A BRIEF GUIDE TO CARRYING OUT BEST INTERESTS ASSESSMENTS

April 2019

A: Introduction

1. The purpose of this document is to provide best interests decision-makers with a brief overview of the relevant law and principles. 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 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 April 2019; 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 arise. In other words, the better the application of the MCA, the fewer best interests decisions will be required. In many respects, having to determine someone's best interests should be seen as a failure: a failure to enable the person to decide for themselves.

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 in P's best interests. It is extremely important to recognise that the MCA does not specify what is in the person's best interests. Rather, it sets down a process by which that conclusion should be reached. 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 recognises that a person who lacks decision-

[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.

making capacity is not an "off-switch" for their rights and freedoms.[4] The process aims to construct 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 being[8] – 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. This way, 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 treatment[9] 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.

D: The checklist

9. Section 4 MCA contains a non-exhaustive checklist of factors which can be summarised as

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[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.

follows.[11] Not all the factors in the best interests 'checklist' will be equally 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. It is all too easy, for instance, to proceed on the basis of unconscious assumptions about the extent to which it is appropriate to "allow" people with learning disability to take risks.

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. As part of the capacity assessment, the decision-maker should already have identified all the salient details of the decision which, because of incapacity, now falls to be made.

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? If it can, do not make a best interests decision now. There is no need to do so.

Permitting and encouraging participation

13. "No decision about me without me" rightly encapsulates this point. 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 word 'permit' here is problematic (although it appears in the MCA), because it suggests that this is something being gifted by others. Instead, the focus should be on <u>supporting</u> P to participate as a vitally important part of the process. The duty also extends to improving the person's ability to participate as well. And, of course, in some situations, you may find that the very process of doing this in fact leads you to reconsider whether they do not, in fact, have the capacity to make their own decision.

The person's wishes, feelings, beliefs and values

14. Involving the person and their supporters ought to reveal these considerations; their importance cannot be overestimated. Do whatever you can to find out:

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[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.

- 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 others[12]).

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. Those who know us are often the best source of information. But it may not always be possible to identify reliable wishes and feelings.[13] It may also be the case that a person's past wishes and feelings may be radically different to those that they now demonstrate.[14] However, as Lady Hale 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."*[15] 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.[16] The test under the MCA 2005 is not a "*what P would have done test*,"[17] 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

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[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.

[13] A good example being *Secretary of State for the Home Department v Skripal* [2018] EWCOP 6 where Williams J had to consider whether it was in the best interests of two seriously ill Russian nationals to have blood samples taken and medical records accessed; there was no evidence of their past or present wishes or feelings regarding the issue at hand. This case was ultimately resolved by reference to the guidance in the statutory Code of Practice to "the duties of a responsible citizen" as a factor that a person might take into account if they were able to.

[14] See, for discussion of this, Alex's article, When past and present wishes collide: the theory, the practice and the future (2015) Elder Law Journal 132, available here.

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

[16] 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.

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

determinative, weight.[18] Pending further elaboration in the Code of Practice (under review at the time of the updating of this guide), we suggest that it is (at a minimum) good practice[19] that where it is possible to identify a 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 for so doing.

18. 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*[20] and *N v ACCG*,[21] 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 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. This is so both in the context of social care and also medical treatment.[22] We address this further in Section F below.

The views of other people

19. 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.[23] A failure to consult where it is practicable and appropriate will mean that the decision-maker (and others) cannot then rely upon the defence in s.5 MCA 2005.[24]

20. 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;

[18] See, for instance, both the *Briggs* case, concerning maintaining life-sustaining treatment and *B v D* [2017] EWCOP 15, concerning experimental stem cell treatment.
[19] 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.
[20] At paragraph 45.
[21] [2017] UKSC 22.
[22] See, in the medical treatment context, *Re RW* [2018] EWCA Civ 1067.
[23] *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).
[24] *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB).

- any deputy appointed by the Court of Protection to make decisions for the person.

21. If nobody fits into the above categories, then an Independent Mental Capacity Advocate must be consulted for serious medical treatment and significant change of accommodation decisions.

22. There is (now old) case law in the field of property and affairs to the effect that consultation is not necessary where it would be unduly onerous, contentious, futile or serve no useful purpose.[25] In practice, however, the circumstances in which it is neither practicable nor appropriate to consult with family members and carers are likely to be extremely limited. If a decision is made that a particular individual should not be consulted there should be clear reasons identifying why – and such a decision is always likely to be susceptible to challenge.

23. In the process of consulting, be aware of the person's right to confidentiality – not everyone needs to know everything.

