Capacity Guide: Practical legal guidelines, from

www.capacityguide.org.uk

January 2022

A: Introduction

1. The purpose of this document is to provide clinicians and social workers with practical legal guidance on the assessment of capacity. Its focus is on (a) how to apply the Mental Capacity Act 2005 ('MCA 2005') when assessing capacity; and (b) how to record assessment, primarily in the context of health and welfare decisions.
2. This document cannot take the place of legal advice. In any case of doubt as to the principles or procedures to apply, it is always necessary to consult your legal department. In particular, if it appears that the person in question is subject to undue influence or coercion, it is always vital to consult your legal department as soon as possible to consider whether and how their interests are to be secured.
3. The courts have now considered questions of capacity on many occasions, sometimes giving guidance as to how the MCA 2005 should be applied in general terms, and sometimes applying the MCA 2005 to particular factual scenarios. This guidance integrates key cases and also Mental Health and Justice ('MHJ') research drawing on the whole body of court experience. Clinicians and social workers have now over 15 years of experience considering questions of capacity under the MCA 2005. This guidance also integrates MHJ research which draws on this experience.
4. Certain 'flashpoints' or 'tensions' have arisen in capacity assessment. Further guidance accompanying this main document identifies these and draws on interdisciplinary MHJ research to give practical assistance. See

also here for further guidance on how to make proper use of tools which appear to measure a person's ability to make decisions.

5. Three notes on language:

    - We use the initial 'P' to mean the person whose capacity is under consideration. Strictly, of course, P is not 'P' unless they are the subject of proceedings before the Court of Protection but we find it helpful to adopt this convention.
    - The word 'assessment' is in our experience all too often used to cover two completely different things: (1) the process of assessing whether or not a person has capacity to make a decision; and (2) the recording of the conclusion reached as to whether or not the person had capacity. Documentations to record the outcome of capacity assessments should enable the person completing them to set out that the person **has** capacity if that is the outcome of the assessment.
    - To save using the phrase "understand, retain, use and weigh" throughout the document, we use the shorthand "can P process" where we mean a situation where we are asking whether P can understand, retain, use and weigh the relevant information.

B: Key principles

6. The core principles of the MCA 2005 are set out in s.1. They are:

    - s.1(2): P must be assumed to have capacity unless it is established that he lacks capacity;

- s.1(3): P is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success;
- s.1(4): P is not to be treated as unable to make a decision merely because he makes an unwise decision;
- s.1(5): an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests; and
- 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.

The presumption of capacity

7. The presumption that P has capacity is fundamental to the Act. It is important to remember that P has to 'prove' nothing:

    - Outside the court setting, if you are going to take action in the name of P's best interests, you will have to show why you have a reasonable belief that they lack capacity to make the decision(s) in question, and that you have taken reasonable steps to establish this (s.5(1));
    - If you are in court, you will need to show the judge why – on the balance of probabilities – it is more likely than not that P lacks capacity to make the decision()s in question (s.2(4)).

8. It is important to be aware that very act of deciding to carry out a formal capacity assessment is not, itself, neutral, and the assessment process can,

itself, often be (and be seen to be) intrusive. You must always have grounds to consider that one is necessary to do at this time.[1]

9. Conversely, you must also be prepared to justify a decision not to carry out an assessment where, on its face, there appeared to be a proper reason to consider that the person could not take the relevant decision and there were best interests to consider:

    - Whilst the presumption of capacity is a foundational principle, you should not hide behind it to avoid responsibility for a vulnerable individual.[2] In our experience, this can happen most often in the context of self-neglect where it is unclear whether or not the person has capacity to make decisions.[3])
    - If you have proper reason to think that the person may lack capacity to take a relevant decision, especially if the consequence of what they are wanting to do is likely to lead to serious consequences for them, it would be simply inadequate for you simply to record (for instance) "as there is a presumption of capacity, [X] decision was the person's choice." Indeed, the more serious the issue, the more one should document the risks that have been discussed with P and the reasons why it is considered that P is able and willing to take those risks. See further the flashpoint guidance on assessing capacity in a risky situation.

