CommunityCare informAdults

Search



Practice Guidance

# Case law and the process of assessing mental capacity

**Author:** Elmari Bishop **and** Tim Spencer-Lane
**Updated Date:** 2 April 2019
**Publication Date:** 7 April 2016


Photo: tashatuvango/Fotolia

## Learning points

- Advice on how to start from the presumption of capacity.
- Tips on preparing for an assessment.
- Advice on distinguishing the fine line between unwise and incapacitous decisions.

*This guide helps you with paragraph 5, mental capacity, and paragraph 9, organisational context, of the knowledge and skills statement for social workers working in adults' services.*

### Please note

This guide is based on case law as it stood at the time of writing and is not to be taken as legal advice. If necessary, legal advice must be sought on the facts of any specific case.

This is an in-depth guide but if you are short of time we have a quick guide to assessing capacity.

# Contents

# Introduction

This guide examines case law about assessing mental capacity for the purposes of the Mental Capacity Act 2005 (MCA). As well as looking at case law, the guide sets out the implications for practice emerging from these cases. If you are short of time you can go straight to the implications for practice by using the links provided.

Section 2(1) of the act states that "a person lacks capacity in relation to a matter if at the material time [he or she] 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 brain".

Section 3(1) of the act then goes on to explain that a person is unable to make a decision if they:
(a) cannot understand the information relevant to the decision,
(b) cannot retain that information,
(c) are unable to use or weigh that information as part of the process of making the decision, or
(d) cannot communicate their decision (whether by talking, using sign language or any other means).

# Five principles

There are five statutory principles that underpin the MCA which should be followed whenever you are assessing capacity or making best interests decisions. These are set out in section 1 of the MCA:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person 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.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. 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.
5. 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 first three principles relate directly to the capacity assessment. The MCA and related code of practice give extensive guidance on how to implement these principles in the process of assessing capacity, as well as guidance on the dual-aspect capacity assessment itself.

# Step 1

Remember the starting point – the presumption of capacity – as well as the importance of not determining inability to make a decision merely on the basis of an unwise decision (principles 1 and 3 of the MCA).

The following two cases demonstrate just how important it is to apply these principles.

## A NHS Trust v P & Anor [2013] EWHC 50 (COP)

### Case summary

Source: 39 Essex Chambers

This case was concerned with a young woman born with sickle cell disease and severe learning disabilities. When she became pregnant the local NHS trust made an application to the Court of Protection concerning her capacity to decide whether or not to continue with the pregnancy.

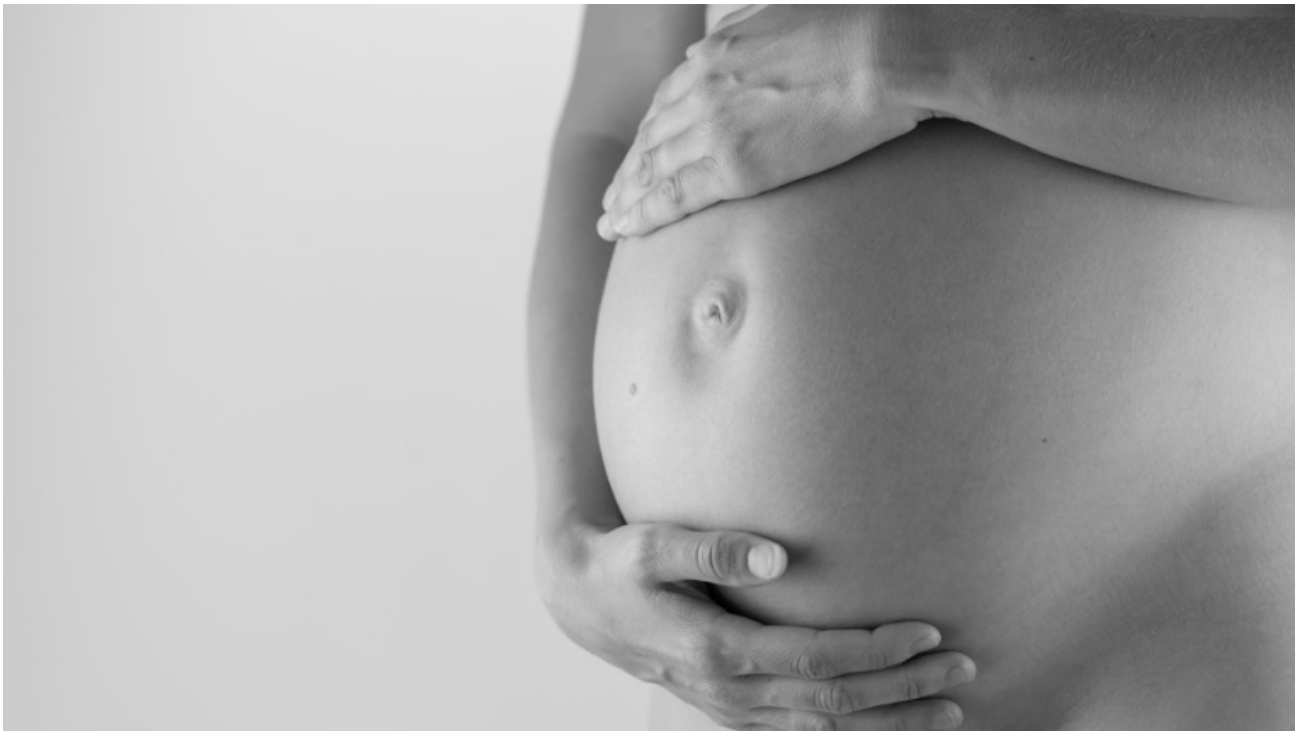

Photo: Gajus/Fotolia

While the judge accepted that she lacked litigation capacity, he concluded that she had capacity to decide whether or not to continue with the pregnancy.

He noted that: "The plain fact is that anyone who has sat in the family jurisdiction for as long as I have, spends the greater part of their life dealing with the consequences of unwise decisions made in personal relationships. The intention of the Act is not to dress an incapacitous person in forensic cotton wool but to allow them as far as possible to make the same mistakes that all other human beings are at liberty to make and not infrequently do."

He added: "It is, as I said, very important to bear in mind, particularly in the field of those with significant learning difficulties who may well be unable to function independently in the community in every aspect of their life, that they may very well retain capacity to make deeply personal decisions about how they conduct their lives."

### Implications for practice

The judge in this case really does set the scene for the use of the MCA and makes the starting point for us as professionals very clear – we must start from the assumption that a person has capacity unless it is properly established that they lack it. So, the starting presumption is always that a person has the capacity to make a particular decision for themselves, even if they are vulnerable, have some impairment or disability or are "unable to function independently in the community in every aspect of their life". This is fittingly also the first principle of the MCA, as set out in section 1(2):

**Principle 1:** *A person must be assumed to have capacity unless it is established that they lack capacity.*

### What the MCA code of practice says:

**Paragraph 2.3:** "This principle states that every adult has the right to make their own decisions – unless there is proof that they lack the capacity to make a particular decision when it needs to be made. This has been a fundamental principle of the common law for many years and it is now set out in the Act."

**Paragraph 2.4:** "It is important to balance people's right to make a decision with their right to safety and protection when they can't make decisions to protect themselves. But the starting assumption must always be that an individual has the capacity, until there is proof that they do not."

We cannot presume that a person lacks capacity just because they have other difficulties. We have to presume that they do have capacity unless it is established they do not.

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

### Case summary

Source: 39 Essex Chambers

JB had a long history of paranoid schizophrenia and also had complex physical health problems, including diabetes. Her right foot became gangrenous, but she refused surgery to remove the foot, which then became mummified and eventually detached from her leg.

