.
8. There are two last important points to emphasise here:
 - (1) Because best interests assessment is a process, what is required is an understanding of how to apply that process to the facts of any given case, and how to document the application of that process. It is only that way that health and social professionals can reach decisions that can properly be defended in the event of any subsequent challenge;
 - (2) What will be required in any given case will depend upon the urgency and gravity of the situation. As the Court of Appeal has emphasised, the defence afforded to health and social care professionals delivering routine acts of care and treatment⁹ is “*pervaded by the concepts of reasonableness, practicability and appropriateness.*”¹⁰ What will be required to have a reasonable belief as to a person’s best interests in the context of an A&E department at 3:00 am will be very different to what may be required in the context of a decision whether an elderly person with dementia should move from their home of 60 years into a care home.

⁴ *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60 at paragraph 11. Hyperlinks in this Guidance Note are to the case comments in the database maintained by the editors of the 39 Essex Chambers Mental Capacity Law [Report](#). For further useful resources, see Section G below.

⁵ The concept of ‘constructing decisions’ is one that we have adopted, with gratitude, from the pioneering work of Adrian Ward, chair of the Mental Health and Disability Committee of the Law Society of Scotland. See, in particular, Chapter 13 of Adrian’s *Adult Incapacity* (2003, W Green).

⁶ [2014] UKSC 67.

⁷ At paragraph 45.

⁸ *Aintree* at paragraph 45.

⁹ Under s.5 MCA 2005 (in some cases read together with s.6).

¹⁰ *Commissioner of Police for the Metropolis v ZH* [2013] EWCA Civ 69 at paragraph 40.

D: The checklist

9. Section 4 MCA contains a checklist of factors which can be summarised as follows.¹¹ Not all the factors in the best interests 'checklist' will be relevant to all types of decisions or actions, but they must still be considered if only to be disregarded as irrelevant to that particular situation.

Equal consideration and non-discrimination

10. The person determining best interests must not make assumptions about someone's best interests merely on the basis of their age or appearance, condition or an aspect of their behaviour.

All relevant circumstances

11. Try to identify all the issues and circumstances relating to the decision in question which are most relevant to the person who lacks capacity to make that decision.

Regaining capacity

12. Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

Permitting and encouraging participation

13. Do whatever is reasonably practicable to permit and encourage the person to participate, or to improve their ability to participate, as fully as possible in any act done or any decision affecting them.

The person's wishes, feelings, beliefs and values

14. Try to find out the views of the person lacking capacity, including:
- The person's past and present wishes and feelings – both current views and whether any relevant views have been expressed in the past, either verbally, in writing or through behaviour or habits.
 - Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
 - Any other factors the person would be likely to consider if able to do so (this could include the impact of the decision on others¹²).

¹¹ This section draws on chapter 3 of the 4th edition of the Law Society/British Medical Association "Assessment of Mental Capacity" (2015), edited by Alex.

¹² A good example of this is *David Ross v A* [2015] EWCOP 46, where Senior Judge Lush authorised the payment of P's brother's school fees from P's clinical negligence award in circumstances where it was clear that P's wellbeing depended in large part upon the wellbeing of her family as a whole.

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15. It is extremely important in this process to take all practicable steps to assist the person concerned in expressing their wishes and feelings (and to document those steps).
16. It may not always be possible to identify reliable wishes and feelings. It may also be the case that a person's past wishes and feelings may be radically different to those that they are now demonstrate. However, as Lady Hale has emphasised: "*insofar as it is possible to ascertain the [person's] wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.*"¹³ Or, as Peter Jackson J has put it: "[t]o state the obvious, the wishes and feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone else, and may even be more important."
17. The precise weight to be placed upon a person's wishes and feelings remains a matter of some debate, in particular where the person's reliably identifiable wishes and feelings suggest a course of action that would be profoundly risky for them.¹⁴ The test is not, in general a "*what P would have done test*,"¹⁵ but it is clear that, at least as regards medical treatment, the weight to be attached to the reliably ascertainable views of P should be given very substantial, if not determinative, weight.¹⁶
18. It is likely that in due course the MCA 2005 will be amended to place a greater emphasis upon identifying and where possible following the wishes and feelings of the person concerned.¹⁷ In the meantime, however, we suggest that it is (at a minimum) good practice¹⁸ that where it is possible to identify the course of action that the person would have taken had they had capacity, then any departure from that course of action must be justified by the health and social professionals involved. The greater the departure, the more compelling must be the reason.
19. There may well be situations in which it is clear that what P wants is not available. As the Supreme Court made clear in *Aintree v James*¹⁹ and also *N v ACCG*,²⁰ a person lacking capacity is not in a better position than a person with such capacity. If the option would not be available for the person

¹³ *Aintree University NHS Hospitals Trust v James* [2014] UKSC 67 at paragraph 45.

