# The Mental Capacity Act 2005 in Practice: Capacity, Consent and Best Interests

THE TALKING THERAPIES UK PRACTITIONER SERIES



# The Mental Capacity Act 2005 in Practice: Capacity, Consent and Best Interests

A premium, in-depth programme on capacity, best interests, planning ahead and liberty for therapists, current to October 2026.

Advanced level · 30 hours of continuing professional development

**TALKING THERAPIES UK**

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First edition, 2026.

This manual accompanies the The Mental Capacity Act 2005 in Practice: Capacity, Consent and Best Interests course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 2. This printing was set on 1 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

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# How to use this manual

This premium programme is a comprehensive, practice-focused course on the Mental Capacity Act 2005 for psychological therapists, counsellors, psychotherapists and allied practitioners in England and Wales. It is written for practitioners who need to know when a person can decide for themselves, how to help them to do so, how decisions are made when they cannot, and where the law's protections and limits lie.

The course is current to October 2026. It teaches the capacity test as the Supreme Court framed it in A Local Authority v JB, the leading cases on best interests, wishes and feelings, and the courts' guidance on capacity for specific decisions such as residence, contact, sexual relations, marriage and social media. It explains the Supreme Court's judgment of 2 June 2026, which replaced the Cheshire West acid test for deprivation of liberty with a multifactorial assessment and recognised valid consent as a distinct concept, together with the Department of Health and Social Care's guidance of June and September 2026. It states clearly that the Liberty Protection Safeguards have not been implemented and that the 2007 Code of Practice remains in force while a revised Code is awaited.

Across six modules and thirty lessons you will study the purpose and principles of the Act and its rights context; framing decisions, conducting assessments and the use or weigh limb; mental disorder, distress and capacity; best interests decision-making, consultation, conflict, restraint and decisions about therapy; lasting powers of attorney, advance decisions and statements, the Court of Protection, deputies and advocacy; young people and parental responsibility; the interface with the Mental Health Act 1983; deprivation of liberty in outline; coercion and the inherent jurisdiction; fluctuating and contested capacity; and recording, liability, research, reform and supervision-level practice.

Every lesson contains a worked clinical example, the common pitfalls in practice and a reflective question, together with key points, a practice task for the week, study activities and further reading. The course includes an extended case study, a glossary and a 25-question assessment with a pass

mark of 80 per cent. Every reference has been checked against its publisher, legislation.gov.uk, the National Archives or the issuing body.

The course treats the Act as an instrument of empowerment as well as protection. It is clear throughout about who makes which decisions, about what the law requires of practitioners, and about where therapists contribute most: in supporting people to decide for themselves and in making sure that their wishes, feelings, beliefs and values shape the decisions made for them. It asks you at each stage to check the current position, because this area of law is changing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 30 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

### What this manual will leave you able to do

- Explain the purpose, principles and human rights context of the Mental Capacity Act 2005, including the debate about supported decision-making.
- Frame a decision, identify the relevant information and conduct a capacity assessment that applies the functional test and the causative nexus correctly.

- Assess and support capacity to consent to psychological therapy and to information sharing, including for people with cognitive impairments.
- Make and contribute to best interests decisions that give proper weight to the person's wishes, feelings, beliefs and values and to the views of others.
- Apply the rules on restraint, least restriction and acts in connection with care, and contribute to reducing restrictive practice.
- Explain lasting powers of attorney, advance decisions to refuse treatment, advance statements, deputies, the Court of Protection and statutory advocacy.
- Apply the law to young people aged 16 and 17 and to children under 16, including Gillick competence and the limits of parental responsibility.
- Distinguish the roles of the Mental Capacity Act and the Mental Health Act, and explain deprivation of liberty after the Supreme Court's 2026 judgment.
- Recognise coercion and undue influence and explain the inherent jurisdiction and the interface with adult safeguarding.
- Record, govern and audit capacity practice, and keep practice current while the Code of Practice and the safeguards are reformed.

PART 1

# Foundations: principles, the test and its rights context

*Why the MCA matters to therapists, its five principles, the statutory test for capacity as the Supreme Court now frames it, consent to therapy, and the human rights and disability rights debates around capacity law.*

CHAPTER 1

# Why the Mental Capacity Act matters to therapists

Every psychological intervention rests on decisions that belong to the client: whether to begin, whether to carry on when the work becomes painful, whether the therapist may write to the GP, whether a session may be recorded for supervision, whether a partner should join. Ordinarily the law assumes the client can make those decisions. The Mental Capacity Act 2005 governs what happens when that assumption is in doubt, and it does not hand the question to doctors or lawyers. Responsibility starts with whoever needs the decision made and proposes to act on it, which in therapy is usually the therapist. A therapist who treats capacity as somebody else's business will eventually rely on a consent that was never valid, or override a choice the client was entitled to make.