Thinking properly about the presumption

Useful guidance on how to think about the presumption can be found in this passage from the judgment in Royal Bank of Scotland Plc v AB:[4]

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.

10. It is also important to remember that some people can 'talk the talk, but not walk the walk', or, in other words, can give a very strong appearance of ability to decide for themselves when in fact they are unable. This might happen, for example, if they have had numerous prior capacity assessments but there are also clinical contexts in which this can happen. There is more guidance about this in the flashpoint guidance.
11. Conversely, it is important to remember that some people don't seem to be able to 'walk, the walk', when, in fact, they can. Taking practicable steps to ensure they can is essential (see also below on the causative nexus).

The support principle

12. To comply with s.1(3) MCA 2005, you must take all practicable steps to help P before concluding that they are nevertheless unable to make a decision.[5] And, importantly, consider why is it that you were unsuccessful in enabling P to decide despite those steps having been taken? This will include asking yourself – and being in a position to record – the answers to questions such as:

- What is the method of communication with which P is most familiar (is it, for instance, a pointing board, Makaton or visual aids)?
- What is the best time of day to discuss the decision in question with P?
- What is the best location to discuss the decision in question with P?
- If you do not know P, would it assist to have another person present who does (and, if they do, what role should they play)?
- Has P made clear (in whatever fashion) that there is someone that they would like to be present, or someone they would really like not to be present?
- What help does P require to learn about and understand the information relevant to the decision? For instance, does P need to be taken to see different residential options? Have you explained to P all the pieces of information that you have identified as being relevant to the decision?
- Is it possible to complete the assessment in one go, or is it necessary to come back and see P on more than one occasion, even if only to put P at their ease and help them engage with the process?[6]
- And, perhaps above all, is there something that you can do which might mean that P would be able to make the decision? Depending upon the circumstances, this could be simply waiting: it is always important to be clear about how much time that you have before a conclusion has to be reached (and, if it does not seem enough, to see what could be done to buy more time). It could also be doing with P to assist them with the particular area of difficulty: see for a good example, ***Re DE*** [2013] EWHC 2562 (Fam), in which (whilst Court of Protection proceedings were ongoing), an intensive programme of education was provided to a learning disabled man, in

consequence of which he gained the capacity to consent to sexual relations.

The 'unwise decisions' principle

13. Different people will make different decisions because they give greater weight to some factors than to others, taking account of their own values and preferences. This principle emphasises that in assessing a person's capacity what matters is the ability to make a decision, not the outcome of that decision. As the Court of Appeal has said:

… there is a space between an unwise decision and one which an individual does not have the mental capacity to take and … it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual's autonomy operates.[7]

14. However, if a decision appears objectively to be unwise – in particular if it is out of character – it should be a **trigger** for considering whether the person has capacity to make it.

Thinking about capacity – whose responsibility is it?

15. Sometimes, people do not stop and think properly about **who** needs to think about the person's capacity.
16. In the courtroom setting, it is ultimately the judge's decision as to whether or not the person has capacity to make the decision(s) in question. They have to do so on the balance of probability,[8] after obtaining all the evidence that they consider necessary to be able to reach this conclusion.
17. Outside the courtroom setting, i.e. in almost all circumstances in which this guidance will apply, the responsibility will lie on you if you are proposing to take the step in question on the basis that it is in P's best interests.[9] It will also fall on you if, on its face, there appeared to be a proper reason to consider that the person could not take the relevant decision and there

were best interests to consider. You will need to have to show that you: have taken reasonable steps to establish whether or not P has capacity to make the decision in question; and have a reasonable belief that P lacks capacity.

18. That does not mean that you cannot seek expert assistance. But it does mean that that you cannot delegate the decision as to capacity to that expert.