Surgeons subsequently wanted to remove part of her leg to reduce the chance of infection. JB was resistant and was considered by her treating psychiatrist to lack capacity to consent to the operation, mainly because her ability to weigh the relevant information was "compromised by her tendency to minimise and disbelieve what the doctors are telling her". Other professionals who assessed JB came to different conclusions about her capacity to refuse the operation; an independently instructed psychiatrist and a surgeon both concluded that JB had capacity to decide about amputation.

The court preferred the evidence of the independent psychiatrist and surgeon that JB understood sufficient information about the proposed operation and the consequences of deciding one way or the other, and was able to weigh that information (despite having a

psychiatric disorder). The judge was also not satisfied that JB's treating psychiatrist had established a causal link between the alledged inability to make the decision and JB's mental illness.

The judge noted that: "What is required here is a broad, general understanding of the kind that is expected from the population at large. JB is not required to understand every last piece of information about her situation and her options; even her doctors would not make that claim. It must also be remembered that common strategies for dealing with unpalatable dilemmas – for example, indecision, avoidance or vacillation – are not to be confused with incapacity. We should not ask more of people whose capacity is questioned than of those whose capacity is undoubted."

The judge also noted that the presumption of capacity principle was not reflected in the way the trust approached this case:

"At all events, it is for the trust to displace the presumption that JB has capacity on a balance of probabilities. It is important that the right question is asked. When assessing JB in October, Dr O approached matters on the basis that JB was 'unable to clearly show that she had considered the option' of amputation. Similarly in January, Dr B remarked that 'one needs to be certain of her capacity' while in February, Dr O recorded that JB 'is unable to fully understand, retain and weigh information…'. These formulations do not sit easily with the burden and standard of proof contained in the Act."

### Implications for practice

The second important point to remember from the onset of any capacity assessment is that people make unwise decisions and that this alone cannot lead to a finding of incapacity, even when these decisions seem extremely foolish or irrational.

As the judge in the case of JB powerfully states in his opening paragraph: "The freedom to choose for oneself is a part of what it means to be a human being…" and in more complex and stressful situations there may be "no right or wrong answers…"

This point is enshrined in the third principle of the MCA as set out in section 1(4):

**Principle 3:** *A person is not to be treated as unable to make a decision merely because they make an unwise decision.*

## What the MCA code of practice says:

Paragraph 2.10: “Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack the capacity to make a decision just because other people think their decision is unwise. This applies even if family members, friends or healthcare or social care staff are unhappy with a decision.”

This is possibly the principle that professionals struggle with the most as safeguarding vulnerable adults is such a key part of the caring profession. It can be difficult to separate the incapacitous decision from the unwise one; and even more so to balance our desire to protect with the principle that a person cannot be considered to be unable to make a decision merely on the basis of an unwise decision.

Many professionals, as in JB’s case, will immediately become concerned about a person’s ability to make their own decisions when they are refusing care or interventions that will keep them safe and well. But we need to remember that professionals cannot conclude that the person is unable to make the decision in question merely on the basis of an unwise decision.

As the judge in the case of JB strongly points out: “The temptation to base a judgment of a person’s capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity. Any tendency in this direction risks infringing the rights of that group of persons who, though vulnerable, are capable of making their own decisions. Many who suffer from mental illness are well able to make decisions about their medical treatment, and it is important not to make unjustified assumptions to the contrary.”

In the case mentioned earlier of *A NHS Trust v P & Anor*, the judge went one step further by reminding us that even the “incapacitous person” should not be wrapped in “forensic cotton wool” but be allowed “as far as possible to make the same mistakes that all other human beings are at liberty to make and not infrequently do”.

The MCA code acknowledges the dilemmas professionals may face with regards to unwise decisions and gives the following advice:

“There may be cause for concern if somebody:

- repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or
- makes a particular unwise decision that is obviously irrational or out of character.

These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person’s past decisions and choices. For example, have they developed a medical condition or disorder that is affecting their capacity to make particular decisions? Are they easily influenced by

undue pressure? Or do they need more information to help them understand the consequences of the decision they are making?" (paragraph 2.11)

If professionals continue to be concerned about a vulnerable person with mental capacity who is seemingly making unwise decisions, then they could also take the matter to the High Court. The High Court can use its inherent jurisdiction to make certain orders to protect vulnerable people who have capacity in certain situations. For more information see Inform Adults' guide to the inherent jurisdiction of the High Court and vulnerable adults.

# Step 2

Remember that capacity is decision/issue and time specific. Saying that someone lacks capacity in a general sense is largely meaningless. You must ask yourself "what is the specific decision that needs to be made at this point in time?" If you do not define this question before you start undertaking the assessment, the exercise is likely to be pointless.

## PC & NC v City of York Council [2013] EWCA Civ 478

### Case summary

Source: 39 Essex Chambers

PC, who had learning disabilities, married NC while he was serving a 13-year sentence for serious sexual offences. NC had always maintained his innocence and PC agreed he was innocent. It was not disputed that PC had the mental capacity to decide whether to marry. Before marrying, PC and NC cohabited.

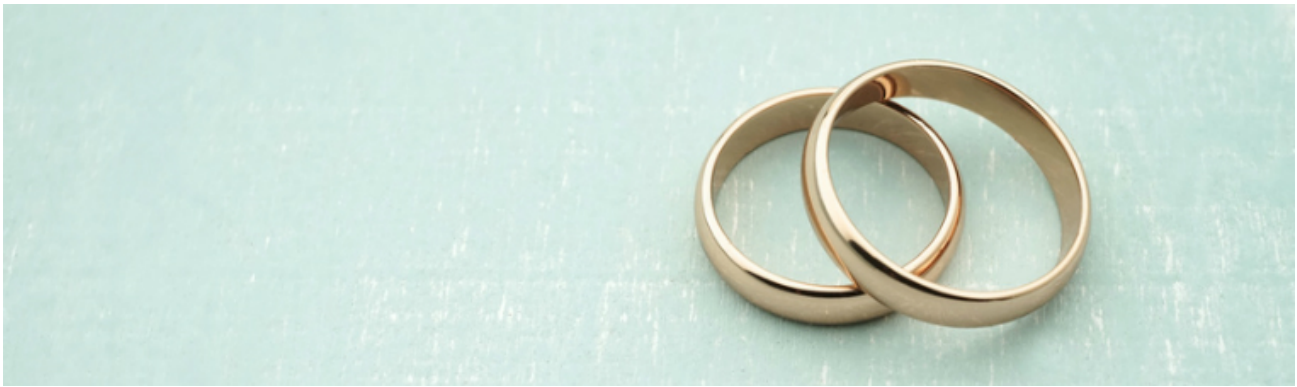

Photo: cobaltstock/Fotolia

NC was released from prison on licence but his licence conditions prevented him from living with PC. Both PC and NC wished to resume living together as husband and wife. All those involved with the case (apart from PC and NC) thought that NC would pose a serious risk to PC, were they to live together. However, there was no evidence that, while NC and PC lived together, she had suffered serious harm at his hands.

The local authority applied to the Court of Protection for a declaration that PC lacked the mental capacity to decide whether to live with NC.

The key question for the court was whether capacity to decide whether to live with another is person-specific, as opposed to being "act specific" (which is the case for capacity to marry).

The Court of Appeal confirmed that the test of capacity is person-specific in such caes. In the words of MacFarlane LJ:

"I do not therefore accept [the argument] that there is no basis for the court to adopt an act specific approach to the question of capacity to marry but to personalise the question of whether there is capacity to decide whether or not to have contact with, or reside with, a particular spouse. One, capacity to marry, involves understanding matters of status, obligation and rights, the other, contact and residence, may well be grounded in a specific factual context. The process of evaluation of the capacity to make the decision must be the same, but the factors to be taken into account will differ."