¹⁴ For more detail on this debate, see the article by Alex and Cressida Auckland '*More Presumptions Please, Wishes, Feelings and Best Interests Decision-Making*' (2015) Elder Law Journal 293, also available [here](#).

¹⁵ *Briggs v Briggs (No 2)* [2016] EWCOP 53.

¹⁶ See, for instance, both the *Briggs* case, concerning maintaining life-sustaining treatment and *B v D* [2017] EWCOP 15, concerning experimental stem cell treatment.

¹⁷ Not least so as to bring it into greater compliance with the Convention on the Rights of Persons with Disabilities, which is a profound challenge to the model of decision-making contained in the MCA 2005.

¹⁸ Indeed, it is arguable that this is required by Article 8 of the European Convention on Human Rights as an aspect of the requirement to respect the person's right to autonomy, a right that they do not lose on the loss of decision-making capacity: see *A Local Authority v E & Ors* [2012] EWHC 1639 (COP) at paragraphs 124 and 125. Applying conventional principles, any interference with a person's right to respect for their autonomy must be justified on the basis that it is necessary and proportionate.

¹⁹ At paragraph 45.

²⁰ [2017] UKSC 22.

even if they had capacity and were demanding it, there is no requirement that it be put on the table by way of a best interests decision-making process. We address this further in Section F below.

The views of other people

20. Consult other people, if it is practicable and appropriate to do so, for their views about the person's best interests and, in particular, to see if they have any relevant information about the person's wishes, feelings, beliefs or values.²¹ But be aware of the person's right to confidentiality – not everyone needs to know everything. In particular, it is important to consult:

- anyone previously named by the person as someone to be consulted on the decision in question or matters of a similar kind;
- anyone engaged in caring for the person, or close relatives, friends or others who take an interest in the person's welfare;
- any attorney under a Lasting or Enduring Power of Attorney made by the person;
- any deputy appointed by the Court of Protection to make decisions for the person.

21. As the purpose of consultation is to enable a best interests decision to be made on behalf of the person, consultation is not necessary where it would be likely to be unduly onerous, contentious, futile or serve no useful purpose.²² Clear reasons should always be given identifying why – for instance – a spouse is not to be consulted on one of these grounds.

Life sustaining treatment

22. Where the decision concerns the provision or withdrawal of life-sustaining treatment (defined in the MCA as being treatment which a person providing healthcare regards as necessary to sustain life²³), the person determining whether the treatment is in the best interests of someone who lacks capacity to consent must not be motivated by a desire to bring about the individual's death.²⁴

E: Applying the checklist and documenting the decision

23. In assessing (and recording) where someone's best interests lie, the critical first step is to identify what the decision is that is to be taken on P's behalf. This means that it will be necessary to identify what the options actually are between which a choice is being made on P's behalf. It may, sometimes, not be possible fully to identify those options before the assessment process starts (because it may be that a further option becomes clear during the process of assessment);

²¹ *Aintree v James* at paragraph 39 – the person undertaking the assessment “*must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be*” (emphasis added).

²² *Re Allen*, 2009 - an unreported decision of Senior Judge Lush (Case Number 1166192).

²³ s.4(10) MCA 2005

²⁴ s.4(5) MCA 2005

however, absent sufficient clarity before the assessment process begins, the almost inevitable consequence will be confusion on the part of all concerned.

24. Having identified – provisionally – each of the options that are on the table, and having taken the steps necessary to identify (for instance) P's wishes and feelings, it can be extremely helpful to draw up a balance-sheet of the benefits and risks or disadvantages to P of each of those options.²⁵ It is often easiest to do this in table form, or using bullet points, so that the reader can easily see the issues and can compare the various options under consideration. Don't forget to include practical implications for P as well as less tangible factors such as relationships with family members and care home staff.
25. For each option, it can be very helpful to set out (with reasons):
 - a. The risks and benefits to P;
 - b. The likelihood of those risk and benefits occurring;
 - c. The relative seriousness and/or importance of the risk and benefits to P.
26. It is extremely important to be clear that it is possible for there to be many apparent risks to P of a particular course of action and only one benefit, but that that benefit is of overriding importance. Such a benefit is sometimes called the factor of "magnetic importance."²⁶
27. Having decided that certain risks are worth taking in P's best interests, or that certain disadvantages are outweighed by benefits, it is important to show that you have considered what could be done to reduce these risks or disadvantages and set out detailed plans for dealing with them. This might include additional care or staff support for particular periods of time, or the provision of financial assistance to ensure that relationships can continue.
28. Where there is the prospect that a proposed option may fail in the short or medium term, there must be thought given to what will happen in those circumstances, so as to minimise the chances that hasty and off-the-cuff decisions will not suddenly be required, to the possible detriment of P.
29. It should be noted that it may well be that the process of carrying out the assessment of the risk and benefits will show either that an option previously thought to be available is no longer available or that an option that had previously ruled out becomes available. If so, it is vital that the balance-sheet is redrawn to take account of the options as they now stand.
30. Although it may seem clear in light of the analysis of benefits and disadvantages, it is helpful to set out separately a conclusion about which option you consider to be in P's best interests and why. This is particularly important where there is a dispute and where the option you prefer entails