Before the Act, the law on adults who could not decide for themselves was made by judges, case by case. The leading authority was Re F (Mental Patient: Sterilisation) [1990] 2 AC 1, in which the House of Lords considered a proposal to sterilise a woman with a serious learning disability who could not consent to the operation. The House held that nobody could consent on her behalf, not even the court, because the Crown's old protective jurisdiction over adults had lapsed. Treatment could still be lawful under the common law doctrine of necessity if it was in her best interests, and the court could declare in advance whether a proposed operation would be lawful. Best interests was then judged largely by whether a responsible body of medical opinion would support the treatment. Re F met an immediate need but left much unsettled: there was no statutory test of capacity, no clear authority for the everyday acts of carers, and no way for an adult to appoint someone to make health and welfare decisions for them in future.

In its report Mental Incapacity (Law Commission, 1995), the Law Commission proposed a single statute instead. It considered defining incapacity by the person's status or diagnosis, by the outcome of their decision, or by their ability to make the particular decision when it had to be made, and it chose the third, functional approach. It also proposed a best

interests checklist, powers of attorney that would survive the donor's loss of capacity and extend to personal welfare, and a court able to make decisions and appoint substitute decision-makers. Much of that design became the Mental Capacity Act 2005, in force since 2007, with its Code of Practice (Department for Constitutional Affairs, 2007). The 2007 Code is still the Code in force. Under section 42, anyone acting in a professional capacity or for payment in relation to a person who lacks capacity must have regard to it, and a court must take a relevant provision, or a failure to follow it, into account. A revised Code has long been promised. In October 2025 the government announced a consultation on an updated Code and on the Liberty Protection Safeguards, expected in the first half of 2026; check the Department of Health and Social Care website for the current position.

The Act applies to people aged 16 and over in England and Wales, although making a lasting power of attorney, making an advance decision to refuse treatment and having a statutory will made all require the person to be 18 or over. For children under 16 the question is competence in the sense recognised in Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, considered in lesson 4.5. Within its age range the Act reaches every kind of decision, from what to wear today to whether to undergo major surgery or move into a care home, and it binds family carers as much as professionals. Most of what happens under it never reaches a court or a formal meeting. A support worker deciding whether a resident with advanced dementia should have a bath, and a therapist deciding whether to continue a session with a client who has become acutely confused, are both acting within the Act.

For therapists the Act bites on four recurring decisions: consent to therapy itself, including assessment and any change of direction; consent to sharing information with a GP, a care coordinator or a relative; consent to recording for supervision, accreditation, training or research; and consent to involving family or friends in sessions or planning. Each is a separate decision with its own relevant information, and a client may be able to make one but not another. A woman with moderate dementia may be well able to decide that she wants a therapist to visit each week, because she knows who the visitor is, enjoys the conversation and can say whether she wants it to continue, while being unable to understand what it would mean for a session to be filmed and kept for a training course. The presumption of capacity applies to each decision, and there is no requirement to assess capacity routinely.

What the Act expects is that the therapist notices a real reason to doubt, such as the person's presentation or circumstances, a concern raised by someone who knows them well, or a condition already known to have affected other decisions, and then assesses capacity for the decision in hand rather than for the person in general.

Where a client lacks capacity for one of these decisions, the decision does not pass to the family. Unless a registered attorney or a court-appointed deputy has authority for it, the person proposing the act makes it, in the client's best interests under section 4 and with regard under section 1(6) to whether the purpose could be as effectively achieved in a less restrictive way. Whether therapy itself can be provided on that basis, and how information can be shared in a client's best interests within confidentiality and data protection law, are covered in lesson 3.5. The structural point matters now: a therapist who doubts a client's capacity to agree to a referral, a recording or a family meeting cannot simply ask a relative to sign instead.