The Court of Appeal set aside the first instance decision by the Court of Protection on the basis that it had not been proven that PC lacked the mental capacity to decide whether to resume living with NC. As a result, the Court of Protection had no power to become involved in PC's living arrangements with NC.

### Implications for practice

This case can be viewed as the 'exception that proves the rule'. While, generally, the analysis of mental capacity to take decisions involving a third party (for example, contact) takes into account the particular circumstances of that third party, marriage is a special case. So far as consenting to marriage is concerned, the case law authorities provide that the necessary mental capacity is act-specific, not person-specific.

Apart from that, the Court of Appeal's decision stresses the need for a careful analysis of the decision in question and a very careful analysis of the evidence to ensure that it is relevant to capacity to make that, and not some other, decision.

## What the MCA code of practice says:

> Paragraph 4.4: "An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general."
>
> This point is also emphasised in paragraph 4.10 of the MCA code which states that we should be able to prove that a person lacks capacity to make a particular decision "at the time it needs to be made".

# Step 3

Preparation for capacity assessments.

## LBX v K, L & M [2013] EWCH 3230 (Fam)

### Case summary

Sources: Community Care Inform Adults and 39 Essex Chambers

This case concerned L, a 29-year-old man with mild learning disabilities. The local authority made an application to the Court of Protection to determine where L should live and whom he should have contact with.

Two expert witnesses were instructed, a doctor to provide an opinion on L's mental capacity and an independent social worker to provide an opinion on L's best interests in relation to contact and residence. Both professionals met L. The social worker also met L's family members and other professionals involved with his care. Part of the social worker's assessment involved trying to identify L's wishes and feelings. In doing so, the social worker used drawings and prepared cards to "facilitate a more concrete conversation with L regarding his wishes and feelings".

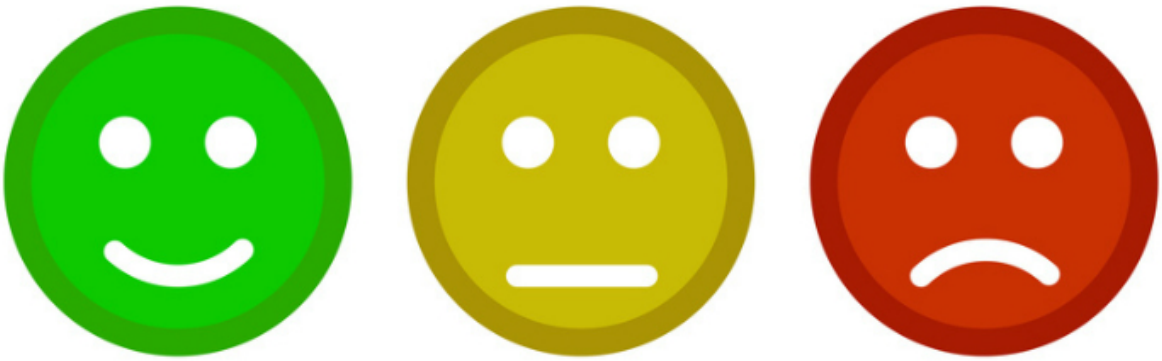

Image: vivat/Fotolia

For example:

- The social worker used “HAPPY”, “OKAY” and “SAD” cards and invited L to place the card which best matched his feelings on drawings representing the different care options under consideration.
- The social worker drew ‘stick men’ and asked L how she should embellish them to show that they indicated different people, such as his aunt and key staff members. In relation to contact, L was asked to add a staff card to a card for a family member if he did not want to see that family member on his own.

As a by-product of this approach, it seemed that L might in fact have mental capacity to make the relevant decisions. The Official Solicitor therefore asked the social worker to give her views about L’s mental capacity to take the particular decisions. The social worker’s opinion was that L had shown the potential to have the mental capacity to make decisions about matters relating to contact and residence if careful steps were taken to facilitate his decision making.

The judge was impressed with the careful and facilitative approach taken by the social worker:

- Her opinions had a “securer evidential foundation” than those of the doctor.
- Her report was “well-structured and each stage was justified by careful analysis”.
- In giving opinions about mental capacity, the social worker had shown she was able to separate out the different aspects of the MCA’s capacity test. She had carefully prepared her assessment in advance, using visual techniques that linked abstract concepts, such as trust, with tangible drawings.
- She had carefully considered what information was relevant to the decisions under analysis.

The doctor’s approach did not show the same level of thought or consideration. In particular, he had not used drawings or pictures as part of his assessment. Also, some aspects of the doctor’s analysis were superficial and based on unchecked assumptions, for example, that certain work had been done by L’s allocated social worker when it had not.

The social worker’s reports raised sufficient doubts about the doctor’s assessment of mental capacity to call for a further assessment before the court made a final decision as to L’s capacity.

## Implications for practice

The judge in this case specifically highlighted the social worker's good practice in relation to preparing for her assessment of best interests. She carefully thought it out in advance, with detailed consideration of the strategies that she was going to use. Even though the focus of her assessment was best interests, not capacity, the approach she took meant she was able to obtain information relevant to decisions on residence, contact and care and reasons for the views L expressed. So when subsequently asked to provide an opinion on L's capacity, she was able to articulate what she considered to be relevant information or not for decisions regarding residence or care, with underlying rationale.

## What the MCA code of practice says:

When assessing capacity in relation to any decision, professionals need to decide from the outset what the relevant issues are in relation to that specific decision and what information the person should be able to understand, retain and weigh in relation to them.

Chapter 3 of the code emphasises the importance of giving relevant information in all decision making: "For example, to make a choice about what they want for breakfast, people need to know what food is available. If the decision concerns medical treatment, the doctor must explain the purpose and effect of the course of treatment and the likely consequences of accepting or refusing treatment." (paragraph 3.7)

The code also states that "information must be tailored to an individual's needs and abilities. It must also be in the easiest and most appropriate form of communication for the person concerned" (paragraph 3.8). So before you even assess a person's capacity you need to be aware of their needs and abilities and plan your assessment accordingly.

Also consider if you need to involve others in your assessment. The code advises: "For some types of decisions, it may be important to give access to advice from elsewhere. This may be independent or specialist advice (for example, from a medical practitioner or a financial or legal adviser). But it might simply be advice from trusted friends or relatives." (paragraph 3.9).

In relation to planning how you can communicate effectively, the code once again provides detailed guidance in chapter 3, paragraph 3.10. This includes:

Ask people who know the person well about the best form of communication (try speaking to family members, carers, day centre staff or support workers). They may also know somebody the person can communicate with easily, or the time of day when it is best to communicate with them.

Think of simple language that you can use. Where appropriate, use pictures, objects or illustrations to demonstrate ideas.

Speak at the right volume and speed, with appropriate words and sentence structure. It may be helpful to pause to check understanding or show that a choice is available.

Think of how you can break down difficult information into smaller points that are easy to understand. Make sure that you allow the person time to consider and understand each point before continuing.

It may be necessary to repeat information or go back over a point several times. Be prepared and allow yourself time to accommodate this.

Think whether you can enlist the help of people that the person trusts (relatives, friends, GP, social worker, religious or community leaders), but do make sure the person's right to confidentiality is respected.

Be aware of cultural, ethnic or religious factors that shape a person's way of thinking, behaviour or communication. For example, in some cultures it is important to involve the community in decision making. Some religious beliefs (for example, Jehovah's Witnesses or Christian Science) may influence the person's approach to medical treatment and information about treatment decisions.