'Delegating' decisions about capacity in the clinical setting

If you are a doctor proposing to carry out a particular operation, you cannot delegate to a psychiatrist colleague the decision whether or not the person has capacity. You may – and in some complex cases may need – to get expert input from that psychiatric colleague, but it is ultimately you, as the treating doctor, to decide whether or not P lacks capacity. If you did not reasonably believe P lacked capacity, and went ahead with the operation in what you thought was P's best interests, you will have no defence under s.5 MCA 2005 to a claim for damages and/or criminal prosecution.

19. The 'reasonable belief' also applies by extension to other people carrying out tasks under the MCA 2005 (for instance considering a person's capacity for purposes of the Deprivation of Liberty Safeguards).
20. It is important also to be clear that there are some situations in which the question is not whether the person **lacks** capacity so as to justify steps being taken in the name of their best interests, but whether the person **has** capacity, for instance to decline an intervention proposed by a doctor. See further the flashpoint guidance on assessing capacity in a risky situation.

C: What does it mean to lack capacity to make a decision?

21. The law gives a very specific definition of what it means to lack capacity for purposes of the MCA 2005. It is a test that derives from interplay between the law, ethics and medicine,[10] but is ultimately a legal test, which can be applied by anyone and for which the court is the final arbitrator.
22. The test is set down s.2(1) MCA 2005,[11] which provides that:

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

Applying the capacity test

The Supreme Court in A Local Authority v JB [2021] UKSC 52 has made clear that you need to start by asking with whether the person can make the decision for themselves. Applying the Supreme Court's approach makes clear that the test is best broken down into three questions you need to be able to answer:

1. **Is the person able to make the decision for themselves?**

If there are legitimate doubts about this then,

2. **Is there an impairment or disturbance in the functioning of the person's mind or brain?**

And if there is an identified impairment or disturbance then,

3. **Is the person's inability to make the decision because of the identified impairment or disturbance?**

23. We will look at each of these questions below but before we do so, need to emphasise some points where clarity is essential.

24. First, capacity is decision-specific. The statement 'P lacks capacity' is, in law, meaningless. You must ask yourself "what is the actual decision in hand"?[12] If you do not define this question with specific precision before you start undertaking the assessment, the exercise will be pointless. By way of example, where a person needs surgical treatment to address gangrene in their leg, the decision in respect of which you need to assess capacity is whether they have the capacity to decide upon the operation proposed. It is not whether they have capacity to make a decision as to all of the potential operations that could be carried out to provide that treatment (the actual options need to be clear including the option of not doing what is proposed).[13]

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

26. Third, before you can determine whether P is able or unable to make a decision, you must identify what the information relevant is to the particular decision in question. It is not necessary that P is able to process every element of what is being explained to them. What is important is that they can process the 'salient factors':[14] the information relevant to the decision. This means that it is your job not just to identify the specific decision (as discussed above) but also what the information is that is

relevant to that decision, and what the options are that P is to choose between.

The relevant information

The courts have now had over 15 years of experience considering different categories of decisions, and have identified the sorts of information that is likely to be relevant (and irrelevant) to decisions such as medical treatment, care, contact, residence, and accessing the internet and social media. The guidelines are set out in this guidance note written by 39 Essex Chambers.

In each case, however, it will be necessary to tailor the information to the particular situation of the person and the decision that they have to take. Some of the time, this may mean that there is more information that the person needs to be able to process than in the 'ordinary' case. Some of the time, there is something about the situation which means that things which 'ordinarily' would need to be processed simply do not form part of the equation.

27. Fourth, the information that is relevant to the decision includes the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision. In a situation where one course of action is much more dangerous for the person than the other, it is legitimate to probe whether the person can understand, retain, use and weigh the relative dangers of the two courses. This is why, although the courts approach questions of medical treatment on the basis that the question is whether the person can make the decision whether or not to have it,[15] it is

legitimate to probe (if relevant) P's ability to process the fact that the medical professionals consider that refusing that treatment will lead to their death, but accepting it will save their life. See further the flashpoint on assessing capacity in risky situations for further guidance in relation to 'high stakes' situations.

