

Mental Capacity Act 2005 decision-making - care, support and treatment

Introduction

This publication explores care and support planning within direct care settings under the **Mental Capacity Act 2005** (MCA). The particular focus is on care planning and delivery of day to day care, support and treatment in direct care settings. Practitioners assessing needs or creating plans under the **Care Act 2014** (CA) and the **Social Services and Wellbeing (Wales) Act 2014** (SSWWA) may, however, find this resource helpful when there are questions of capacity to be considered during wider care and support planning.

The House of Lords and the Care Quality Commission (CQC) have identified a need to improve the understanding and practical application of the MCA across health and social care. In accordance with the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** (HSCA) this practice tool provides an overview of the law, in England and Wales, in relation to the MCA. It is designed to support:

- > work with people in developing plans for care, support or treatment
- > delivery of direct care, support and treatment.

This tool supports practitioners and other professionals to:

- > Understand the importance of consent within care, support, treatment planning and delivery, and how this should be obtained.
- > Ensure people and their wishes, feelings, beliefs and values are at the heart of decisions.
- > Embed the MCA into day-to-day care, support and treatment planning and delivery.
- > Identify when to complete or arrange formal assessments of capacity within direct care planning.
- > Identify when and how to make and record best interests decisions within direct care planning.

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Setting the context

In a **review** of the MCA in 2014, The House of Lords Select Committee highlighted that, although being a 'visionary piece of legislation', there remained a need for greater understanding of the MCA across health and social care. The committee noted that 'prevailing cultures of paternalism (in health) and risk-aversion (in social care) prevented the Act from becoming widely known or embedded'.

The concerns identified were:

- > a failure to carry out capacity assessments
- > poor-quality assessments
- > the concept of unwise decision making facing institutional obstruction due to risk-aversion and paternalism
- > best interests decision-making often not being undertaken correctly
- > the least restrictive option not routinely or adequately being considered.

Similarly, CQC's **2018/19 annual report** noted that they '*continued to see providers that do not understand the wider legal principles of the MCA*'. An earlier **review** by CQC in 2016 also found 'a lack of personalised care plans' and 'a lack of involvement of families and carers in people's care'. A **case study** undertaken by CQC in 2018 explored how nine regulated services had made the transition from an inadequate rating (or equivalent) to a rating of good.

One of the key findings was care plans being found to be lacking in detail and not showing that the care being provided was person-centred.

The legal framework in practice

Anyone involved in direct care, support or treatment is required to address matters of consent and mental capacity within day-to-day care or treatment planning. Legal frameworks and the associated regulations (*The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 No. 2936*) require that:

- > **Assessments** are carried out with the person regarding their **needs** and **preferences** for their care, support and treatment.
- > Care, support and treatment is **appropriate**, meets the person's **needs**, and reflects their **preferences**.
- > If the person **lacks mental capacity** to make specific decisions, and no lawful representative has been appointed (for example under an **enduring** or **lasting power of attorney**), their **best interests** must be established and acted on in accordance with the MCA.
- > Clear care and/or treatment plans are developed with the person, that include **agreed goals** and are **made available** to the person and all practitioners and others involved in providing the care and support. Where relevant, the plan should include ways in which the person can **maintain their independence** in accordance with the MCA.

(HSCA s.9)

The MCA provides a legal framework to **protect** and **empower** people who may lack mental capacity to make their own care or treatment decisions. The Act provides a set of **statutory principles** to ensure that, wherever possible, people remain in control of their own lives regardless of their age, disability, conditions or behaviours. The overarching aim of the MCA is to be '*enabling and supportive of people who lack capacity, not restricting or controlling of their lives*' (Department of Constitutional Affairs, 2007).

Where it is found a person lacks mental capacity to make a specific care planning decision, the MCA aims to promote people's autonomy and details how care planning decisions should be made in their best interests and least restrictive of their rights and freedoms. A best interests care and support planning decision should only ever be made as a last resort, after all efforts and support have been undertaken to enable the person to make their own decisions without success.

The Mental Capacity (Amendment) Act 2019 provides for the repeal of the Deprivation of Liberty Safeguards (DoLS) and ushers in a replacement scheme commonly referred to as the **Liberty Protection Safeguards (LPS)**. Full implementation of the LPS is expected in April 2022. It was initially proposed that, within the scheme, responsible bodies would have the ability to ascribe new roles and responsibilities to registered managers in an attempt to 'incentivise the ownership of mental capacity and deprivation of liberty within all care providers and workforce' (O'Shaughnessy, 2018). However, the government has since announced that this aspect will no longer be implemented from April 2022, though it may be revisited in the future.

It is also important to be mindful of other key legislation that applies to care and support planning and delivery. For example:

- > The **Care Act 2014**:
 - Contains a duty to promote the **wellbeing** of people with care and support needs.
 - Definition of wellbeing includes: ‘*control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided)*’.
 - Requires practitioners to maximise peoples ‘involvement in the process’.
 - Highlights ‘*the importance of beginning with the assumption that the individual is best placed to judge the individuals wellbeing*’ and ‘*the need to ensure that decisions about the individual are made having regard to all the individual’s circumstances*’.
- > The **Human Rights Act 1998 (HRA)** places a legal duty on providers of care and support (acting as a public authority performing public functions) to **respect, protect** and **fulfil** human rights (**s.6**).
 - **The HRA sets out fundamental rights that are vital to care planning and provision:**
 - o the right to peaceful enjoyment of possessions (article 1, protocol 1)
 - o the right to life (article 2)
 - o prohibition of torture, inhuman and degrading treatment (article 3)
 - o the right to be free from slavery or forced labour (article 4)
 - o the right to liberty (article 5)
 - o the right to respect for private and family life (including home and correspondence, article 8)
 - o the right to freedom of thought, conscience and religion (article 9)
 - o the right to non-discrimination in the enjoyment of all other rights (article 14).

The **British Institute of Human Rights** (BIHR) has produced a **set of resources** aimed at placing human rights at the heart of service delivery. Within the **resource for practitioners** BIHR outline that:

Human rights are the basic freedoms and protections that every person has simply because they are human. Human rights are about people being treated with dignity, respect and fairness, having a say over their lives and participating in decisions that are made about their care, support and treatment.

(BIHR, ND)

Care Act 2014



Care and support planning interface between CA and MCA:

In both the MCA 2005 and the CA 2014 the person is expert in their own life, their **wishes and feelings** are vital.

The CA 2014 places a duty to **promote wellbeing**, which includes **'control over day to day life,'** and the MCA 2005 is all about enabling people and promoting autonomy.