Life sustaining treatment

24. 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 life[26]), 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.[27]

25. Whether a treatment is 'life-sustaining' depends not only on the type of treatment, but also on the particular circumstances in which it may be prescribed. For example, in some situations giving antibiotics may be life-sustaining, whereas in other circumstances antibiotics are used to treat a non-life-threatening condition. It is up to the doctor or healthcare professional providing treatment to assess whether the treatment is life-sustaining in each particular situation.

26. It is also up to the doctor or healthcare professional in each situation to decide, first, whether the life-sustaining treatment in question is in fact on offer (see further section F):

    - Some treatments may be clinically futile because there is no realistic prospect that they could achieve their physiological aim, for instance that CPR could actually restart the person's heart and breathing.

    - Some treatments cannot be provided for clinical reasons: for instance, it might not be physically possible to reinsert a feeding tube for a person being fed by clinically assisted nutrition and hydration.

[25] *Re Allen*, 2009 - an unreported decision of Senior Judge Lush (Case Number 1166192).
[26] s.4(10) MCA 2005
[27] s.4(5) MCA 2005

- Some treatments may be covered by specific policies: for instance, a hospital may have a policy that antibiotics cannot be used in certain situations because of the risk of antibiotic resistance. Or a particular drug may not be on offer because it does not meet national commissioning criteria.

- There may be some other reason why in the specific circumstances of the patient's case why the treatment is not clinically indicated.

27. In deciding whether a treatment is on offer, the treating doctor should take into account any statement in advance made by the patient in the same way as a request made by the patient who has capacity to make such decisions.

28. If the treatment is not on offer, the treating doctor cannot be required by this Act to provide it.[28] There may well be other routes to resolve any dispute that may arise in consequence of the decision not to offer the treatment, but they fall outside the scope of this Act, and cannot be resolved by the Court of Protection.

29. If the treatment is in principle on offer, then the decision will need to be made as to whether it is in the patient's best interests to give it. Alongside the guidance in the Code of Practice, doctors and other staff should refer to relevant professional guidance for the **process** of making the decision,[29] including the need (for instance) for a second opinion.

30. In making a best interests decision about giving or continuing life-sustaining treatment, there is always a strong presumption that it will be in the patient's best interests to prolong his or her life, and the decision-maker must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion.

31. However, the strong presumption in favour of prolonging life can be displaced where:

- There is clear evidence that the person would not want the treatment in question in the circumstances that have arisen;

- The treatment itself would be overly burdensome for the patient, in particular by reference to what is known about whether it is more important to the patient to be kept alive at all costs or to be kept comfortable;

- There is no prospect that the treatment will return the patient to a state of a quality of life that the **patient** would regard as worthwhile. The important viewpoint is that of the patient, not of the doctors or healthcare professionals.

[28] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at paragraph 18.

[29] In the case of CANH decisions, the BMA/RCP guidance available here.

32. If at the end of the process there is agreement that it is not in the patient's best interests to give or continue the treatment, the life-sustaining treatment should either be withheld or stopped, as to do otherwise would be to act unlawfully. There is no need in such a case to obtain the authorisation of the Court of Protection before doing so. However, if at the end of the process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, an application should be made to the Court of Protection.[30]

33. Decisions in relation to life-sustaining treatment should be kept under review. That the decision was taken to start a life-sustaining treatment because this was in the patient's best interests does not mean that it will continue indefinitely to be in their best interests. How often the review will be required will depend on the nature of the patient's case.

E: Applying the checklist and documenting the decision

34. In assessing (and recording) where someone's best interests lie, the critical first step is to identify what decision is to be taken on P's behalf. This means that it will be necessary to identify what options are actually available to P. It may, sometimes, not be possible to identify all those options before the assessment process starts (because it may be that a further option becomes clear during the process of assessment); however, a lack of sufficient clarity before the assessment process begins, is likely to lead to confusion on the part of all concerned.

35. 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.[31] It is often easiest to do this in table form, or using bullet points, so that the reader can see the issues and 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.

36. 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.

[30] *NHS Trust v Y* [2018] UKSC 46 at paragraph 125.
[31] Following the well-established 'balance sheet' approach identified by Thorpe LJ in *Re A* [2000] 1 FLR 549 at 560.

37. 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."[32]

38. 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.

39. 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.

40. 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.

41. 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 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.

42. 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*."[33] 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.

43. Best interests meetings can be particularly useful in contexts where the decisions are complex or involve serious consequences for P. A detailed record of these meetings should be maintained, summarising all the information exchanged and clearly documenting the decisions made. A draft of the record should be circulated so that factual accuracy can be checked. Family members

[32] See, for instance, *Re M, ITW v Z, M and Others* [2009] EWHC 2525 (Fam).
[33] *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.

should be encouraged to attend and/or provide a written statement, which allows them to provide all the information relating to P that it might be difficult for them to articulate in a short space of time.