The Act does not appoint a single decision-maker. Responsibility falls on whoever proposes to do the act or make the decision: the care worker for personal care, the doctor for the treatment they propose, the local authority for the residential arrangements it makes, the therapist for the therapy they offer. A health and welfare attorney under a registered lasting power of attorney, or a deputy appointed by the Court of Protection, decides within the scope of their authority, and such an attorney can act only when the donor lacks capacity for the decision in question. The Court of Protection resolves disputes and decides the most serious matters. Relatives as such have no power to consent for an adult, although their views must be considered in any best interests decision. This allocation matters because of section 5. A person who has taken reasonable steps to establish whether someone lacks capacity, and who reasonably believes that they do and that the act is in their best interests, incurs no greater liability than if the person had capacity and had consented. The protection does not cover negligence, and it attaches to the person who acts, whose belief must be their own. That is why the Code expects the person who will act to form their own view of capacity even when a specialist has been asked for an opinion: the specialist advises, the decision-maker decides.

Therapists often know more than anyone else in a network about how a person communicates, what frightens them, what they value and how their

thinking changes with mood or fatigue. Offering that knowledge to other people's assessments and best interests decisions is good practice. Taking over a decision that belongs to someone else, or presenting an opinion as though it settled their decision for them, is not. A therapist is not a Best Interests Assessor under the Deprivation of Liberty Safeguards unless trained and approved for that role. Requests for formal capacity opinions from other agencies, solicitors or courts raise questions of competence, contract and indemnity that should be checked against the organisation's policy, with legal advice where the stakes are high. The practical guide written for doctors and lawyers (BMA and Law Society, 2022) treats a clear request, naming the decision and the legal test, as the foundation of any useful opinion. Nothing in this course is legal advice.

Seven years after implementation, a House of Lords Select Committee examined how the Act was working (House of Lords Select Committee, 2014). It called the Act "visionary" but found that it had not been embedded, with professionals often unaware of it, and it described the Deprivation of Liberty Safeguards as "not fit for purpose". A Law Commission review then recommended replacing those safeguards (Law Commission, 2017), and Parliament enacted the Liberty Protection Safeguards in the Mental Capacity (Amendment) Act 2019. They have not been implemented: in April 2023 the government delayed them beyond the life of that Parliament. The Deprivation of Liberty Safeguards therefore remain the operative scheme for people aged 18 and over in hospitals and care homes, and lesson 5.2 explains how a Supreme Court judgment in June 2026 changed the test for deprivation of liberty.

The Committee's findings matter to therapists because the failure it described lay in ordinary practice rather than specialist procedure, and two opposite errors still follow from it. In the first, a diagnosis, a care home placement or a history of distress is treated as settling the question, contrary to section 2(3), which prevents incapacity being established merely by reference to age or appearance, or to a condition or aspect of behaviour that might lead others to make unjustified assumptions. In the second, the presumption is treated as a conclusion rather than a starting point, so that a person whose decision-making is genuinely compromised is left to cope because nobody looked. Both errors flourish where capacity is seen as something specialists assess on request rather than something every practitioner considers when a decision is needed. The 2007 Code

compounds the difficulty because it predates most of the leading case law. Its account of the test begins with the diagnostic question, whereas the Supreme Court in A Local Authority v JB [2021] UKSC 52 set out an order that begins with the decision and the person's functional abilities, as lesson 1.3 explains. Where the Code and later judgments differ, the judgments state the law. NICE guidance on decision-making and mental capacity (NICE, 2018) offers a more recent account of good practice in supporting decisions, assessing capacity and making best interests decisions, and is a sound benchmark for a service reviewing its own practice.

Worked clinical example. Dr Farah Siddiqui, a counselling psychologist, provides sessional psychological support to several care homes in Sefton under a contract covering individual therapy and staff consultation. The manager of one home, Paula Bennett, telephones to ask whether Farah could "do a capacity assessment" on Desmond Clarke, an 84-year-old resident with vascular dementia whom Farah has never met. Paula explains that his daughter, Janice, wants one on file, that he keeps saying he wants to go home, and that he has started refusing his evening tablets. Farah does not book a visit. She asks four questions instead: which decision needs to be made, whose decision it is, what has caused the doubt about his capacity, and how soon the decision is needed.

The answers show that there is no single capacity question. Desmond's wish to go home raises a decision about where he lives, which involves the local authority that arranged his placement and may also require consideration of the Deprivation of Liberty Safeguards. His refusal of tablets raises a decision about medication, which belongs to his GP as prescriber. Janice's wish for something on file turns out to reflect her plan to take over his bank account; she holds no lasting power of attorney, so the real questions are whether Desmond can make one now and, if not, whether an application for a deputy is needed. Making a power of attorney is Desmond's own decision if he has capacity for it, and appointing a deputy is for the Court of Protection; neither is for the home or for Farah. Farah explains to Paula that an assessment is always of a particular decision at a particular time, that the person who will act on it is responsible for it, and that Desmond's diagnosis does not establish incapacity for any of these decisions.