Care Act 2014



Mental Capacity Act 2005



Care and support planning interface between MCA and HRA:

Under the MCA 2005, a lack of mental capacity should not be seen as an 'off switch' to rights and freedoms. There is a least **restrictive principle of rights** and freedoms.

The HRA 1998 only permits interference of fundamental rights when proportionate and necessary to prevent harm to the person.



Mental Capacity Act 2005



Human Rights Act 1998



Human Rights Act 1998



Care Planning Interface between the MCA, CA and HRA:

Care and support needs might be identified under the CA 2014 but this does not give sufficient justification to interfere with fundamental rights and freedoms without appropriate consent (with capacity) or authority under the MCA 2005.

Six steps: The MCA and good care planning

Step one: The first three MCA principles applied

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

Principle 2: 'A person is not to be treated as unable to make a decision unless **all practicable steps** to support them to do so have been taken without success'.

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

Co-production must be the starting point for all care, support and treatment planning. This means plans are developed with the person and those important to them unless the person chooses otherwise. The person's individual **wishes** and **preferences** should be central to each aspect of their care or treatment plan - they should be created applying the first three **MCA principles** and built upon **valid consent**. It is the difference between providing care that is lawful and care that is unlawful.

The first three principles are fundamental to how practitioners should approach all care, support and treatment planning. However, the presumption of capacity does not mean that an unwise decision should not be further explored; especially when behaviour or circumstance gives reason to cause doubt. If a decision appears to be unwise it should be considered an opportunity for further investigation as to whether or not the person has capacity to make it.

For example:

John has known cognitive difficulties and often refuses vital personal care. At care planning, it might be tempting to conclude that an unwise decision, to refuse care, clearly evidences a lack of capacity to create his own care plan. However, because of the presumption of capacity, a lack of capacity can only be found following a proper assessment of his ability to make the decision, and on the basis of evidence that he lacks that capacity. John must also be given all the necessary information and support possible to enable him to make his own decision.

The **MCA Code of Practice** (2005) states that:

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.

(para 2.4, p.21)

The requirement of maximising a person's ability to make their own care and support decisions, enabling them to have capacity wherever possible, comes from the second MCA principle. It is crucial for the person to be provided with the **right information and support**, tailored to their **needs** and **circumstances**, throughout the whole care and support planning process and any provision of care and support.

Information

People with care, support and treatment needs require the **right information and support** to understand and choose between available care planning options in a clear and transparent way. Having the right information at the right time, and communicated in the right way, is an integral part of supporting people to make their own decisions.

People need sufficient information to make decisions. In **CC v KK [2012] EWHC 2136** in the Court of Protection Mr Justice Baker emphasised the need to **present the options** to the person concerned and not to start with a 'blank canvas.' Such information will inevitably include, as a minimum, details of:

- > the nature of the care or treatment decision (including options available)
- > the reason why the decision is needed
- > the likely effects of deciding one way or another, or making no decision at all.

Support

The Everyday Decisions Project published **research** in 2017 exploring how people who may lack mental capacity make everyday decisions and how social care practitioners support them in doing so. Their research identified examples of good practice taking place but also that 'sometimes people are found to lack capacity when they might have been able to make their own decision with the right amount of support' (p.5).

It is vital not to start with a focus on assessment when capacity is in doubt; rather, the attention must be on providing all available support. This can be the difference between a person being able to exercise their legal rights and autonomy, or not. Most people who receive care and support will be able to make everyday decisions, expressing their own will and preferences, without the need for an assessment of their mental capacity. This is because the practical information and support provided is sufficient to enable them to consider the care, support or treatment and make their own decision.

The National Institute for Health and Care Excellence (NICE, 2020) **guidelines** state that practitioners should take a personalised approach to supporting people who may lack capacity. This includes making any **reasonable adjustments** and considering the wide range of factors that can affect a person's ability to make a decision. They support effective communication by allowing sufficient time for discussions and by using a range of tools such as inclusive communication, visual materials, visual aids, communication aids and hearing aids. These help people to take an active role in decision-making.

Health and social care practitioners should also include family members, carers, and significant and trusted people in supporting decision-making, in line with the person's needs and preferences, and involve an advocate when needed.



The Social Care Institute for Excellence also has a film on **supported decision-making**.

Tool 1 - The HELPED table

Tool 1 supports thinking about, and planning, when and how to have good conversations with people about their care, support and or treatment.

The HELPED table (adapted from Central Bedfordshire Council's MCA Practice Guidance Document 2017).	
<p>Hour</p> <p>H</p>	<p>Are there:</p> <ul style="list-style-type: none"> > Particular times of the day when the person's understanding is better? This will include consideration of the positive and negative effects of any relevant medication. > Changes or patterns in mood throughout the day? > Distractions relating to daily routine? > Unnecessary time pressures and timeframes being placed upon the person? <p>Consider if the decision can be delayed until a later time when circumstances are right for the person.</p>
<p>Environment</p> <p>E</p>	<p>Depending upon the nature of what is being discussed, is the environment:</p> <ul style="list-style-type: none"> > Private and confidential so the person feels able to talk freely? > A place where the person feels at ease? > Relaxed and comfortable without distractions? > A particular location that will make elements of the decision easier to understand?
<p>Language</p> <p>L</p>	<p>Consider:</p> <ul style="list-style-type: none"> > How does the person best receive information? > How does the person best give or express their views and opinions? <p>Consider whether:</p> <ul style="list-style-type: none"> > Are there any specialist assessments required, for example speech and language? > Are any translator or interpreter services required? > The person might find pictures and other tangible aids helpful.
<p>People, Programmes and Person-centred Planning tools</p> <p>P</p>	<p>People:</p> <ul style="list-style-type: none"> > Can anyone else help or support the person to feel more at ease, make the required decision or express a view? For example, family or friends. > Advocacy – The <i>Care Act 2014</i> introduced the provision of advocacy support for those that, regardless of mental capacity, have no one appropriate to support them when participating in the assessment, planning, care review, safeguarding enquiry or safeguarding review processes. If the person has no one to provide support and has 'substantial difficulty' with participating in such processes, a Care Act advocate should be arranged. <p>Programmes:</p> <p>It should be considered whether there are programmes or training courses that might improve the person's understanding of their situation or decision (in the short or longer term).</p> <p>Person-centred planning/decision-making tools:</p> <p>These can provide a practical way of supporting an individual in understanding their own situation and making their own decisions.</p>
<p>Equipment</p> <p>E</p>	<p>Is there any equipment or aids that will assist with the decision-making process? This might include communication aids, pictures or photographs.</p>
<p>Diagnosis</p> <p>D</p>	<p>Would any medical or clinical support, including treating a medical condition, help improve the person's capacity?</p>