44. Practical guidance in relation to making decisions, and the process of recording decision-making in relation to clinically assisted nutrition and hydration, but also of wider application, can be found in the guidance published by the BMA/RCP (endorsed by the GMC), available here – see, in particular, appendix 1.

F: Wider questions

45. 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?
- When is a decision not a best interests decision?

Who determines best interests?

46. In the Code of Practice, and in everyday use, the "decision-maker" is frequently used. However, in general, it is important to understand that the Act does not identify any formal decision-makers. The exceptions are where:

- The person has made a valid advance decision to refuse treatment which applies to the treatment in question. In law, the effect is that the person is deciding, at that point, not to consent to the treatment starting or being continued. Their decision cannot be overridden because others do not think it is in their best interests;
- If a Lasting Power of Attorney or Enduring Power of Attorney has been made and registered, or a deputy has been appointed under a court order, then the attorney or deputy will be the decision-maker for decisions within the scope of their authority;
- The Court of Protection makes the decision on behalf of the person.

47. In every other case, the Act does not say that any specific person or type of person is the decision-maker. Parliament's intention was that, wherever possible, a decision as to what is in the best interests of a person unable to take the relevant decision would be reached informally and collaboratively between those involved in their care or interested in their welfare, whether that be paid/professional or unpaid. This means that:

- That a hospital has put someone down in the patient records as their 'next of kin' does not mean that they have any legal right to make any decision on their behalf;

- A professional does not have a right to make the decision on behalf of the person simply because they occupy a particular position.

48. However, it still makes sense to think of a "decision-maker" because of the way in which the Act works.

49. Anyone who wants to carry out an act in connection with the care or treatment of another will only be protected from criminal and civil liability under s.5 MCA 2005 if they reasonably believe that the person lacks capacity to make the relevant decision and that the action to be taken is in the person's best interests.

50. In some cases, the person who is going to carry out the act could be thought of as "the decision-maker" because they are having to decide whether they have the necessary reasonable belief to be able to benefit from the defence. For instance:

    - A GP taking a blood sample from a patient who they reasonably believe to lack capacity to consent would be the decision-maker as to whether taking that blood is in their patient's best interests.

    - The paid carer who has to decide whether to step in to intervene to prevent a person with dementia from injuring themselves will have to decide there and then whether they reasonably believe that the person lacks capacity and that the step is in their best interests (and, if it amounts to restraint, whether the additional conditions of necessity and proportionality are met).

51. In other cases, the person actually carrying out the act will be acting on the direction or under the supervision of another, or subject to a plan drawn up by someone else. In each case, the person will, themselves, have to be satisfied that they are acting in the best interests of the individual before carrying out the act, but are likely to being relying upon the views set down in the plan. In that case, it will be the person who is responsible for the plan who could be thought of as "the decision-maker." In the hospital context, for instance, the consultant in charge of the patient's care should be thought of as the decision-maker.

52. In any such situation, especially if there are different staff involved in the person's care from different organisations, it is important that there is one person who is identified as having the responsibility for the coordination of the process to determine what is in the individual's best interests. This may be the person who can be seen as the "decision-maker" in the way set out above, but in some cases, it could be more appropriate for that person to delegate this task to someone who has the right set of skills to facilitate the process of considering all the matters set out under the Act.

53. In all cases involving an organisation or a public body there must, however, ultimately be one person who is prepared to take responsibility on behalf of that organisation or body for the

conclusion that the step being taken is in the best interests of the individual concerned. That does not mean that they have the right to take that decision, but simply that they are accountable for it.

54. 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.

55. 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 authorisers 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 authoriser will actually be involved in the delivery of care and treatment to the person concerned. Rather, their task is to assess whether the 'best interests plus' test set down in DOLS is met[34] as part of the determination of whether authority should be granted to a managing authority to deprive the person of their liberty.[35]

When is a decision not a best interests decision?

56. 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.[36] 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.

57. 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.[37] In the social care context, professionals must also be very careful that, by adopting too cautious an

[34] 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.
[35] See Charles J in *Re NRA & Ors* [2015] EWCOP 59 at paragraphs 64-68.
[36] See the decision of the Supreme Court in *N v ACCG* [2017] UKSC 22.
[37] See, for instance *Aintree University Hospitals NHS Foundation Trust v James and others* [2013] UKSC 67.

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,[38] such that the available options between which a choice could be made on the service user's behalf would have been unduly constrained.

58. 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.

59. 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*".[39]

G: Useful resources

60. 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.

[38] 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.
[39] *N v ACCG* at paragraph 43.

- 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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