If necessary, consider using a professional language interpreter. Even if a person communicated in English or Welsh in the past, they may have lost some verbal skills (for example, because of dementia). They may now prefer to communicate in their first language. It is often more appropriate to use a professional interpreter rather than family members.

If using pictures to help communication, make sure they are relevant and the person can understand them easily. For example, a red bus may represent a form of transport to one person but a day trip to another.

Consider whether an advocate would improve communication in the situation.

# Step 4

Taking all practicable steps to help someone make their own decision (principle 2 of the MCA).

## A NHS Trust v DE (appearing by his litigation friend the Official Solicitor) and others [2013] EWHC 2562 (Fam)

### Case summary

Source: Bailii

DE was a 37-year-old man who lived with his parents and was in a loving and sexual relationship with a woman, who also had learning disabilities.

The woman became pregnant, which caused DE much distress. The maternal grandmother, with whom the child's mother lived, was granted a special guardianship order over the child, giving the grandmother parental responsibility.

DE and his partner expressed the wish to continue their relationship but DE consistently expressed the view that he did not want to have more children. His parents, who were very supportive of and committed to DE, and who cared for him, thought that it was in his best interests to have a vasectomy. The matter was referred to the courts to decide whether to grant a number of orders, including an order for DE to undergo a vasectomy. It was not disputed that DE lacked the mental capacity to decide for himself whether to have a vasectomy.

After an intensive programme of sex education, professionals involved with DE were of the opinion that he had gained the mental capacity to consent to sexual relations, although it would be necessary for him to have some 'top-up' sessions to ensure that he remembered how to keep himself safe from sexually transmitted infections and diseases. The Court of Protection judge agreed that he had capacity to decide whether to have sexual relations but not to decide whether to have a vasectomy. The court held that it was in DE's best interests to have a vasectomy, even though this would permanently remove his ability to have children.

## CH (by his Litigation Friend, The Official Solicitor) v A Metropolitan Council [2017] EWCOP 12

### Case summary

Source: Bailii

This case concerned a man referred to as CH, who had Down's syndrome and an associated learning disability since birth. He married his wife WH in 2010. In 2014, they sought fertility treatment and it was during this time that a consultant psychologist assessed CH as lacking capacity to consent to sexual relations.

The local authority became involved and advised WH to abstain from sexual intercourse with CH as this would be criminal offence under the Sexual Offences Act 2003. WH also understood that should she fail to comply, the local authority would implement further safeguarding measures, such as the removal of CH or herself from their home. WH moved to a separate bedroom and significantly reduced any physical expression of affection towards CH. CH could not understand why she was doing this. The judge noted that the impact this must have had on CH was "not difficult to imagine."

The consultant psychologist, however, also made it clear that CH needed a course of sex education to help him achieve capacity to consent to sexual relations. But for reasons that the judge felt had never been satisfactorily explained, the local authority failed to implement this advice, despite requests from the families involved to do so.

CH's sister, initiated proceedings in the Court of Protection, to force the local authority to arrange the course. This led to a sex education course being delivered to CH and the therapist involved reporting that CH had made progress. It was confirmed in writing that CH now had capacity to consent to sexual relations. This view was accepted by the local authority and given effect through a court declaration. CH and WH resumed a sexual relationship.

The local authority was held liable for failing to implement principle 2 of the MCA in a timely manner. CH's wife also brought her own claim for a violation of Article 8 of the ECHR which had been settled on confidential terms. For CH, the court approved a settlement which included an apology, damages and court costs.

The judge concluded that "[m]any would think that no couple should have had to undergo this highly intrusive move upon their personal privacy yet such a move was in its essentials entirely lawful and properly motivated. As I have said, perhaps it is part of the inevitable price that must be paid to have a regime of effective safeguarding."

### Implications for practice

Both these cases emphasise the importance of taking all practicable steps to help someone make their own decision (principle 2 of the MCA). You have to ask yourself if there is something that you can do which might mean that an individual would be able to make the decision for themselves. In the case of DE (while Court of Protection proceedings were ongoing), an intensive programme of sex education was provided, which resulted in him having the capacity to consent to sexual relations.

The main failure by the local authority in the case of CH, was that it failed to implement a sex education course, in line with principle 2 of the MCA, in a timely manner. And what this case further demonstrates is that authorities may be held liable for such

failures. Therefore, taking all practicable steps to help someone make their own decision is not just 'good practice', but a statutory requirement under the second principle of the MCA.

In the case of DE, safeguarding measures were implemented in his best interests and court proceedings were commenced. But at the same time, DE received sex education which resulted in him gaining capacity to consent to sexual relations. In the CH case, the judge highlighted that protecting vulnerable people in their best interests (which may involve interference with or restrictions on their lives) where there are serious safeguarding concerns (for example, where capacity to consent to sexual relations is brought into question), is part of "effective safeguarding" and in "its essentials entirely lawful and properly motivated."

But this is not where the role of supported decision making ends. We should, once we've assessed a person as lacking capacity, continue to take all practicable steps to enhance that person's capacity, so that they may eventually gain the capacity to make the relevant decision for themselves. This is within the spirit of the MCA.

## What the MCA code of practice says:

Chapter 3 is dedicated to this principle. Two key points that this chapter highlights in relation to taking all practicable steps to help someone make their own decision are:

1. Providing all the relevant information that a person may need to make a particular decision; and
2. If they have a choice, then we need to ensure that they have been given information on all the alternatives (p29).

So the MCA code makes it absolutely clear that in order to take all practicable steps we should think about what the relevant information and/or options are around a particular decision and provide this information to the person to enable them to make the decision for themselves. And what case law is saying is that it is wrong to take a one-size-fits-all approach. It should not be assumed that a one-off session providing the relevant information will be sufficient. If it is necessary and appropriate, a longer-term strategy over a course of weeks (or however long it may reasonably take) to educate and support the person concerned to attain mental capacity should be adopted.

It is only once all practicable steps have been taken without success that it can properly be said that the person is unable (or lacks capacity) to make the decision for themselves. And as clearly evident from the cases of DE and CH, the courts are placing more and more emphasis on this principle and will decline to find a person lacks mental capacity unless it can be evidenced that serious steps have been taken without success to support the person to make the particular decision.

# Step 5

Applying the test for capacity.

The MCA sets out a dual-aspect test for capacity. Section 2 of the MCA states that a person lacks capacity if they are "unable to make a decision" (the functional test) "because of an impairment of, or a disturbance in the functioning of, the mind or brain" (the diagnostic test). Section 3 goes on to explain what is meant by being unable to make a decision.

It is important to take note that the terms "diagnostic" and "functional" do not come from the MCA itself. It is in the MCA code of practice where these elements are set out as stage 1 (diagnostic test) and stage 2 (functional test) – MCA code of practice 4.11 and 4.13. Please note, however, that case law has now confirmed that the code does not set out the order of the tests correctly – the functional test should always come first before the diagnostic test (see PC and NC v City of York Council and Kings College NHS Foundation Trust v C, both of which are considered below).Case law has stressed the importance of the 'because of' element in section 2 of the MCA, also known as 'the causative nexus'. This requires us to ask whether the inability to make the decision (functional test) is 'because of' the impairment or disturbance (diagnostic test). This reflects the wording of section 2.

The test for lack of capacity can therefore be said to consist of the following elements:

1. The functional element: is the person unable to make a decision?
2. The diagnostic element: is there an impairment or disturbance of mind or brain?
3. The 'because of' element: is this inability because of the identified impairment or disturbance? (*PC & NC v City of York Council– see below*)

We will now examine the above three elements and relevant case law that should be guiding our practice when applying these elements to the capacity assessment.

# Stage 1: the functional test

The functional test, which should be applied when determining whether a person is unable to make their own decision, is set out in the MCA section 3(1) as:

**Inability to make decisions**
(1) For the purposes of section 2, a person is unable to make a decision for himself if he is

unable –
(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means).