²⁵ Following the well-established 'balance sheet' approach identified by Thorpe LJ in *Re A* [2000] 1 FLR 549 at 560.

²⁶ See, for instance, *Re M, ITW v Z, M and Others* [2009] EWHC 2525 (Fam).

significant disadvantages to P, such as a loss of independence, intrusion into a longstanding relationship, or inevitable distress caused by a change of environment. In such a case, it is also important to be clear why no less restrictive course can be chosen so as to comply with the principle set down in s.1(6) MCA 2005.

31. Setting out the separate conclusion can also guard against a danger that the courts have identified in the otherwise useful balance-sheet approach, namely that completing a table can lead to a loss of attribution of weight to each factor *"all elements of the table having equal value as in a map without contours."* In other words, *"[i]f a balance sheet is used it should be a route to judgment and not a substitution for the judgment itself."*²⁷ Making sure that you have clearly identified in narrative form at the end in a separate conclusion why the particular option you have identified is in P's best interests can help make sure that you do not fall into this trap.

F: Wider questions

32. In this section, we address two wider questions that regularly cause confusion in the context of the assessment of best interests.

Who determines best interests?

33. It is important to note that with very few exceptions, the MCA 2005 does not identify who is to decide whether a person lacks capacity and (if they do) what is in their best interests. This was deliberate because Parliament's intention was that the vast majority of such decisions in the context of care and treatment will be taken informally by those charged with delivering such care and treatment.²⁸ This silence can in practice cause considerable difficulties in settings where the expertise of different individuals (including the person's family) is being called upon.

34. We suggest the following principles provide a route map through:²⁹

- A person who wishes to carry out an act in connection with the care or treatment of another on the basis of their best interests will only be protected from criminal and civil liability if they are reasonably satisfied that the person lacks capacity in the material regard(s) and that the action to be taken is in the person's best interests;³⁰

²⁷ *Re F (A Child) (International Relocation Cases)* [2015] EWCA Civ 882 at paragraph 52; see also *M v Mrs N* [2015] EWCOP 76 at paragraph 46.

²⁸ See in this regard *G v E (Deputyship and Litigation Friend)* [2010] EWHC 2512 (COP).

²⁹ These are adapted from an article written by Alex and Ben Troke of Browne Jacobson LLP for the Faculty of Intensive Care Medicine's *Critical Eye July 2015* newsletter.

³⁰ Section 5 MCA 2005; where the action will involve restraint, the additional safeguards required by s.6 must be satisfied: are the actions also necessary and proportionate having regard to the potential of harm to P if they are not (including the likelihood and the seriousness of that harm)?

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- In very many cases, what will be in the person's best interests is a decision that will be reached informally and collaboratively between the health or social care professionals (as the experts in their respective disciplines), the person themselves (where this is possible) and the person's family³¹ (as experts in the patient), seeking to make the decision that is right for the patient as an individual human being;
 - Importantly, however, in the event of a dispute as to what may be in the person's best interests, the MCA 2005 does not give a special status either to health or social care professionals or to the person's family simply by virtue of their respective statuses. If there is a dispute about best interests among available options which cannot be resolved by discussion, then – ultimately – it is for the Court of Protection to decide on the person's behalf;
 - That the person's family, friends or advocate family demand a particular course of action as being in the person's interests does not compel health or social care professionals to offer it if it would not be available if the person had capacity. We return to this below;
 - Where the person has made a valid and applicable Lasting Power of Attorney giving authority to an attorney (or attorneys) to take decisions on their behalf, then, whilst it is for health and social care professionals to propose options, the decision as to the person's best interests is for the attorney (or attorneys), not the health or social care professional. As with a person with capacity, or any family member, an attorney cannot demand an option that health or social professionals have (properly) not put on the table;
 - Similarly, where a person has a court-appointed deputy with authority to make the material decision, the deputy can choose on the person's behalf and in their best interests between the options proposed by the health or social care professionals;³²
 - Where there is a dispute as to where a person's best interests lie (or where health or social care professionals have reason to doubt that an attorney or a deputy is making decisions on their behalf in their best interests), the only place to get an authoritative determination of where those best interests lie is in the Court of Protection.