Step two: Obtaining consent

NICE (2018) **guidelines** state:

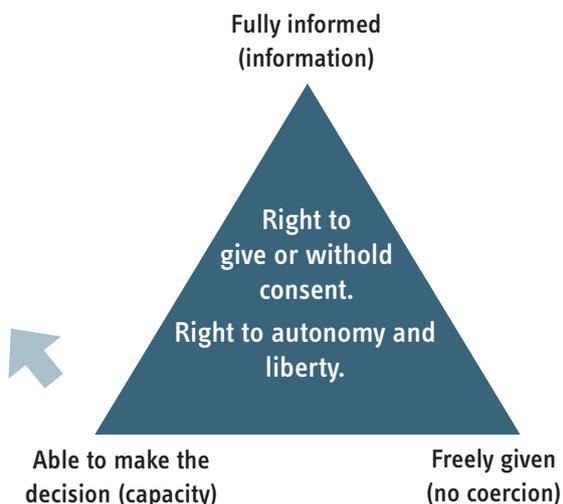
*Organisations with responsibility for care and support plans should record whether a person has capacity to consent to **any** aspect of the care and support plan.*

It is important to acknowledge that compliance does not indicate mental capacity or consent; compliance is not the same as **valid consent**. Valid consent involves people:

- > being informed and supported
- > being free from pressure, force or coercion by others (allowed to make their own decision freely)
- > having the mental capacity to give consent to the care or treatment in question.

The triangle of consent (all care and support decisions regardless of setting).

Presume capacity until proven otherwise.
Provide support and information.
Unwise decisions do not necessarily mean a lack of mental capacity.



HSCA: Regulation 11

“11(1) Care and treatment of service users must only be provided with the consent of the relevant person.”

“11(3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.”

The importance of discussing with the person the various options available and the ‘material risks’ of each option (including those associated with doing nothing) was highlighted in the leading judgment of **Montgomery v Lanarkshire Health Board [2015] UKSC 11**. In deciding whether the information given to a person is adequate, it must be considered from the perspective of a reasonable person in the same position rather than from the perspective of the professionals involved. It is worth noting this was about informed consent in the specific context of medical treatment. As such, exactly the same approach may not apply across the board. However, the general principle undoubtedly will.

Where the person is fully informed, and free from duress or other undue influences, the person’s ability to make the care or treatment decision then needs to be considered. If mental capacity is in doubt, firstly reconsider the support and information provided to the person and explore if additional information or support might further help improve their capacity. However, a person’s mental capacity might need to be explored in more detail if any of the following is apparent:

- The person’s behaviour or circumstances cause doubt.
- The person repeatedly makes unwise decisions that put them at significant risk of harm or exploitation.
- The person makes a particular unwise decision that is obviously irrational or out of character.
- Other people have expressed concern about the person’s capacity to make a particular decision.

Step three: Assessment of mental capacity - take a tailored approach

Where there is appropriate reason to doubt or question the presumption of capacity, the practitioner/care planner must consider the test of capacity (MCA, sections 2-3) and record this within their records. It is vital to remember that the person in question does not need to prove they have capacity; the presumption is that they have capacity until proven otherwise. It is for the practitioner to make a determination, on the balance of probabilities, one way or the other.

Section two of the MCA states:

*...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 this definition, care planning must reflect that mental capacity is:

- a) only in relation to **a matter** (issue-specific); and,
- b) only in relation to the **material time** (time-specific); and,
- c) about a person's decision-making **inability** (a functional test of ability/inability); and,
- d) the inability must be **because of an 'impairment of, or a disturbance in the functioning of, the mind or the brain'** (there must be a causal link made between the impairment and inability).

The term 'assessment of capacity' can cause uncertainty for some practitioners within direct care and support planning, raising questions such as:

- > Am I qualified to complete assessments of mental capacity?
- > Does this mean I need to complete assessments of mental capacity for *all* people that cannot make a care and support planning decision, for each and every plan?
- > What happens if I 'get it wrong?'

Such concerns are understandable, and a good way to ease them is to reflect on the conversations that already take place with each person about each aspect of their day-to-day care or treatment. For the majority of situations, these care and support planning conversations, if carried out applying the MCA and its principles, are normally sufficient to be the assessment.

NICE **guidelines** (2018) explain that:

While the process applies to all decisions that fall within the scope of the Mental Capacity Act 2005, both large and small, the nature of the assessment and the recording of it should be proportionate to the complexity and significance of that decision.

39 Essex Street Chambers use a simple term within their 2019 guidance:

*A capacity assessment is, in many ways, an attempt to have a **real conversation** with the person on their own terms and applying their own value system.*

(Butler-Cole et al., 2020)

Tool 2 - Mental capacity

Applying this mindset provides a helpful perspective. Not all care planning decisions require standalone mental capacity assessments. It is a matter of considering what might be the correct level of capacity assessment and recording needed, depending upon the particular needs and circumstances of the person and the nature of the decision at hand.

The following mental capacity tool may be useful in supporting practitioners to think about the types of circumstances that may require more or less formal capacity assessment and the level of recording that might be required.

The mental capacity tool



The first three principles of the MCA must **always** be applied before doubting or assessing a person's mental capacity. Every effort must be made to enable the person to make their *own* care and support decision(s). This requires practitioners to provide people with sufficient **information** and **support** in order to make a decision.