If a person can do all of the above, they should be regarded as able to make the relevant decision for themselves. If they are unable to do any one of the above, they will satisfy the functional test. But this in itself doesn't necessarily y mean that the person will lack capacity within the meaning of section 2 of the MCA. It is important to remember at this point that this inability to make the decision must be 'because of' the impairment or disturbance in the functioning of the mind or the brain (see below) identified during stage 1 of this assessment process (see Stage 3 – Establishing the causative nexus).

# Stage 2: the diagnostic test

Section 2 (1) of the MCA states that:

"For the purposes of this Act, 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 brain."

## What the MCA code of practice says:

The code sets out the diagnostic test. This is where we ask: does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

At paragraph 4.11 the code states that the diagnostic test "requires proof that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act".

Paragraph 4.12 sets out the following examples of an impairment or disturbance in the functioning of the mind or brain may be included in this definition, such as:

- conditions associated with some forms of mental illness
- dementia
- significant learning disabilities
- the long-term effects of brain damage

- physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- delirium
- concussion following a head injury, and
- the symptoms of alcohol or drug use.

It is worth noting that the list in the code refers to *significant* learning disabilities.

There is an abundance of case law on how to assess capacity, and in particular on how the functional test should be applied in practice. We will examine these cases next, before summarising the implications for practice and linking this to guidance in the MCA code of practice.

## Case summaries

### PCT v P, AH & the Local Authority [2009] EW Misc 10 (COP) – capacity to engage in the decision-making process

Source: 39 Essex Chambers

P, aged 24, had a severe form of uncontrolled epilepsy and lived with AH who had adopted him when he was eight-years-old. The evidence suggested he had mild learning disabilities although AH did not necessarily accept this.

An application was made to the Court of Protection to decide his capacity to make his own decisions about a number of matters including his medical treatment, accommodation and contact. The primary care trust supported by the local authority and the Official Solicitor, wanted P to live in independent living accommodation with limited contact with AH. AH was devoted and committed to the care of P, but there was also a strong co-dependency between them and they shared bizarre beliefs about the motives of the professionals involved in his care, which created distrust and animosity.

The judge noted the structure of the 'functional' element of the MCA's test for mental capacity. If a person cannot understand the information relevant to a decision or retain it, they lack capacity. A person also lacks capacity if unable to "use or weigh" the information as part of the process of making the decision under analysis. The judge observed that cases turning on this aspect of capacity (using or weighing) tend to be the most difficult.In these cases, the focus is on capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another".

The judge came to the conclusion that P lacked capacity to make decisions in relation to all areas where declarations were sought. Among the judge's reasons for these conclusions, he relied on P's inability to envision taking any view that was contrary to AH's so enmeshed was his relationship with her. The judge went on to decide it was in P's best interests to "be accommodated in some form of independent living", with significant support, as proposed by the public authorities. Contact with AH was to be restricted to weekly sessions, initially at least, which were "lightly supervised".

## Re FX [2017] EWCOP 36 – refusal to engage in the capacity assessment

Sources: Bailii and 39 Essex Chambers

FX, 32, has a diagnosis of Prader-Willi Syndrome (PWS). This is a rare genetically determined disorder associated with particular physical and behavioural characteristics. FX was overweight and had multiple health problems. He was also unable to control his compulsion to constantly eat and the majority of his care is focused on this. FX was subject to the Deprivation of Liberty Safeguards and an application was made on his behalf against the authorisation.The case focused on whether FX had capacity to make decisions in relation to residence and care. The court heard from two witnesses: an advanced social work practitioner (SN) and an independent psychiatric expert, Tony Holland. Both were restricted in their ability to assess capacity by a refusal by FX to engage.

The judge reminded herself of the case of *Re P* [2014] EWHC 119 COP in which the judge said "it seems to me that patient's lack of engagement or co-operation with the assessment may contribute in itself to a conclusion that a patient is unable to "understand the information relevant to the decision" (section 3(1)... a) and/or (perhaps more significantly, if the patient is shown to understand) unable to use or weigh that information as part of the process (section 3(1)(c))".

However, in the case of FX the judge was "satisfied that his reluctance to discuss his PWS arises from embarrassment and frustration. This explanation does not, in itself, establish that he has relevant understanding".

Unlike SN, Holland found it difficult to engage with FX, and the judge noted that "in undertaking his assessment Holland considered records for FX from last year, he spoke with a senior staff member at Care Home C and met FX on two occasions. On the first occasion for 10 minutes and subsequently for 40 minutes. Unfortunately, he established minimal rapport with FX and FX did not wish to engage with any discussion about his PWS". Holland concluded that FX lacked capacity in relation to residence and care.

The judge noted that the difficulties Holland had in engaging with FX fed into his report. In particular, she noted that Holland's report::

- Demonstrated an obvious knowledge of PWS and great commitment to improving the lives of those who have the condition, but this led him to conflate best interests with capacity.
- Had set the bar for capacity too high.
- Failed to conduct a proper analysis of the presumption of capacity and had shifted the burden to FX to demonstrate that he possessed capacity.
- Did not consider whether any of FX's reported actions were unwise decisions rather than indications of lack of capacity.
- Lacked clarity about the particular decisions to be made by FX.

SN took a different view. She had the advantage of being able to meet more extensively with FX and was able to have more productive discussions with him. She conducted her assessment from the correct starting point of assuming that FX has capacity and applying the relevant statutory framework and guidelines.

The judge concluded that: "When I consider those matters about which there is evidence of FX's understanding [...] I am satisfied that FX is able to understand, retain, use or weigh the relevant information set out in *LBX v K & M* and to communicate his decision. Holland did not specifically address this with FX but confirmed in his oral evidence that he would expect FX to understand this. The assessment of SN reinforces this.

"In addition, from the evidence of SN, I am satisfied that FX understands that he has PWS and that it is an eating disorder. He has identified that he needs support when going out in the community and that he needs support with portion control. He understands that rejecting support at Care Home A caused him to gain weight. He understands that he is overweight and that this affects his health. He knows that losing weight would improve his sleep apnoea. He wishes to lose weight and he is trying to do so. He understands that staff try to help him by suggesting healthy options when out but that sometimes he rejects advice."

The judge therefore held that FX had capacity to make the relevant decisions.

## Kings College NHS Foundation Trust v C and V [2015] EWCOP 80 – on applying the functional test

Source: Community Care Inform Adults

The issue for the court was whether a woman, C, had the capacity to decide whether to consent to the life-saving treatment that her doctors wished to give her following her attempted suicide. The treatment was renal dialysis. Without such treatment, the inevitable outcome was C's death. If the treatment was administered, it was likely that C's life would be saved, albeit there remained a risk that she would require dialysis for the rest of her life. C refused to consent to dialysis and her decision was supported by her family.