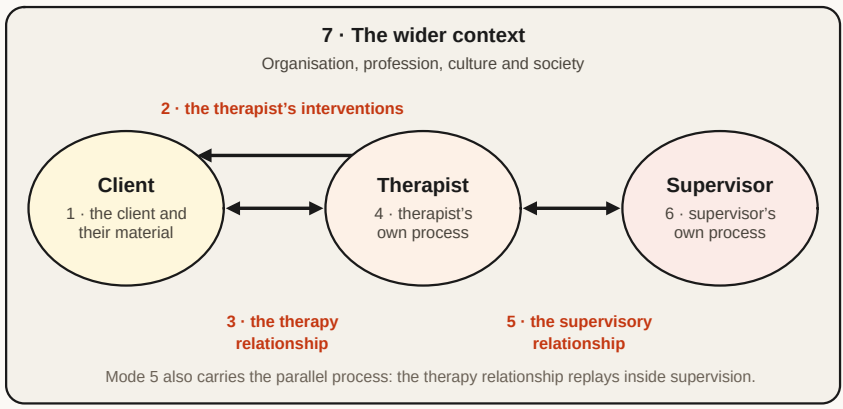
She then offers what she can properly contribute. She meets Desmond, explains who she is and why she has come, and asks whether he is willing to

talk with her; he is. She learns that he hears poorly on his left side, is most alert after breakfast and becomes agitated when people stand over him, and that the evening tablets are large and hard for him to swallow, which he explains clearly. With his agreement she passes these observations to his GP, Dr Kofi Owusu, and to the social worker, Tom Hughes. At a joint visit the next morning, sitting on Desmond's right, the GP assesses his capacity to decide about the medication. Desmond understands what the tablets are for and what may happen without them, and he accepts a liquid preparation. The GP records that he has capacity for that decision. Tom begins a separate assessment about accommodation, which will take more than one visit. Farah records the original request, the decisions she identified and who is responsible for each, Desmond's agreement to see her, what she learned and with whom she shared it, and her reasons for not assessing capacity herself. She notes for Paula that Janice's views will be relevant to any best interests decision but give her no authority to decide. In supervision she observes that the request, taken at face value, would have produced an assessment of nothing in particular by someone who would not act on it.

Common pitfalls. The first is accepting a request to assess capacity without asking which decision, whose decision and why the doubt has arisen; the remedy is to decline to assess in the abstract and to name the decision in writing before any assessment begins. The second is letting a diagnosis or a setting stand in for evidence, so that a care home resident with dementia, or a client on a psychiatric ward, is treated as lacking capacity across the board; section 2(3) forbids this, and the answer is to look for evidence about the specific decision. The third is treating relatives as substitute decision-makers, for example asking a son to sign consent to a recording, or sharing session content with a parent because they seem entitled to know. Unless a relative holds a registered lasting power of attorney or a deputyship covering the decision, their role is to be consulted, not to decide, and confidentiality still applies. The fourth is the reverse error of hiding behind the presumption: writing "capacity presumed" in the notes of a client whose presentation plainly raises doubt, such as a client in an acutely psychotic state agreeing to the release of detailed notes to an employer. The presumption is where the inquiry starts. When there is a real reason to doubt, the practitioner who needs the decision must look, and must record what they found.

Reflective question. Think of the consents you relied on in your last week of

practice: to begin or continue therapy, to share information, to record, or to involve someone else. For which of them could you state the decision precisely, say what you would have treated as a reason to doubt the client's capacity, and name who would have been the decision-maker had the client lacked capacity? Where did your practice rest on assumption rather than on a judgement you could explain to a court?




After Hawkins and Shohet.

**FIGURE 1.1 The seven-eyed model of supervision**

*Hawkins and Shohet's seven modes give supervision its lenses: the client and their material, the therapist's interventions, the therapy relationship, the therapist's own process, the supervisory relationship itself (including parallel process), the supervisor's process, and the wider organisational and social context around all of it.*

## Points worth keeping

- Before the Act, Re F left the treatment of adults lacking capacity to the common law doctrine of necessity, with best interests judged largely by medical opinion.
- The Law Commission's 1995 report chose a functional, decision-specific test of capacity over status and outcome approaches, and much of its design became the 2005 Act.
- The Act applies from age 16, but lasting powers of attorney, advance decisions to refuse treatment and statutory wills require the person to be 18 or over.
- Consent to therapy, to information sharing, to recording and to involving

family are separate decisions, each assessed only when there is a real reason to doubt capacity.