35. In the context of authorising deprivations of liberty under Schedule A1 to the MCA 2005 ('DOLS'), Parliament has given a specific role to both best interests assessors and signatories to consider where the person's best interests lie. This is a particular – but very important – aspect of best interests decision-making because neither the best interests assessor nor the signatory will actually be involved in the delivery of care and treatment to the person concerned. Rather, their

³¹ Or close friends – i.e. those people 'properly interested in the person's welfare' for purposes of s.4(7) MCA 2005.

³² A health and welfare deputy can never have authority to refuse consent to the carrying out or continuation of life-sustaining treatment in relation to P: s.20(1) MCA 2005.

task is to assess whether the 'best interests plus' test set down in DOLS is met³³ as part of the determination of whether authority should be granted to a managing authority to deprive the person of their liberty.³⁴

The available options

36. It is critically important that health and social care professionals are clear that not all decisions involving a person lacking capacity in one or more domains are, in fact, best interests decisions.³⁵ In almost all cases involving either the delivery of medical care or the provision of social services there will be two stages:
- a. A decision by the health or social care professionals as to what options to offer, taking into account the relevant duties upon those professionals (for instance, in the case of social care professionals in England, the duties imposed upon the local authority upon whose behalf they act to assess and meet eligible needs by the Care Act 2014). This is not a best interests decision because it is not a decision that the person themselves would take;
 - b. A best interests decision that is reached by the collaborative process identified above on the person's behalf as to which option to accept.
37. In practice, there may be some blurring of the lines. For instance, the courts have made it very clear that doctors must be extremely careful when deciding what treatments to offer (or not to offer) not to be unduly swayed by their value judgments as to the quality of the patient's life.³⁶ In the social care context, professionals must also be very careful that, by adopting too cautious an approach to risk, they do not thereby inadvertently render the resulting package of care so expensive that it becomes unavailable. Put another way, it can be very easy inadvertently for risk aversion to become self-fulfilling: being insufficiently accepting of potential risks faced at home by a service user with (say) learning disabilities could then lead to a conclusion that they require 24 hour care. Such 24 hour care would, inevitably, be significantly more expensive than a placement in a care home; the inevitable consequence would then be that only the care home would be on offer,³⁷ such that the available options between which a choice could be made on the service user's behalf would have been unduly constrained.

³³ It is 'best interests plus' because the question is not merely whether the deprivation of liberty is in the person's best interests, but also whether it is necessary and proportionate for them to be deprived of their liberty (having regard to the likelihood and seriousness of the harm that they would suffer otherwise): see paragraph 16 of Schedule A1.

³⁴ See Charles J in *Re NRA & Ors* [2015] EWCOP 59 at paragraphs 64-68.

³⁵ See the decision of the Supreme Court in *N v ACCG* [2017] UKSC 22.

³⁶ See, for instance *Aintree University Hospitals NHS Foundation Trust v James and others* [2013] UKSC 67.

³⁷ Where two options both properly meet a person's social care needs, a public body may take into account that one costs less than another: *McDonald v Royal Borough of Kensington & Chelsea* [2011] UKSC 33.

38. Ultimately, however, there will be some decisions that are those for professionals to take as representatives of the relevant public bodies upon whose behalf they act in the discharge of the powers and duties of that body. Those are not best interests decisions, and meetings where such decisions are considered and reached are not best interests meetings. In practice, a failure to be clear as to this both in conversations with others (in particular family members) and in the context of best interests assessment is likely to lead to confusion. The courts are increasingly likely to be severe in their criticism where such confusion has led to unnecessary proceedings before the Court of Protection in circumstances where, in fact, there was never more than one option on the table, and the real location for any challenge should have been the Administrative Court, challenging the funding decisions.
39. That having been said, when matters are before the court, the Supreme Court made clear in *N v ACCG* that robust case management by the Court of Protection “*does not mean that a care provider or funder can pre-empt the court’s proceedings by refusing to contemplate changes to the care plan. The court can always ask itself what useful purpose continuing the proceedings, or taking a particular step in them, will serve but that is for the court, not the parties, to decide*”.³⁸

G: Useful resources

40. 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.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

³⁸ *N v ACCG* at paragraph 43.

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