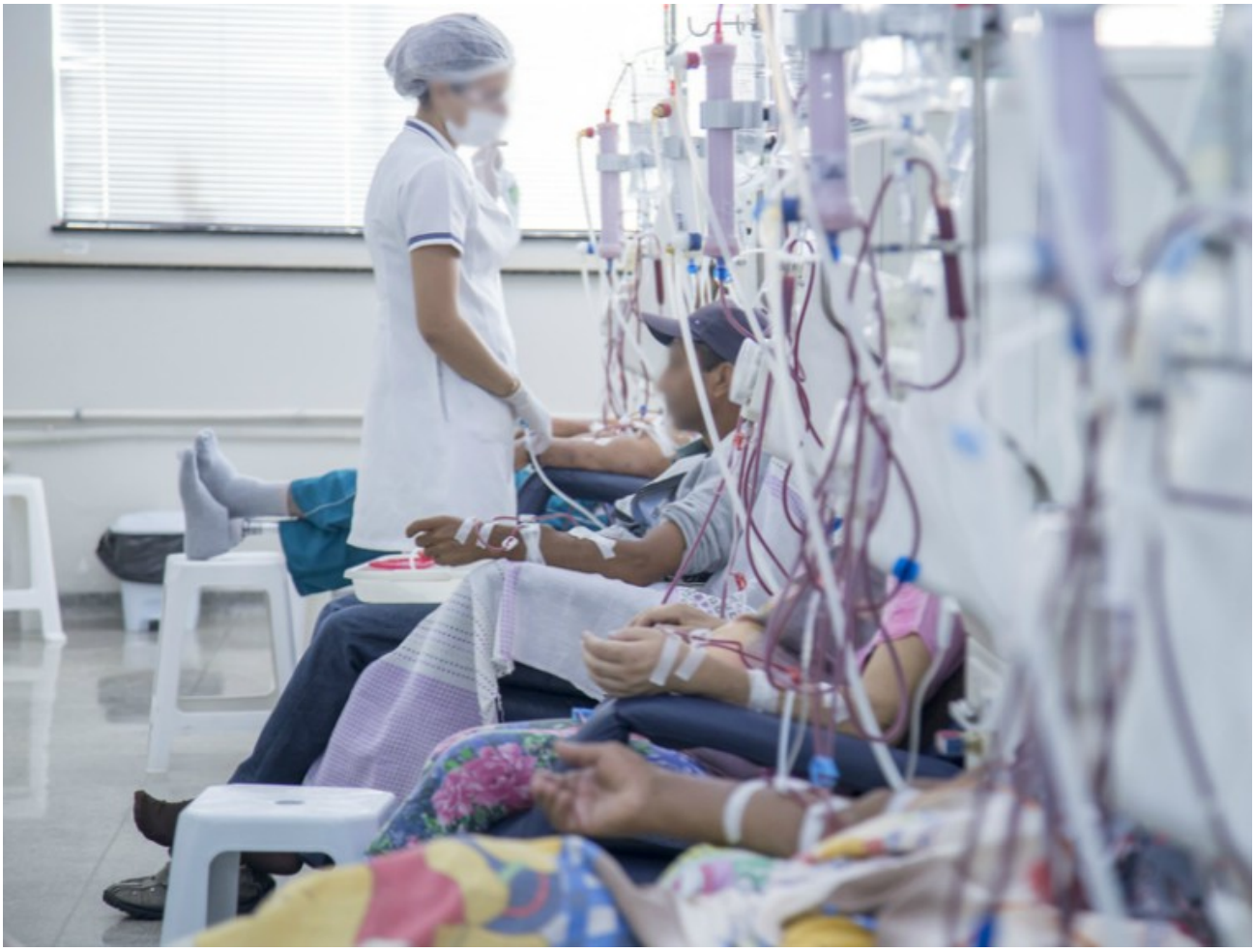

Photo: mailsonpignata/Fotolia

C's life revolved largely around her looks, men, material possessions and living the high life. Her decision making was often impulsive and self-centred without regret. She had four marriages and a number of affairs and spent the money of her husbands and lovers recklessly before moving on when the money ran out. She was a reluctant and at times indifferent mother to her three daughters and her consumption of alcohol was excessive.

Her attempted suicide had followed diagnosis and treatment for breast cancer and the acrimonious breakdown in a long-term relationship, which had a significant effect on her emotional and financial wellbeing. Her daughter said that, following C's admission to hospital, her mother said that she would try to kill herself again and was adamant that she wanted to die.

The trust submitted that C lacked belief in, and was unable to use or weigh her positive prognosis, and was unable to contemplate a future that included her recovery. This inability was because of a personality disorder, diagnosed by the two psychiatrists, thereby satisfying the diagnostic test.

The court held that it is not necessary for a person to use or weigh *every* detail of the respective options available to them in order to demonstrate capacity, merely the *salient factors*. What is required is that the person is able to employ the *relevant* information in the

decision-making process and determine what weight to give it relative to other information required to make the decision.

The judge said: "...a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process."

The judge found that C did acknowledge her positive prognosis, weighed that information in the decision-making process but chose to give it no weight as against other information, within the context of her values and outlook. C had given a number of different reasons for not wanting to continue her treatment, including the risk of a life lived on dialysis, her wish not to endure the pain associated with treatment and the risk she would not be able to attain her former lifestyle.

In the concluding statements of the judgment, the judge said: "C's decision is certainly one that does not accord with the expectations of many in society. Indeed, others in society may consider C's decision to be unreasonable, illogical or even immoral within the context of the sanctity accorded to life by society in general. None of this, however, is evidence of a lack of capacity."

The judge also concluded that, had he found the functional test met, he would have had difficulty concluding that her inability was because of an impairment of, or a disturbance in the functioning of, the mind or brain. Not only was the evidence about the nature of her impairment not conclusive, but he found the evidence from the trust's psychiatrists "equivocal" as to whether her alleged inability was the result of a personality disorder or of being a stubborn, strong-willed individual.

## CC v KK & STCC [2012] EWHC 2136 (COP) – accommodation – give the person options and avoid the protective imperative

Source: 39 Essex Chambers

KK was an 82-year-old woman with Parkinson's disease, vascular dementia, and paralysis down her left side. She had lived on her own in a rented bungalow, which she moved to after her husband died. She was assessed as lacking capacity to make residence decisions and placed in a nursing home. She wanted to return to the bungalow but a standard authorisation was issued under the Deprivation of Liberty Safeguards (although this was no longer in place by the time of the hearing).