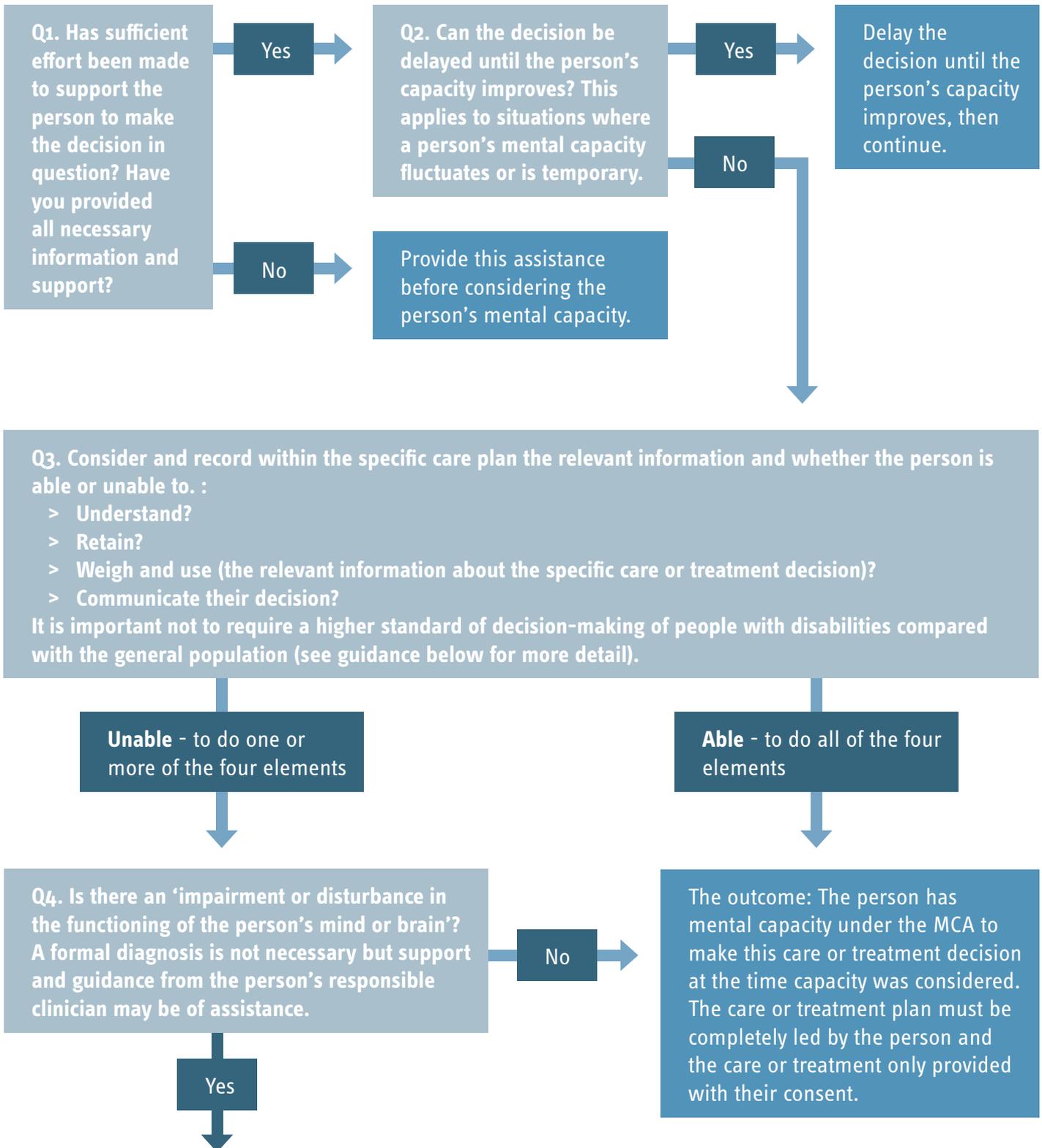
The greater the risk to a person's health or wellbeing, or if there are likely to be conflicting opinions, the more robust the assessment and recording required. The complexity of the care and support planning decision will also be relevant.

The following examples should only be used as a reflective guide. Good recording is crucial.

	Choices about daily preferences	The day-to-day care or treatment that is received and decisions on how it is provided.	More complex care or treatment planning decisions that may have increased risks of harm or complexity, or conflicting opinions associated with them.	Highly complex care planning decisions that require specialist expertise and/or involve high risks or interference with fundamental rights and freedoms.
Examples	<ul style="list-style-type: none"> > Tea or coffee? > What to watch on TV? > When to go to bed? > What to wear? 	Support with washing, dressing, meals, taking medication, mobility, social and community activities.	Bedrails, 1:1 support, personal care with the person resisting.	Covert medication, decisions about contact with family or friends or sexual relationships, serious financial decisions or writing a will.
Nature of assessment of mental capacity that might be required.	<p>These decisions will normally not require a formal capacity assessment or best interests decision to be recorded. The support provided and daily care records should reflect application of the statutory principles in practice – for example assuming capacity and providing support. If there is a reasonable belief the person lacks capacity, a choice should be made on their behalf which is considered to be in their best interests with the section 4 elements considered at the time and proportionately. As a minimum:</p> <ul style="list-style-type: none"> > Support the person to express their own preferences. > Consider the person’s wishes, feelings beliefs and values. > Consider insights from others that know the person well. > Consider whether any choice or preference the person is making is also in their best interests and the least restrictive option on their rights and freedoms, whilst protecting their safety and happiness. 	<p>A less formal assessment would normally be sufficient if integrated into care, support and treatment planning and the care plan.</p> <p>Considerations of mental capacity and best interests should be fully built into the care planning process (this is explored further within subsequent steps).</p>	<p>These types of decisions might warrant a separate standalone assessment form that accompanies the person’s care or treatment plan.</p> <p>Any standalone MCA forms must adhere to the statutory principles, the test of mental capacity and the best interests decision-making process.</p> <p>If your organisation does not have such forms, the commissioners of the service or local authority may be able to provide guidance.</p>	<p>These types of decisions will likely warrant assessments being completed by specific professionals, such as a social worker, doctor or legal professional. This will depend upon the nature of the care or treatment plan in question.</p> <p>For example, assessments of mental capacity about medication should be carried out by the medical practitioner responsible for the prescription. They would also be responsible for making and recording a best interests decision that the provider can then refer to within their own care planning records.</p> <p>Although it is not a statutory requirement, consider whether a ‘best interests case conference’ or ‘best interests meeting’ might assist the decision-maker – especially if there are disagreements or complex competing issues.</p> <p>In some circumstances a decision may need to be referred to court.</p>

Tool 3 - Recording a clear outcome

Where mental capacity is in doubt, practitioners may find the following flowchart useful in supporting them to incorporate the necessary information and record a clear outcome in the person's care or treatment plan.



Yes

Q5. Is the person's inability to make the decision because of the identified impairment or disturbance in the functioning of the person's mind or brain?

No

For a person to lack mental capacity under MCA, the inability to make a decision must be 'because of' an 'impairment or disturbance in the functioning of the person's mind or brain'. In other words, the impairment must be the reason for their difficulties in understanding, retaining, weighing/using the information or communicating their decision.

Yes

The outcome: The person lacks mental capacity under the MCA to make this care or treatment decision at the time capacity was considered. The following two steps explain how to make this determination and then create a care or treatment plan in the person's **best interests** following the MCA principles and complying with section 4 of the MCA 2005. Any subsequent care or treatment plan must have the person – and what is important to them – at the centre. It must be informed by their **wishes, feelings, beliefs and values** and be in consultation with those that are important to the person.