(1): Is the person able to make a decision?

Breaking the test down

The law puts things in the negative: s.3(1) MCA 2005 states that P is unable to make a decision for himself if he is unable:

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

This does not mean that you should focus solely on the person's apparent difficulties. Asking what they can do is important in terms of upholding the presumption of capacity, although it should not lead you to downplay appropriate probing as to whether or not the person is able to do the things in the list above.

28. Starting with the question of whether the person is able to make the decision for themselves is important. If you start with the question of whether the person has an impairment or disturbance:

    - (a) There is a danger that you will mentally 'tick off' the presence of an impairment or disturbance and then will not sufficiently question whether that impairment or disturbance is actually **causing** the inability to make the decision;[16]
    - (b) Linked to this, there is also a risk that the structuring perpetuates the discriminatory approach to those with mental disorders, as it essentially loading the capacity assessment against them by 'pre-filling' the first element of the test. For example, it makes it – subconsciously – easier for you to move from thinking 'this person has schizophrenia' to concluding 'this person lacks capacity to make [X] decision.'
    - (c) Focusing on what it is thought that the person is functionally unable to do means that support can be targeted appropriately, for instance to help them understand the information relevant to the decision, or to use and weigh it. If, with that support, the person is able to make the decision, there is then no need to go further: they have capacity to make it.

29. That having been said, depending upon the circumstances, it may be that more focus needs to be placed upon either the causal impairment or the functional test – for instance – if P is in a psychiatric ward with a clear diagnosis of a mental disorder, then it may be that more attention is required to considering whether that disorder means that they are unable to take the specific decision in question.

30. In all cases, though, all three elements of the single test must be satisfied in order for a person properly to be said to lack capacity for purposes of the MCA 2005.
31. Before looking at each of these elements in turn, it is important to unpick one consequence of the fact that the test contained in ss.2-3 MCA 2005 is a legal one which has to be applied in real life. The test contains very broadly defined functional abilities – for instance "to use" information. However, it is rarely enough simply to leave it that – either in terms of thinking about the person's abilities or in recording your conclusions. Put another way, it is important always to be able to explain **why** a person's particular difficulties mean that they do not have one (or more) of the functional abilities required of them by s.3 MCA 2005.
32. In doing this, we suggest that it may be useful to draw upon the typology that was developed by the MHJ project. This typology illustrates how the Court of Protection judges (drawing upon the experts appearing before them, the other evidence they have had, and interpreting the language of the MCA 2005) have sought to explain why a person cannot do one or more of things required of them under the MCA 2005. The typology classifies these 'explanatory rationales.'
33. There are nine categories of 'explanatory rationales' in the typology, or nine types of decision-making problem used to explain whether a person is deemed to have or lack capacity for the specific decision. These are the ability or inability:

    - (1) To grasp information
    - (2) To remember
    - (3) To imagine or abstract

- (4) To appreciate (appreciation including (a) the potential for delusions/confabulations; (b) issues relating to insight into their condition or care needs; or (c) other issues)
- (5) To care or value
- (6) To think through a decision non-impulsively
- (7) To reason (including (a) flexibility of thinking; (b) balancing pros/cons; or (c) other reasoning)
- (8) To give coherent reasons
- (9) To express consistent preferences

34. The typology serves two purposes:

    - It will enable you to probe in more detail what the problem might appear to be, and – importantly – to provide the person with support to assist them with that problem area;
    - When starting from the clinical phenomena, using these 'explanatory rationales' will (a) enable you to be more transparent and accountable in explaining your reasoning;[17] (b) enable you to be confident that you are thinking in ways which are legally defensible. The MHJ team have, in a separate article, suggested that there are ways some of the explanatory rationales **should** be used and linked to particular functional abilities.