- The decision-maker is whoever proposes the act, unless a registered attorney or deputy has authority, and relatives otherwise have no power to consent for an adult.
- Section 5 protects a person who took reasonable steps to establish capacity and reasonably believes the person lacks it and that the act is in their best interests.
- The House of Lords Select Committee in 2014 called the Act visionary but not embedded, and judged the Deprivation of Liberty Safeguards not fit for purpose.
- The 2007 Code remains in force but predates key judgments such as A Local Authority v JB, and where they differ the judgments state the law.

**PRACTICE TASK**

*This week: Take five current or recent client files and list every consent you relied on: to start or continue therapy, to share information, to record sessions and to involve family members. For each, write the decision down as precisely as you can, note whether anything in the record should have prompted doubt about capacity, and identify who would have been the decision-maker had the client lacked capacity. Then find your organisation's policy on the Mental Capacity Act and check what it says about responding to requests from other agencies for capacity assessments. If it says nothing, draft three sentences you could propose to your manager or, if you work independently, adopt for your own practice.*

*Study activities: The first is a reflective-practice activity of about 25 minutes. Its purpose is to surface the assumptions you bring to questions of capacity. Recall a client whose capacity you doubted, or whose capacity you now think you should have doubted, and write a short account of what prompted the doubt, what you did and who decided what. Then annotate the account against section 2(3) and against the principle that the decision-maker is the person who acts, marking each point where a diagnosis, a setting or a relative's view did work that evidence should have done. The second is a skills-practice activity of about 30 minutes. Its purpose is to rehearse a professional response to a vague request. With a colleague playing a care home manager, practise a telephone conversation in which you establish the decision, the decision-maker, the reason for doubt and the timescale, and agree what you can and cannot contribute. Swap roles, then write a short email confirming what was agreed.*

*Further reading:*

*House of Lords Select Committee on the Mental Capacity Act 2005 (2014) Mental Capacity Act 2005: post-legislative scrutiny. HL Paper 139. London: TSO.*

*Law Commission, 1995. Mental Incapacity. Law Com No 231. London: HMSO.*

*Department for Constitutional Affairs, 2007. Mental Capacity Act 2005 Code of Practice. London: TSO.*

*NICE, 2018. Decision-making and mental capacity (NG108). London: NICE.*

CHAPTER 2

# The five principles in depth

A woman who has neglected herself for years tells the rehabilitation ward that she is going home at the weekend, to a cold house with a steep staircase, against the advice of everyone involved. The ward's question is whether she can be stopped. Section 1 of the Mental Capacity Act 2005 requires other questions to be asked first. Its five principles frame every later provision of the Act. Three of them protect the person's right to decide and operate before any conclusion about capacity is reached; the other two govern what may be done for a person who lacks capacity. A common and serious error is to apply the last two before the first three have done their work.

The first principle, in section 1(2), is that a person must be assumed to have capacity unless it is established that they lack it. This is a rule about the burden and standard of proof as much as an ethical stance. Whoever asserts incapacity must establish it, and section 2(4) sets the standard as the balance of probabilities: incapacity must be shown to be more likely than not, on evidence about the decision in question. If the evidence is evenly balanced or thin, the person is treated as having capacity. The presumption does not forbid assessment. Where there is a real reason to doubt, assessment is how the presumption is tested, and declining to look because capacity is presumed misreads the principle. The presumption fixes the starting point and the burden; it does not predict the answer.

The second principle, in section 1(3), is that a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. It works alongside section 3(2), under which a person is not to be regarded as unable to understand information if they can understand an explanation given in a way appropriate to their circumstances. Together they make support a legal precondition of any finding of incapacity, not a courtesy. What is practicable depends on the decision, its urgency and the person. For a decision that can wait, it may mean several conversations at the time of day when the person is most alert, in a quiet room, with hearing aids working, an interpreter present, or written and pictorial material. For an urgent decision fewer steps will be practicable,

but some always are. The steps must also have been tried without success, so a finding of incapacity reached after one conversation in a corridor will rarely withstand scrutiny. The Code of Practice (Department for Constitutional Affairs, 2007) describes many forms of help, and NICE guidance (NICE, 2018) treats support for decision-making as a distinct part of good practice. Lesson 2.2 covers technique. The legal point is that if the steps are not recorded, no reviewer or court can know they were taken, and the finding becomes vulnerable.