Step four: Making a determination on capacity to make a specific care, support or treatment decision

Functional Test Guidance

Case law has provided guidance as to what constitutes relevant information when considering a person's ability to make decisions about their care and support. **LBX v K, L and M [2013] EWHC 3230 (Fam)** and **Re B [2019] EWCOP 3** provide a helpful prompt on what to cover when supporting a person, as well as what information they are expected to understand, retain, use and weigh as part of the decision-making process:

- a) Their assessed support needs.
- b) The type of support available (options).
- c) Who will provide such support?
- d) What would happen without support, or if support was refused?
- e) Care and carers are not always perfect, but there are processes of making a complaint if they are not happy.

The Court of Appeal (**[2019] EWCA Civ 913**) has made clear that the guidance arising from legal cases, such as this, should be tailored to the particular circumstances of the person being assessed.

Functional Test:

Consider and record whether the person is able to:

- > Understand the relevant information about the specific care or treatment decision?
- > Retain this information?
- > Weigh and use this information?
- > Communicate their decision?

Understanding information relevant to the decision

This does not need to be in great depth. A broad understanding of the salient points is often all that is required. Consider whether the person is able to understand:

- > the nature of the decision
- > the options available
- > the consequences (including if no decision was made).

It is essential that the person is provided with:

- > all the necessary information about the care and support planning decision and possible options, and that all practicable steps have been taken to assist the person to understand.

The care and support planning discussions should:

- > take place in the best environment for the person
- > be at a time that suits their needs and circumstances, to maximise their engagement and ability to consider the matters
- > use simple language, visual aids or any other means, if the person's circumstances require this.

The discussions and support provided need to be clearly recorded.

Retain relevant information

Information only needs to be retained for **long enough to make the care, support and treatment planning decision**. There is no set time limit for how long and it will likely depend upon the complexity of the care, support and treatment decision or amount of information required to be considered. It is important to support the person where possible. Written notes, learning opportunities or visual aids are supportive steps that could be taken.

Use or weigh relevant information as part of the process of making the decision

Consider whether the person understands various parts of the care or treatment decision. This is about the person:

- > weighing the **advantages** and **disadvantages** from their own value base
- > considering what is important to them and how this influences their decision-making.

It may be necessary to involve others to support the person in the weighing up process, such as an **advocate, carer, friend or family member**.

Communicate

Consider whether the person is able to communicate their decision. This might be through speech, but could be through sign language or any other means. It is important not to confuse the other elements of assessing capacity with the person's functional ability to communicate. If the person is able to communicate their decision, in any way, they would not fail this element of the capacity assessment.

For day-to-day decisions, capacity should still be considered and the determination made on the 'balance of probabilities' (**s2.4**). The assessment of capacity can be built into daily care and support planning records.

An inability to do one or more of the four points - understand, retain, weigh/use or communicate - *because* of an impairment, would mean the person lacked mental capacity to make that particular care and/or treatment decision at the time the care plan needed to be made with the person.

When mental capacity has been brought into question, the practitioners need to record the consideration of mental capacity and outcome, so that the legal basis of the care, support and treatment is clear. An example of wording could be:

*a. 'I reasonably believe [insert name of person] **has mental capacity** to make the decision about [insert care and/or treatment plan need] because, although there were grounds to question their mental capacity in this area because of [insert the reasons], following the care planning discussion on [insert date] they appeared on the balance of probabilities to understand, retain, weigh and use the information about this at the time of creating the care and/or treatment plan. [Insert name of person] communicated that he/she wanted the following support.'*

OR

*b. 'I reasonably believe [insert name of person] **lacks mental capacity** to make the decision about [insert care and/or treatment plan need] because, despite being given the information and support of [insert details of the information support provided], following the care planning discussion on [insert date] they appeared on the balance of probabilities not to be able to [insert reasons, such as they could not understand, retain, weigh or use the information or communicate their decision] at the time of creating the care and/or treatment plan. I reasonably believe that this inability is because of their impairment or disturbance of [insert details of impairment]. The following care and/or treatment plan has been created with [insert name of person] in their best interests under section 4 of the MCA 2005.'*

Practitioners involved in care or treatment may consider using a summary document for each person they support to organise the person's care or treatment plans and records. Tool 4 - Care and Support Planning Tool may be a useful aid for this purpose.

Tool 4 - Care and Support Planning

Which aspects of the person's care and support do you 'reasonably believe' they were, or were not, able to make decisions on?

This looks at the care and support the person needs, and the different parts of the decision-making process. Evidence of how this was determined should be included in the associated care and support plans.

To have mental capacity a person must be able to do all of the following for each care and support need/tasks:

- > **Understand** the information relevant to the care and support need/task.
- > **Retain** the information relevant to the care and support need/task long enough to make the decision.
- > **Use and weigh** the information relevant to the care and support need/task as part of their decision-making process.
- > **Communicate** a decision on the care and support need/task.

Care and support plans where decisions are required.	Understand (Y or N)	Retain (Y or N)	Weigh-up or use (Y or N)	Communicate (Y or N)	Outcome: Consent (C) or Best Interests Care Plan (BI)
List care and support plans (for example, 'Personal care').					
Continue listing the various care and support plans.					

Where the relevant person is considered to lack mental capacity, in any aspect of their care and support, provide an explanation of which parts of the decision-making process you 'reasonably believe' they were unable to do and how you came to this conclusion.

This is referring to understanding, retaining, weighing up or using the information and communicating their decision. This inability must be because of 'an impairment of, or a disturbance in the functioning of, their mind or brain'.

Step five: Best interests

This resource relates to direct care, support and treatment planning under the MCA within direct care settings, rather than the assessment of need and the drawing up of care plans to address those needs under the **Care Act 2014** and the **Social Services and Wellbeing (Wales) Act 2014**. This section applies to scenarios where a person has at least two options in relation to their care, support or treatment and the option that is in their best interests is being determined.

Principle 4: ‘An act done or decision made, for or on behalf of a person who lacks capacity, must be done, or made, in their best interests’.

Principle 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’.

Best interests only apply if there is a ‘reasonable belief’ that the person is unable to make the decision themselves. This is regardless of how well-intended the care and support planning decision or action may be.

It is not about making a ‘perfect’ decision. The focus must be on applying the required considerations and sources of information in order to arrive at a balanced, person-centred, care planning decision.

The approach is to consider the decision from the person’s own view, not a generic or general perspective. A lack of mental capacity is not an ‘off-switch’ to the person’s rights and freedoms; their wishes and preferences need to be central to all best interests care and support plans (**Way Valley NHS Trust v Mr B [2015] EWCOP 60**). The aim is to make the right decision for the person as an ‘individual human being’ (**Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67**).

This requires practitioners to see the uniqueness of every individual, with their own values, likes and dislikes, and to consider their best interests in a person-centred way. Seeing the situation and options through the eyes of the individual, their own value base and trying to take account of the individual’s ‘own assessment of the quality of their life’ is vital **EWHC 3456 (COP)**.