35. The typology also suggests that there are certain types of decision-making problems that are more associated with particular conditions. This may be useful for alerting you to particular problems (and, in turn, particular ways of questioning or probing[18]) associated with particular conditions. However we strongly caution against using it as a tool to single out people

with particular conditions as **automatically** having those problems with decision-making.

36. Taking the law and court practice as guidance, we look at each of the functional limbs of the test in turn, and explain how the typology may help in application.

Is P able to understand the relevant information?

37. The courts have repeatedly emphasised that the level of understanding required must not be set too high.[19]
38. Further, you must not start with a 'blank canvas.' In other words, you must present the person you are assessing with detailed options so that their capacity to use and weigh those options can be fairly assessed.[20] This is particularly important where a person's particular impairment may make it more difficult for them to envisage abstract concepts. But it is also important to give the person sufficient information about the options that they are being asked to choose between that they are given the opportunity to understand (if they are capable of doing so) the reality of those options. In other words, and to take a common example, you should not simply seek to assess a person's ability to decide between living at home and living in a care home in the abstract, but rather by reference to what continuing to live at home would be like (for instance, what care package would the relevant local authority provide) and what living in an actual care home would be like.[21]
39. The ability to understand also extends to understanding the reasonably foreseeable consequences of reaching a decision or failing to do so (s.3(4)).
40. The inability to understand has been associated with specific explanatory rationales in the courts. See here [criteria page for understanding]

Is P able to retain the relevant information?

41. We repeat the need to be precise about the information in question.
42. P needs to be able to retain enough information for a sufficient amount of time in order to make a decision. The Act specifies at s.3(3), however, that 'the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.'
43. This is an important consideration, particularly when dealing with the elderly or those with deteriorating memories. Capacity is the assessment of the ability to make a decision 'at the material time.' If information can be retained long enough for P to be able to make the relevant decision at the relevant time, that is sufficient, even if P cannot then retain that information for any longer period.
44. The inability to retain has been associated with specific explanatory rationales in the Courts. See [criteria page for retaining]

***Is P able to use or weigh the relevant information?*[22]**

45. Again, it is necessary to be clear what the information is (and how it is said to be relevant to the decision). As with understanding, it is not necessary for a person to use and weigh every detail of the respective options available to them, merely the salient factors. Therefore, even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision.[23]
46. It is particularly important here to be aware of the dangers of equating an 'irrational' decision with the inability to make one – P may not agree with the advice of professionals, but that does not **automatically** mean that P

lacks capacity to make a decision.[24] For example, a religious belief in faith healing or a religious belief that blood products cannot be accepted as treatments will not necessarily be found to reflect inability to use or weigh health information due to an impairment of disturbance.

47. Further, if a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for that person.[25] This means you need to be very careful when assessing a person's capacity to make sure – as far as possible – that you are not conflating the way in which they apply their own values and outlook (which may be very different to yours) with a functional inability to use and weigh information. This means that, as much as possible, you need as part of your assessment – your conversation with P as well as other sources of information – to glean an idea of their values and their life story as it relates to the decision in question.
48. The inability to use and weigh has been associated with specific explanatory rationales in the courts. See [criteria page for using and weighing]

Is P able to communicate their decision?

49. It is very important to understand how this limb of the test works. It presupposes that the person has been able to make a decision: in other words, that they have been able to understand, retain, use and weigh the relevant information – the problem is that they cannot communicate the decision that they have made. It is therefore a limb of the test which only applies to a very limited group of people, for instance those with locked-in syndrome who may, despite all practicable steps, be unable to communicate.

50. If, therefore, the person appears unable to understand, retain, use or weigh relevant information, but is nevertheless seeking to communicate something, then:

    - The record of your assessment should **not** say that they are unable to communicate their decision – it should say that they are unable to make a decision, and what they are communicating are wishes and feelings;
    - You should take into account what they are communicating for purposes of constructing the best interests decision: see further the 39 Essex Chambers guide to this process here.

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

(2) Is there an impairment or disturbance in the functioning of the person's mind or brain?