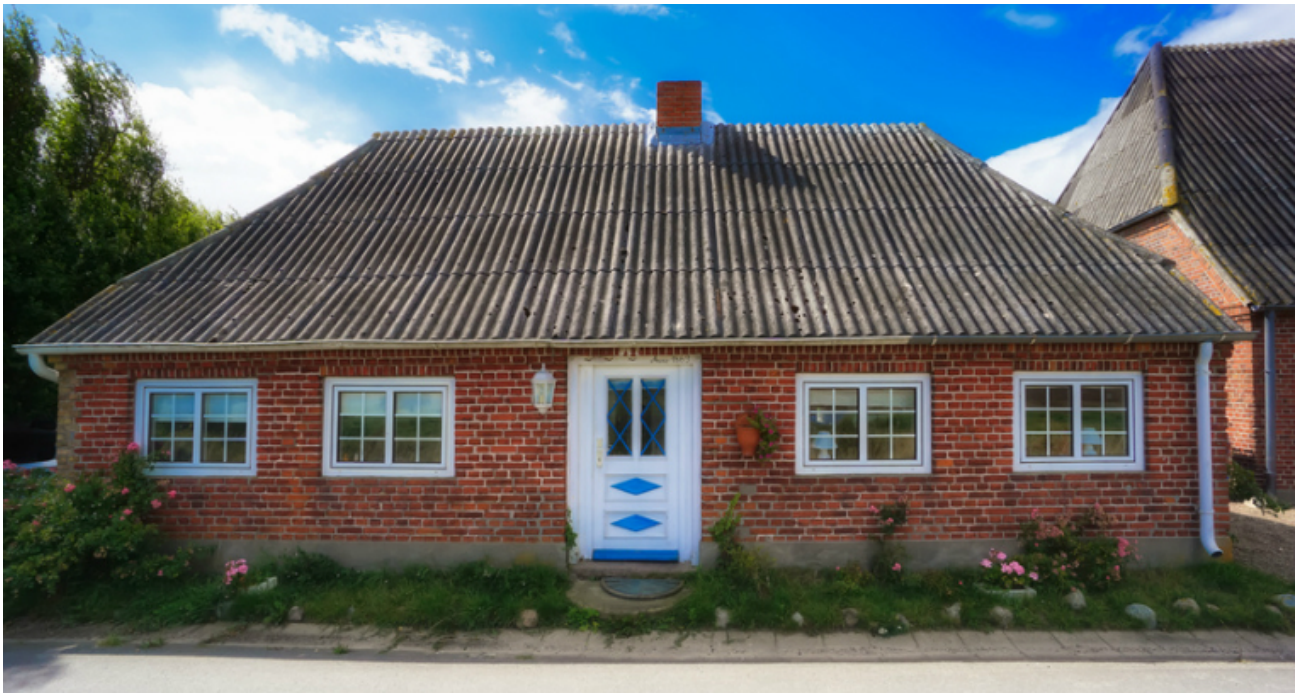

Photo: Traumbild/Fotolia

The judge emphasised that professionals and the court must not be unduly influenced by the 'protection imperative'; that is, the perceived need to protect the vulnerable adult. Assessments of capacity must be "*detached and objective*", and not drawn towards the need to protect the person from harm.

The judge also pointed out that although we may see being physically secure and comfortable in a care home as important, the person might attach more weight to being emotionally secure and comfortable in their own home. He reminded us that "there is, truly, no place like home, and the emotional strength and succour which an elderly person derives from being at home, surrounded by familiar reminders of past life, must not be underestimated".

The judge also made it clear that capacity assessors should not start with a blank canvas: "The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed."

The judge heavily criticised the local authority's assessment of KK's capacity:

"I find that the local authority has not identified a complete package of support that would or might be available should KK return home, and that this has undermined the experts' assessment of her capacity. The statute requires that, before a person can be treated as lacking capacity to make a decision, it must be shown that all practicable steps have been taken to help her to do so.

"As the Code of Practice makes clear, each person whose capacity is under scrutiny must be given 'relevant information' including 'what the likely consequences of a decision would be

(the possible effects of deciding one way or another)'. That requires a detailed analysis of the effects of the decision either way, which in turn necessitates identifying the best ways in which an option would be supported. In order to understand the likely consequences of deciding to return home, KK should be given full details of the care package that would or might be available.

"The choice which KK should be asked to weigh up is not between the nursing home and a return to the bungalow with no or limited support, but rather between staying in the nursing home and a return home with all practicable support. I am not satisfied that KK was given full details of all practicable support that would or might be available should she return home to her bungalow."

The judge concluded that KK had capacity to make residence decisions. Even though she couldn't "understand and weigh up every nuance or detail", she could still understand and weigh "the salient features" and the judge did not agree that her understanding was "superficial". She understood that she needed total support with care workers visiting four times a day; she understood she may need prompting to eat and drink; she understood she may be lonely; and she understood the risk at night might be greater. While she may have underestimated or minimised some of her needs, she did not do so to an extent that suggested that she lacked capacity to weigh up information.

## Implications for practice and what the MCA code of practice says

The above cases illustrate the courts' thinking when assessing a person's capacity and in particular applying the functional test for capacity in section 3 of the MCA, which provides extremely helpful guidance for all professionals in their day-to-day practice. This guidance and that found in the MCA code of practice can be summarised as follows:

**Avoid the protection imperative by being detached and objective:**
– The *CC v KK & STCC* judgment tells us we have to be mindful from the outset to avoid the 'protection imperative' and our assessments of capacity must be detached and objective, and not drawn towards the need to protect the person from harm. Just because the person's preferred option may put them at risk of harm or is different from the views of professionals, doesn't mean that they lack capacity to make the decision for themselves. This may be an unwise decision but not an incapacitated one.

**Identify the relevant information or salient factors:**
– Chapter 3 of the MCA code of practice emphasises the importance of giving 'relevant information' for all decision making. This was described by the judge in *CC v KK &*

*STCC* as "the salient factors" and "not every detail". Nobody can make an informed decision without being made aware of the salient details.
– Identifying both the specific decision and the information relevant to it can be a somewhat subjective exercise, with a real danger of capacity assessments being led by the assessor's desire to act in the person's best interests. But as the *CC v KK & STCC* judgment reminds us – detachment and objectivity is crucial. You need to ask yourself what any person would need to consider in relation to such a decision, as well as what would be relevant for that person in making that decision.

**Give the person options:**
– The *CC v KK & STCC* judgment makes it clear that capacity assessors should not start with a blank canvas: "The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed."
– But it is worth remembering that (as noted under point 2 above) the person only needs to understand the salient factors. In *Kings College v C and V* the court said that the person must be able to employ the *relevant* information in the decision-making process and determine what weight to give it relative to other information required to make the decision.

**Remember to take all practicable steps to help the person make the decision:**
– We need to remember that the relevant information should be explained in a way that is in line with the person's needs and abilities. As the MCA code of practice states it must be "in the easiest and most appropriate form of communication for the person concerned" (paragraph 3.8). So think about using simple language, visual aids and any other means to help them understand. This is part of taking all practicable steps to help the person make their own decision, which has been discussed in much more detail under step 4 of this guide.

**In relation to retaining information:**
– In relation to retaining the relevant information, section 3(3) of the MCA states 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".* The person should only be able to retain the information for as long as it takes to understand and weigh such information in order to make their own decision.

**In relation to weighing information:**
– *PCT v P, AH & the Local Authority* tells us we need to look at the person's capacity "to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another".
– We need to always be mindful that different people may give different weight to different factors. As the judge in *CC v KK & STCC* points out – the person might attach more weight to being emotionally secure and comfortable in their own home, as opposed to being physically secure and comfortable in a care home.
– And as emphasised in the *Kings College v C and V* case "…a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the

decision in question and chosen to attach no weight to that information in the decision making process".
– Also remember that, as highlighted in the *Re FX* case, refusal to engage in the capacity assessment, or reluctance to discuss certain topics, should not in itself be taken as evidence that the person is unable to understand, retain or weigh the relevant information.

**Don't set the bar too high:**
– *Heart of England NHS Foundation Trust v JB* (discussed under "step 1" above) tells us to guard against imposing too high a test of capacity to decide issues such as residence, to avoid discriminating against people with mental health problems. People with disabilities should not be judged to lack capacity simply because their level of understanding is not the same as that of a person without a disability.

**Come to a clear conclusion on the balance of probabilities:**
– And lastly, the code of practice advises that we need to be able to show on the balance of probabilities (ie it is more likely than not) that the person lacks capacity to make the decision.
– The person being assessed furthermore doesn't have to prove or demonstrate that they have capacity, the burden of proof lies with the assessor. Therefore, it is the assessor who must be able to clearly evidence their determination.

# Stage 3: establishing the causative nexus

The MCA section 2(1) states, "For the purposes of this Act, 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 brain." This is referred to by the courts as the "causative nexus" and the case law below provides guidance on how this needs to be applied in practice when assessing capacity.

## LB Redbridge v G, C and F [2014] EWHC 485 (COP)

### Case summary

Source: 39 Essex Chambers

This case centred on an elderly lady, G (aged 94), considered to be a vulnerable adult. She lived on her own until she was introduced by a friend at church to C. G said she needed help at night so the arrangement was that C would move in to provide it and that she would live there, rent-free, in return. C's husband, F, also moved in with G.

The local authority became concerned about reports regarding the behaviour of C and F and their influence over G, her home and her financial affairs and with respect to her personal safety. The social worker who became involved to investigate these concerns tried to visit G to see her on her own, but was obstructed by C and F, which led to the police attending on more than one occasion.