The courts have given increasing weight to the wishes, feelings, beliefs and values of the individual, placing such matters at the centre of the best interests decision-making process. It is important to ensure that any best interests care or treatment planning encourages the **person to participate** (s4.4) and takes account of their **past or present wishes, feelings, beliefs and values** (s4.6).

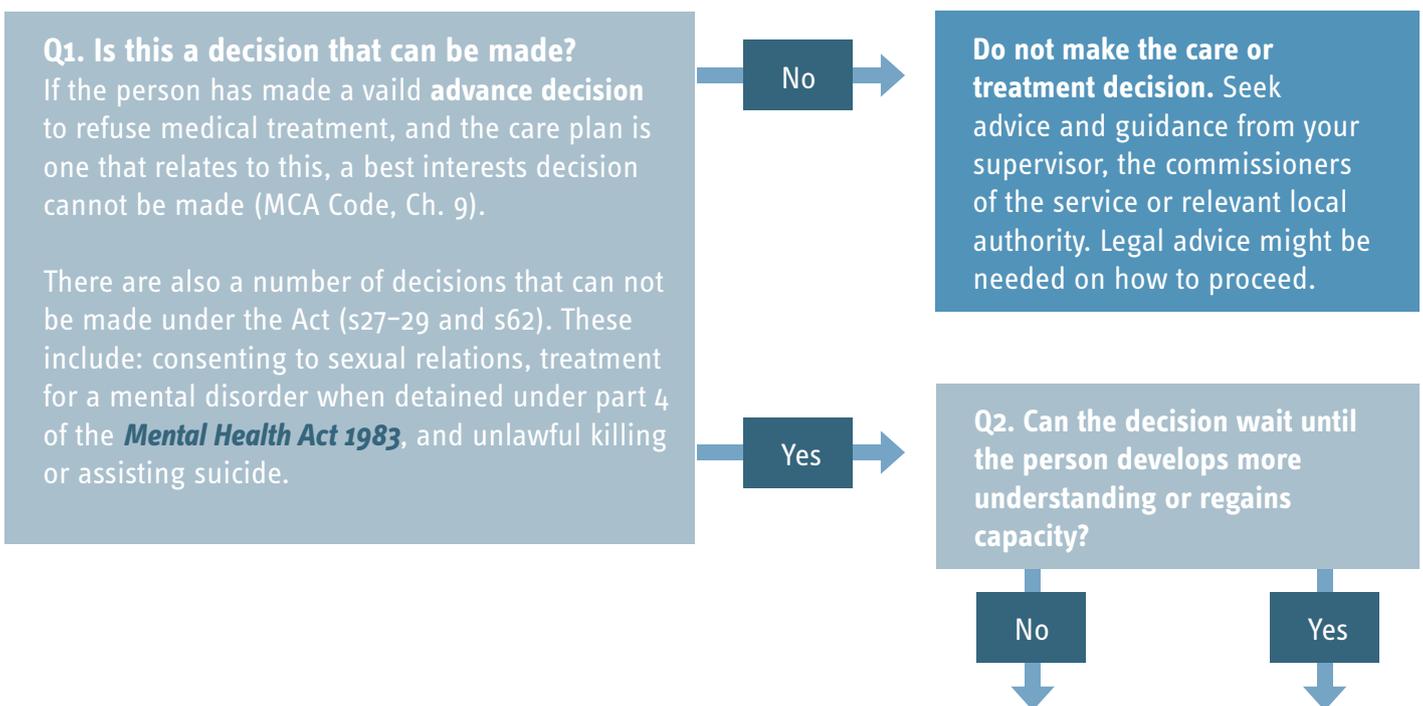
There is also a vital requirement to consult others involved in the person's life as to what they believe the person would want. Their insights may be invaluable in terms of understanding who the person is, especially where they are unable to express their own views and preferences. In the consultation with others, practitioners may start by asking the following questions about the individual:

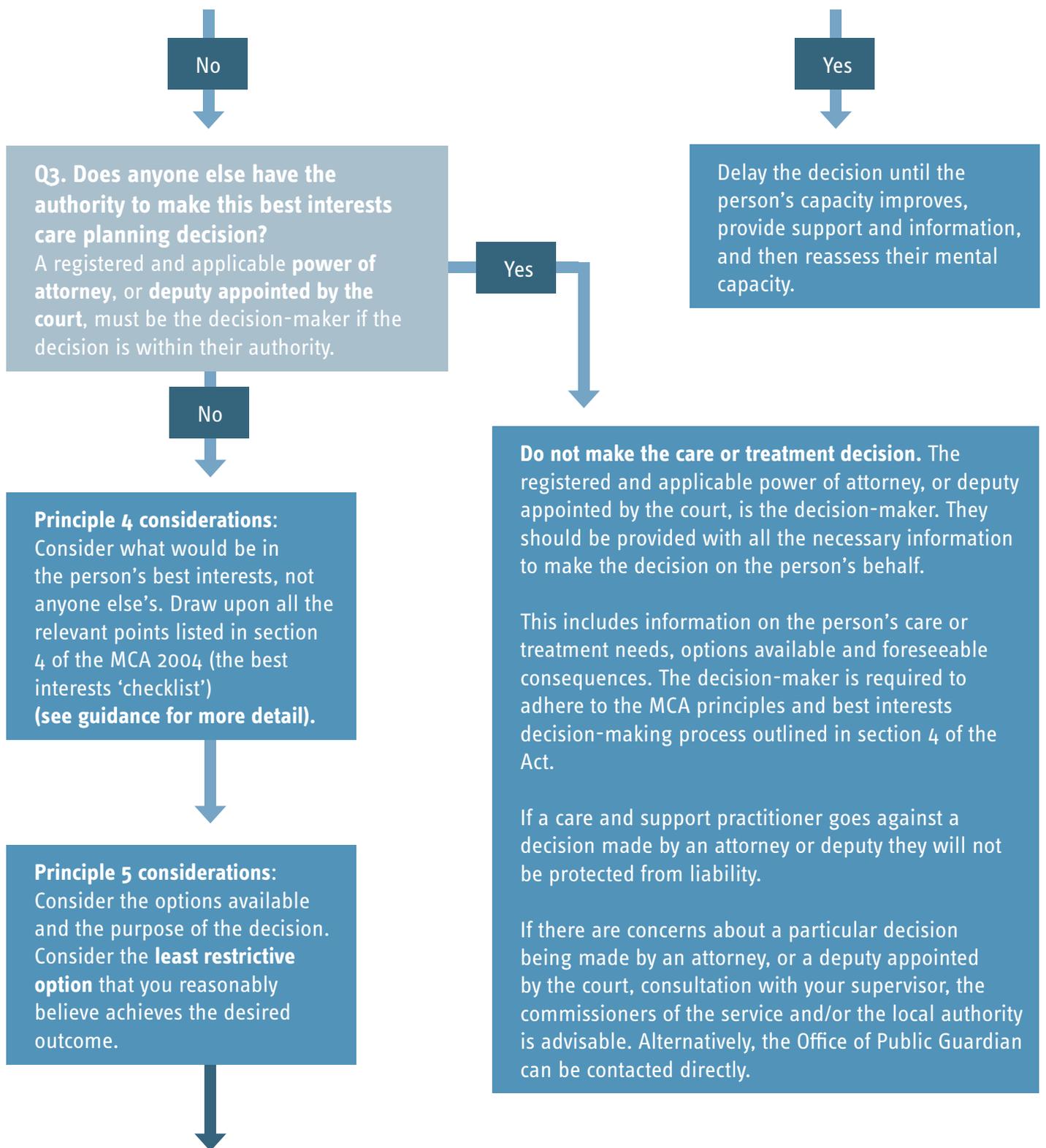
- > What were/are their interests?
- > What is/was important to them?
- > What informed previous similar decisions they made?
- > What would be the individual's views and opinions/attitude on such matters?