53. In many cases, and especially if you are not medically qualified, you will be relying on clinical information about whether P has an impairment or disturbance in the functioning of the mind or brain, and, if so, what it is.

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

    - Some impairments or disturbances are sufficiently self-evident to mean that lay interpretations may be legitimate. Examples would include coma or acute confusional states in which the person is clearly thinking and behaving in a manner inconsistent with their baseline state (e.g. through delirium or intoxication with alcohol or drugs).
    - It is not necessary for the impairment or disturbance to fit neatly into one of the diagnoses in the ICD-11 or DSM-5. The important thing is that there is a proper basis upon which to consider that there is an impairment or disturbance. For example, coma is not in the DSM-5 and many of the diagnostic subdivisions and language of DSM-5 may be less relevant to capacity assessment.
    - Finally, particular care needs to be exercised if you are considering a person who appears to have a very mild learning disability or an unusual personality– this may well not be enough, in isolation, to constitute an impairment or disturbance of the mind or brain for these purposes.[26])

(3): Is the person's inability to make the decision because of the impairment or disturbance in the functioning of their mind or brain?

55. In all cases, it is important to be able to answer this third question – sometimes called identifying the 'causative nexus.'[27] In other words, are you satisfied that the inability to make a decision is because of the impairment of the mind or brain? Any pro forma form for the assessment of capacity that does not include a final box asking precisely this question is likely to lead you astray.

The causative nexus in the courts

In PC and NC v City of York Council not being precise about the cause of the person's difficulties made all the difference. The first judge who looked at the case considered that the woman, PC, lacked capacity to decide whether to resumed married life with her husband upon his release from prison because her inability to process the risks that he posed to her "significantly relate[d] to" her mild learning disability.

The Court of Appeal said that he was wrong to reach the conclusion that the woman lacked capacity. It made clear that the MCA requires the inability to be "because of" of the impairment, which is evidentially a more difficult test to satisfy.

56. To reiterate, there has to be, and you have to show that you are satisfied why and how there is, a causal link between the disturbance or impairment and the inability to make the decision(s) in question. *JB*'s case,[28] again, shows how easy it is to assume that merely because a person has schizophrenia, they are then unable to take decisions regarding surgical procedures – this is entirely incorrect. The disturbance or impairment in the functioning of the mind or brain must also not merely impair the person's ability to make the decision, but render them unable to make the decision.[29]
57. To test whether you are satisfied that the 'causative nexus' is satisfied, you can ask one (or more) of these questions:

- The “plausibility” question: ask whether it is clinically plausible that the inability is caused by the impairment or disturbance? For example, if someone does not appear to retain information is this plausibly explained by a personality disorder?
- The “subjective” question: ask “would the relevant decision be one P would have taken had they not had the impairment or disturbance”? For example, if someone was not in a delirium, or not in a severely depressed phase of affective disorder, would they be making this decision to refuse treatment?

58. And always remember the ‘other explanation’ question: i.e. ‘is the inability better explained by a lack of practicable steps or by factors which are temporary (e.g. effect of medication, pain) which mean the decision can be delayed?’
59. It does not matter if there appear to be more than one impairment or disturbance affecting the person, and it is not possible to identify precisely which appears to be making them unable to process the relevant information, so long as you can be satisfied that the reason is down to at least one of them (or more than one in combination).**[30]**
60. However, there will be situations in which it is not entirely easy to identify whether a person is unable to make what professionals consider to be their own decisions because of:

    - An impairment or disturbance in the functioning of their mind or brain (for instance the effect of dementia);
    - The influence of a third party (for instance an over-bearing family member); or
    - A combination of the two.

61. Examples of such cases include:
    - The older patient on the hospital ward who looks to their child for affirmation of the 'correctness' of the answers that they give to hospital staff;
    - A person with mild learning disability in a relationship with an individual who (even when that individual is not in earshot) is clearly still cautious about expressing any opinions that may go against what they think may be the wishes of that individual.