There were doubts as to whether G was able to make her own decisions about her finances and general welfare, but it was unclear whether this was because she lacked capacity in line with the MCA, or due to the influence of C and F. The judge concluded that G's inability to make a decision was "because of" an impairment of her mind or brain so that the matter came under the MCA:

"The court has decided…that G lacks capacity under the provisions of the Mental Capacity Act 2005 and that further investigation needs to be carried out to decide how her best interests will be met and her comfort and safety assured. Her wishes and feelings will be taken into account at every stage as will her desire to remain in her own home. It is the court's intention that every measure that can be put in place to secure her in her own home is put in place. There is an equal need to ensure that she is not overborne or bullied and that she can lead her life as she wants it led."

## PC & NC v City of York Council [2013] EWCA Civ 478

### Case summary

Source: 39 Essex Chambers

This was the case about PC who married NC while NC was serving a 13-year prison sentence for serious sexual offences. Before NC's imprisonment, they had lived together and wished to do so after his release. This case has already been discussed earlier to illustrate the point that the assessment of mental capacity is decision or issue specific. Another important feature of the case is that it draws attention to the "the causative nexus".

The Court of Protection initially ruled that PC lacked capacity to decide to resume co-habitation with NC, but the Court of Appeal ruled that the local authority had not proven that she lacked mental capacity in this respect. Applying the statutory presumption of capacity, that meant she was to be taken to have mental capacity to decide whether to resume living with NC. The fact that she had a learning disability (an impairment of mind or brain) did not of itself mean that she couldn't make this decision. The Court of Appeal also expressed doubt as to whether the judge had properly applied the "because of" element of the test. The court's concern arose from the judge having referred to the inability to make a decision to be "referable to" or "significantly relate to" the disturbance or impairment of mind or brain. That risked watering down the legal requirement for the inability to be "because of" a person's impairment or disturbance in mind or brain.

The Court of Appeal also confirmed that the correct sequence for a capacity assessment was to consider the functional test first, and only if this test is met to then consider whether it is because of an impairment/disturbance. Lord Justice MacFarlane said:

"There is, however, a danger in structuring the decision by looking to section 2(1) primarily as requiring a finding of mental impairment and nothing more and in considering section 2(1) first before then going on to look at section 3(1) as requiring a finding of inability to make a decision. The danger is that the strength of the causative nexus between mental impairment and inability to decide is watered down. That sequence – 'mental impairment' and then 'inability to make a decision' – is the reverse of that in section 2(1) – 'unable to make a decision…because of an impairment of, or a disturbance in the functioning of, the mind or brain'. The danger in using section 2(1) simply to collect the mental health element is that the key words 'because of' in section 2(1) may lose their prominence and be replaced by words such as those deployed by Hedley J: 'referable to' or 'significantly relates to'.

"Approaching the issue in the case in the sequence set out in section 2(1), the first question is whether PC is 'unable to make a decision for herself in relation to the matter', the matter being re-establishing cohabitation with NC now that he is her husband and now that he has regained his liberty. In this regard the fact that PC has capacity in all other areas of her life (save for litigation) and, in particular, has capacity to marry, is very significant."

## Implications for practice

The LB Redbridge case shows how establishing the causative nexus is especially important in cases where an individual's inability to make decisions may be related to the presence of third parties. The judge in this case stressed the importance of establishing whether G's inability to make a decision was because of the impairment/disturbance, or because "she is a vulnerable adult deprived of capacity by constraint, coercion or undue influence".

The judgment records G as saying that she felt caught in a spider's web, with C as the spider. This highlights the complexities in establishing what affected G's ability to make a decision.

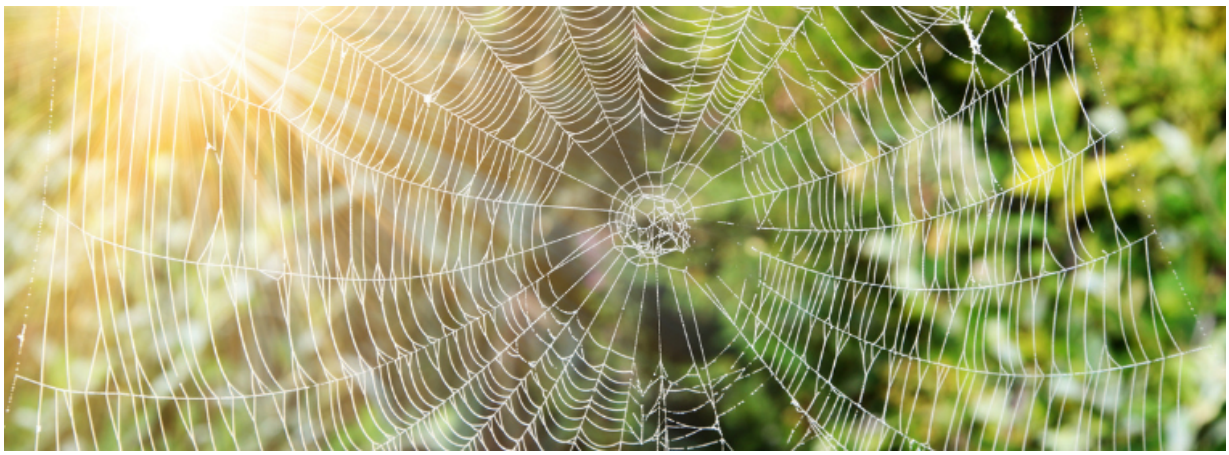

Photo: Thaut Images/Fotolia

Sometimes we, as professionals, come across cases where people are so entangled in difficult social circumstances (like a spider's web) that it can be very difficult to establish the exact reason for the person's inability to make a decision, especially if they themselves seem unwilling to make a decision one way or the other, which may leave them at significant risk. We need to bear in mind that the person may simply be making an unwise decision, rather than lacking the mental capacity to make the decision.

You need to decide "on the balance of probabilities" what the underlying reasons may be for apparent flaws in a person's approach to decision-making. If it is "because of" an impairment of the mind or brain, then the MCA is engaged, but if it is "because of" other influences, then you can't say that the person lacks capacity within the meaning of the MCA and you therefore can't proceed to make decisions in their best interests under the MCA. In such cases, the issue becomes what, if anything, should be done to try and safeguard the individual. The appropriate course to take will depend on the circumstances of a particular case. Options include involving the police, configuring or reconfiguring a care package with a view to reducing the risks faced, or applying to the High Court for it to exercise its inherent jurisdiction in relation to vulnerable adults.

This LB Redbridge case also stresses that it is particularly important to be aware of the dangers of equating an irrational decision with the inability to make one – an individual may not agree with the advice of professionals, but that does not mean that they lack capacity to make a decision. As the judge made clear, "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".

# Conclusion

Applying the functional test of the capacity assessment involves assessing whether the person can understand, retain and use and weigh the relevant information, and communicate their decision.

The outcome of this assessment will determine what happens next. If the conclusion is that the person is able to make the relevant decision, the MCA has no further role to play. If the conclusion is that the person is unable to make the relevant decision, and this is because of an impairment or disturbance in mind or brain, the issue is whether to take action for the individual in their best interests.

For care staff, authority to act is found in section 5 of the MCA. Generally, this permits acts of care or treatment to be performed if (a) reasonable steps have been taken to establish whether the person lacks capacity in relation to the matter in question, and (b) in doing the act, it is reasonably believed that the person lacks capacity and the act is in the person's best interests. This can involve significant interference with fundamental human rights such as rights connected to a person's private life and family life. It is crucial, therefore, that the assessment of capacity which precedes the acts is soundly undertaken.

### + Further information

> This guide forms part of Inform Adults' knowledge and practice hub on mental capacity and deprivation of liberty.