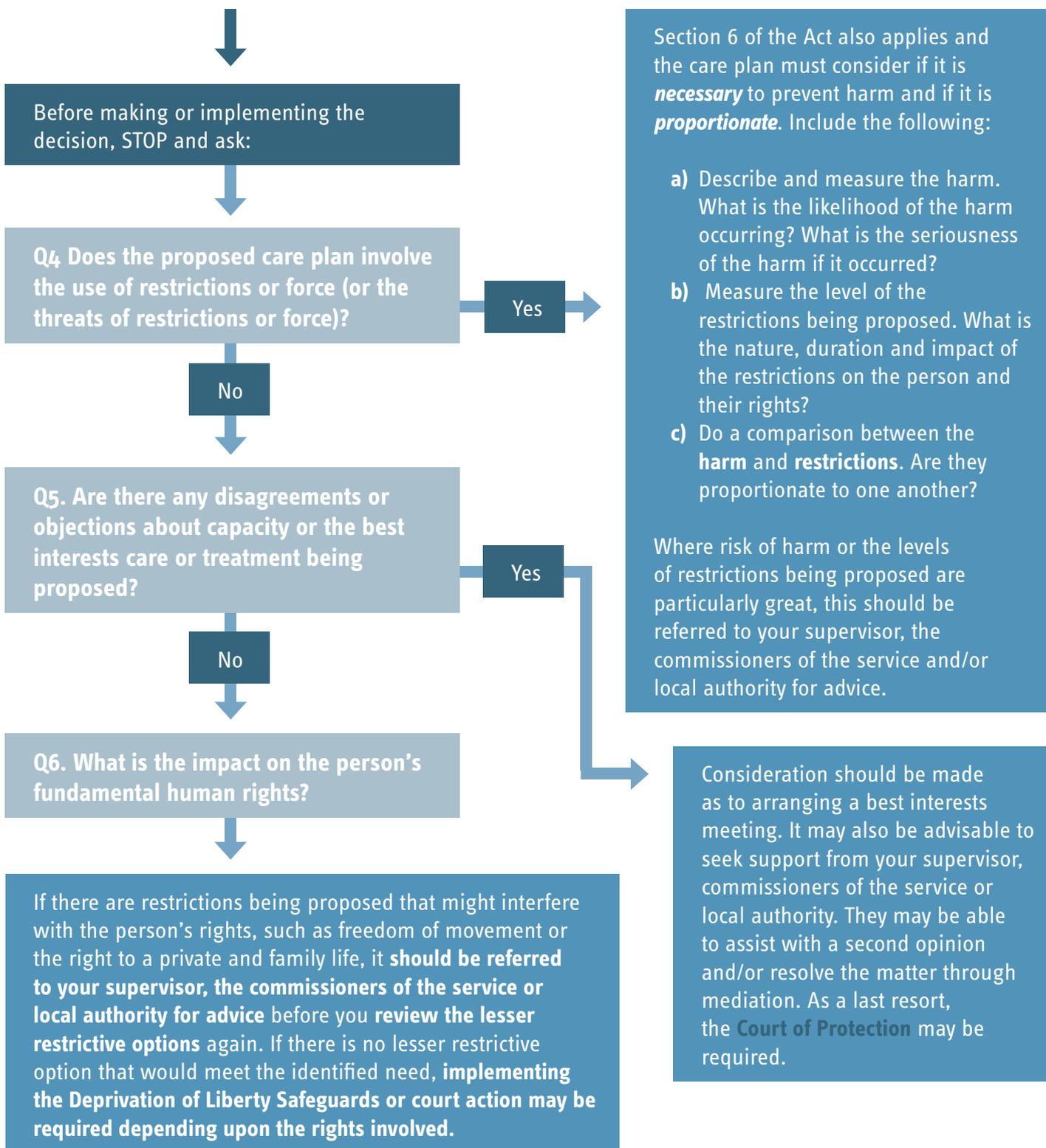
Having initially framed the consultation from this person-centred perspective, the practitioner can then move on to asking those being consulted about their own personal views on the matter.

There should also be consideration as to whether there are any other practitioners, or other expertise, that could inform the best interests decision. For example, medical decisions should be led by the responsible medical practitioner. The commissioners of the service or allocated practitioner may need to give input so that the decision is as informed as possible. Care and support planning is not always an individual activity - there will be many situations in which a range of people and types of expertise might need to be involved.

Where a best interests care, support and treatment plan is required, the following process should be documented within the specific care, support or treatment plan - with a clear outcome and reasons as to why the decision was considered to be in the person's best interests and **least restrictive of their rights and freedoms**.







Having followed the above process the care and support planner must **weigh it all up**, and create a care and support plan with all these elements included and recorded.