62. This situation is addressed in more detail in the flashpoint guidance.

D: Good capacity assessment and recording

63. In almost all cases, the core of a capacity assessment is – or should be – a real conversation with the person on their own terms, which facilitates the person to apply their own value system to the decision at hand.[31]
64. It is important to understand that it is not only medical professionals – and in particular not only psychiatrists – who can carry out a capacity assessment. It is frequently the case that professionals or others who know the person better, and in particular who have seen the person over time, will be able to do a more robust capacity assessment than a person (of whatever discipline) 'parachuted' in for a snapshot assessment.[32]
65. Whoever you are – but especially if you are being 'parachuted' in – you need to do your homework and try to make sure that you are familiar with the situation. In other words, ensure you are familiar with P's health problems, circumstances, incidents where risks have materialised etc. This is particularly important if you have been asked to consider someone's capacity and you do not already know them, so do not have the advantage

of having a sense of where the decision sits in the wider context of their life.

What makes a good capacity assessment?

A very good summary of what makes a good capacity assessment and, in turn, a good record of that assessment, can be found in this statement from a judge (although this relates to medical treatment, the principles are equally applicable to other contexts):

The fundamental principles of self-determination, freedom from non-consensual medical treatment and personal inviolability, and the equally fundamental principles behind the right to health, are most respected by capacity assessments that are criteria-focussed, evidence-based, person-centred and non-judgmental. Such assessments engage with the demand (or plea) of the person to be understood for who they are, free of pre-judgment and stereotype, in the context of a decision about their own body and private life. (emphasis added)[33]

66. A good **record** of a capacity assessment that reaches the conclusion that a person lacks the capacity to make a specific decision will show that you have:
    - Been clear about the capacity decision that is being assessed;
    - Ensured P (and you) have the concrete details of the choices available (e.g. regarding treatment options; between living in a care home and living at home with a realistic package of care);
    - Identified the salient and relevant details P needs to understand/comprehend (ignoring the peripheral and minor details);

- Balanced the protection imperative with the free choice imperative
- Demonstrated the efforts taken to promote P's ability to decide and, if unsuccessful, explained why;
- Recognised that assessment is not necessarily a one-off matter, and that you have taken the time to undertake to gather as much evidence as is required to reach your conclusion – including, for instance, returning to have a further conversation with P or obtaining corroborative evidence;
- Been clear about why the relevant impairment/disturbance in the functioning in P's mind or brain is causing them to be unable to make the decision;
- Answered the question: why is this an incapacitated decision as opposed to an unwise one?

67. Verbatim notes of questions and answers can be particularly valuable in the record of the assessment, because they can allow the reader then to get a picture of the nature of the interaction and judge for themselves both the nature of the questions asked and of the responses received.[34] This is especially important if the situation is one where your conclusion is finely-balanced: the closer to the line, the more the onus is on you to explain why you have a reasonable belief that the person has (or lacks) capacity to make the decision.
68. If you are assessing a person's capacity to make a number of different decisions, it is important to take a step back and ask before reaching a conclusion as to the person's decision-making capacity in relation to each decision whether they all make sense logically together. This point was reinforced by the Court of Appeal in ***B v A Local Authority***,[35] in which it

emphasised the danger of approaching decisions in 'silos' and reaching mutually incompatible conclusions.

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

    - Contemporaneous documentation is infinitely preferable to retrospective recollection;
    - Do not assert an opinion unless it is supported by a fact;
    - "Yes/No" answers in any record are, in most cases, unlikely to be of assistance unless they are supported by a reason for the answer;
    - What is reasonable to expect by way of documentation will depend upon the circumstances under which the assessment is conducted. An emergency assessment in an A&E setting of whether an acutely confused patient has the capacity to run out of the ward into a busy road will not demand the same level of detail in the assessment or the recording as an assessment of whether a 90 year old woman has the capacity to decide to continue living in her home of 50 years where the concerns relate to her declining abilities to self-care.