Tool 5 - Best interests guidance

Section 4 MCA – Best interests guidance	
Considerations	Types and sources of information that must be taken into account.
<p>1. Avoiding discrimination (based on s4.1)</p> <p>Reflect on whether you have included all the options available; without limiting them because of the person’s age, appearance, condition or behaviour.</p>	<p>5. Identify and consider all the relevant circumstances (based on s4.2).</p> <p>Reflect on:</p> <ul style="list-style-type: none"> > What ‘all the relevant circumstances’ of the care or treatment in question are. > Their assessed support needs. > What is important to the person in relation to the care and support needed. > The type of support available (options). > Who will provide such support? > What would happen without support, or if support was refused?
<p>2. Changes in capacity (based on s4.3).</p> <p>Reflect on whether there is a chance the person can make their own decision at a later date/time. If so, can and should the decision be delayed?</p>	<p>6. The wishes, feelings, beliefs and values of the individual (based on s4.6).</p> <p>Reflect on:</p> <ul style="list-style-type: none"> > How can I include more than what the person is or is not able to verbalise? Might observations be necessary? > What appears to be their beliefs or values associated with this aspect of their care and support? > What is and was important to the person – their likes and dislikes? <p>These elements should be the centre of the best interests decision-making process.</p>
<p>3. Permitting and encouraging the individual to participate (based on s4.4).</p> <p>Reflect on how best to engage the person:</p> <ul style="list-style-type: none"> > How do they best receive and give information? > How do you ensure the individual is an active participant in the decision-making process? 	<p>7. The views of other people (based on s4.7).</p> <p>Reflect on:</p> <ul style="list-style-type: none"> > Which people are involved and interested in the person? > How can you obtain their insights into the person – for example, what they know about what the relevant person’s attitude was, or might have been, towards such care and support matters?
<p>4. Consider the motivation (based on s4.5).</p> <p>Reflect on:</p> <ul style="list-style-type: none"> > Whether the care plan involves ‘life-sustaining treatment’? > If so, the decision must not be motivated by a desire to bring about the person’s death. 	

Step six: Implementing and reviewing the best interests care plan

It may not be practical or possible to have a full and detailed discussion, sufficient enough to evidence capacity and or best interests, each and every time care or treatment is delivered. This is why the **code of practice** importantly emphasises that care plans must be created and reviewed in such a way that those implementing them can have confidence - and 'reasonable grounds for believing' - that the process involved considerations of capacity and best interests at the time of care or treatment planning (DCA 2007, para 6.34).

However, given that capacity may change over time, practitioners need to communicate with the person, to the extent that is practical and appropriate, before any care, support or treatment is delivered. This ensures people are treated with dignity and respect and supports practitioners to explore whether the person's capacity and decision(s) remain the same. For example, a person with a best interests care and support plan might regain capacity, or be able to take part in care and support planning at a different time, and at such times their care or treatment in question should only be provided with their consent - fully directed by their express wishes and preferences.

Care and support plans need to be viewed as **living documents** which are open to ongoing change and development. It is vital that people with care and support needs are encouraged to be involved in revisiting and refining their care or treatment plans.

Summary

The MCA allows for proportionate assessments and record-keeping whilst also ensuring there are protections in place for both those receiving care and support, and those providing it.

Many people will have mental capacity in all areas of their care and support, whilst others may lack mental capacity in some or all areas. Mental capacity and consent to care or treatment are '**issue specific**', meaning that these need to be considered for each and every care or treatment planning decision separately.

Similarly, they are also '**time specific**', meaning that they also need to be reconsidered at the point of providing the actual care or treatment, as well as when the plans are developed. This practice tool has provided suggestions on how to approach this in proportionate and meaningful ways so that duties are followed, people's rights are realised and the empowering potential of the act is delivered.



Related Research in Practice resources

Embedding human rights in adult social care: Leaders' Briefing (2017)

Embedding human rights in assessment for care and support: Frontline Briefing (2020)

Enablement in dementia: Practice Tool (2016)

Legal Literacy: Change Project

Liberty Protection Safeguards: Practice Guidance (2021)

Mental health law: Risks, rights and responsibilities: Webinar (2019)

Person-centred approaches to adult mental health: Frontline Briefing (2018)

Risk enablement: Chart (2016)

Risk enablement: Frontline Briefing (2016)

Risks, rights, values and ethics: Frontline Briefing (2018)

Strengths-based practice: Brief Guide (2020)

What is the Mental Capacity Act 2005? Brief Guide – Easy Read version (2017)



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www.ageuk.org.uk/globalassets/age-uk/blocks/promo/ourrightsourvoices_toolkit.pdf

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www.39essex.com/mental-capacity-guidance-note-brief-guide-carrying-capacity-assessments

Care Quality Commission (2016) *Better Care in My Hands: A review of how people are involved in their care*.

www.cqc.org.uk/sites/default/files/20160519_Better_care_in_my_hands_FINAL.pdf

Care Quality Commission (2018) *Driving improvement: Case studies from nine adult social care services*.

www.cqc.org.uk/sites/default/files/20180607_drivingimprovementasc_report.pdf

Care Quality Commission (2019) *The State of Health Care and Adult Social Care in England 2018/19*.

www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

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www.gov.uk/government/publications/mental-capacity-act-code-of-practice

House of Lords Select Committee (2014) *Mental Capacity Act 2005: Post-legislative Scrutiny*. London: The Stationery Office.

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Harding, Rosie and Tascioglu, Ezgi (2017) *Everyday Decisions Project Report: Supporting Legal Capacity through Care, Support and Empowerment*. Project Report. Birmingham Law School, Birmingham.

www.legalcapacity.org.uk/wp-content/uploads/2017/12/Everyday_Decisions_Project_Report.pdf



Further resources

Mental Capacity Act 2005

www.legislation.gov.uk/ukpga/2005/9/contents

Mental Capacity Act 2005 Code of Practice

www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Mental Capacity (Amendment) Act 2019

www.legislation.gov.uk/ukpga/2019/18/enacted

Human Rights Act 1998

www.legislation.gov.uk/ukpga/1998/42/contents

Care Act 2014

www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 No. 2936

www.legislation.gov.uk/uksi/2014/2936/contents/made

National Mental Capacity Forum

www.scie.org.uk/mca-directory/forum

MIND

www.mind.org.uk/information-support/legal-rights/mental-capacity-act-2005

Mental Health Foundation

www.mentalhealth.org.uk/a-to-z/m/mental-capacity

Mental Law Online

www.mentalhealthlaw.co.uk/Main_Page

Alex Ruck Keene's blog

www.mentalcapacitylawandpolicy.org.uk

39 Essex St

www.39essex.com

Lucy Series blog

<http://thesmallplaces.wordpress.com>

Mental Health Law online

www.mentalhealthlaw.co.uk/Main_Page



Further resources

Mental Capacity Act (MCA) and care planning (SCIE Report 70)

www.scie.org.uk/mca/practice/care-planning

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) 2006

https://treaties.un.org/doc/Publication/CTC/Ch_IV_15.pdf

Everyday Decisions (researching legal capacity in everyday life)

www.legalcapacity.org.uk