Footnotes

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1 See ***Re SB (capacity assessment)*** [2020] EWCOP 43 as an example of a case where the Court of Protection decided that it was not necessary or appropriate to order a further capacity assessment in a case where (1) nothing was actually going to turn on the outcome of that assessment; and (2) the very process of carrying out that assessment might itself cause P anxiety and distress.

2 As the House of Lords Select Committee looking at the MCA 2005 reported, this unfortunately happens all too frequently – in our experience, most often in the context of self-neglect. House of Lords

Select Committee on the MCA 2005 (2014) *Mental Capacity Act 2005: Post-legislative scrutiny*, HL Paper 139, at paragraph 105.

3 See, for instance, the cases discussed in ***Learning from SARS: A report for the London Safeguarding Adults Board*** (July 2017

4 **[2020] UKEAT 0266_18_2702**. The judgment relates to capacity to conduct proceedings before the Employment Tribunal, but the principles are of broader application.

5 See also here Chapter 2 of the **Code of Practice** to the MCA 2005.

6 For an example of the difference that this can make, see the contrasting assessments of P's capacity to make decisions as to residence and care in ***Re FX*** [2017] EWCOP 36.

7 ***PC and NC v City of York Council*** [2013] EWCA Civ 478 at paragraph 54.

8 Section 2(4) MCA 2005 providing that "[i]n proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities."

9 For more on this, see the 39 Essex Chambers **Guidance Note: Determining and Recording Best Interests**.

10 For the history of the test, see Ruck Keene, A., Kane, N. B., Kim, S. Y., & Owen, G. S. (2019). **Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection. International journal of law and psychiatry**, 62, 56-76.

11 Referred to as the "core determinative provision" in ***PC and NC v City of York Council*** [2013] EWCA Civ 478 at paragraph 56.

12 See *PC* at paragraph 40.

13 This was the position that was addressed in ***Heart of England NHS Foundation Trust v JB*** [2014] EWHC 342 (COP).

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

15 See e.g. ***Kings College NHS Foundation Trust v C and V*** [2015] EWCOP 80.

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

17 See further section [xx] on explaining your reasoning.

18 Although designed for lawyers, The Advocates Gateway also includes helpful tools for framing questions for people with particular communication needs: Home – The Advocate's Gateway (theadvocatesgateway.org).

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

20, 21 *CC v KK & STCC* [2012] EWHC 2136 (COP).

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

23 *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 37.

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

25 *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 38.

26 See *WBC v Z* [2016] EWCOP 4 (autism) and *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 (unusual personality

27 *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 52.

28 *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP).

29 *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 31.

30 *Pennine Acute Hospitals NHS Trust v TM* [2021] EWCOP 8 at paragraph 37.

31 See *Kings College NHS Foundation Trust v C* [2015] EWCOP 18, in particular at paragraph 38.

32 See in this regard both *A Local Authority v SY* [2013] EWHC 3485 (COP) at paragraph 22 (emphasising that "*appropriately qualified social worker is eminently suited to undertake* […] *capacity assessments*" for completing a COP3 form) and *PH v A Local Authority v Z Limited* [2011] EWHC 1704 (COP) at paragraph 56. By "appropriately qualified" social worker is meant a social worker who can properly claim to have the necessary expertise (and be able to explain why they do).

33 *PBU & NJE v Mental Health Tribunal* [2018] VSC 564. The judge in question is an Australian one, the case coming from Victoria, but applying a framework that looks very much like the MCA, and drawing on English case-law.

34 As a judge has noted (in relation to expert reports, but equally relevant to other reports): "[t]*he interview with P need not be fully transcribed in the body of the report (although it might be provided in an appendix), but if the expert relies on a particular exchange or something said by P during interview, then at least an account of what was said should be included.*" See *AMDC v AG & Anor* [2020] EWCOP 58 at para 28(g) per Poole J.

35 [2019] EWCA Civ 913.