The third principle, in section 1(4), is that a person is not to be treated as unable to make a decision merely because the decision is unwise. It writes into statute the rejection of an outcome approach to capacity that the Law Commission had considered and turned down (Law Commission, 1995): the quality of a choice, judged by someone else's standards, cannot be the test. The principle has common law roots. In Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290 a man with paranoid schizophrenia was held, under the test the courts applied before the Act, to have capacity to refuse an amputation his doctors advised. Kings College Hospital NHS Foundation Trust v C [2015] EWCOP 80 shows the principle at its hardest. A woman refused dialysis that her doctors considered life-saving, for reasons rooted in values many people found difficult to accept, and the court held that she had capacity to refuse, emphasising that an unwise or unconventional decision is not evidence of incapacity. In PC v City of York Council [2013] EWCA Civ 478 the Court of Appeal stressed that there is a space between an unwise decision and one a person lacks capacity to make, and that autonomy operates within it. Two qualifications keep the principle honest. The Code accepts that an unwise decision may justify a closer look, particularly where it is out of character or part of a pattern exposing the person to serious harm. And the operative word in section 1(4) is merely: the decision itself is not evidence of incapacity, but the reasoning that produced it can be. A person who cannot weigh a risk because a delusion or a compulsion removes it from consideration is in a different position from one who weighs the same risk and accepts it.

The fourth principle, in section 1(5), is that an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done or made in their best interests. It applies only where the person lacks capacity for the decision, or is reasonably believed to lack it, and it governs every such act, from choosing clothes to consenting to surgery. Section 4

sets out the checklist that Module 3 examines: no decision on the basis of age, appearance, condition or behaviour alone; consideration of whether the person is likely to regain capacity; encouragement of their participation; and regard to their past and present wishes and feelings, beliefs and values, and to the views of those caring for them. In Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67 the Supreme Court said that the purpose of the test is to consider matters from the person's point of view, with welfare understood in the widest sense. Best interests is therefore not the decision-maker's opinion of what would be good for the person, still less what suits the service.

The fifth principle, in section 1(6), requires that before the act is done or the decision made, regard must be had to whether the purpose can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. Two features are often missed. It is a duty to consider, not a rule that the least restrictive option must always be chosen; the option chosen must be in the person's best interests, and sometimes only a more restrictive option achieves the purpose. And it operates among options that actually exist. In N v ACCG [2017] UKSC 22 the Supreme Court held that the Court of Protection decides between available options and cannot compel a public body to provide an option it has not offered. A practitioner may see a less restrictive arrangement that would suit the person well, but if no one will fund or provide it, the principle cannot bring it into being. What the practitioner can do is name the alternative in the record and in discussion with commissioners, so that its absence is visible.

Read together, the principles work as a sequence, and they can pull against each other. Taking time to support a decision may delay protective action that a risk seems to demand. The sharpest conflict, though, is between the unwise decisions principle and the practitioner's sense of a duty of care. A capacitous person's refusal of help does not end the duty to offer it, to keep the offer open and to share concerns where the law allows, but it does mean the help cannot be imposed. Where a local authority has reasonable cause to suspect that an adult has needs for care and support, is experiencing or at risk of abuse or neglect, and because of those needs cannot protect themselves, section 42 of the Care Act 2014 requires it to make enquiries, and the statutory guidance recognises self-neglect as a form of neglect for this purpose. An enquiry is not a power to override a decision made with capacity, and the Making Safeguarding Personal approach expects the

response to be person-led and focused on the outcomes the person wants.

The deepest difficulty with the principles is psychological rather than textual. Practitioners who fear for a person's safety are pulled towards protective outcomes, and the pull acts on the capacity assessment itself, so that the riskiness of the choice quietly becomes the evidence that the person cannot make it. This has come to be called the protection imperative. In CC v KK and STCC [2012] EWHC 2136 (COP), which concerned an older woman in a care home who wished to return to her own home, the court warned against it and found that she had capacity to decide where to live. It held that capacity should be assessed against the realistic options, which in her case included a return home with a package of care, rather than against an abstract test, and it cautioned against paternalism. The case exposes a weakness in the Act's design. The principles assume that capacity assessment and best interests reasoning can be kept apart, yet the same professionals usually do both, in the same meeting, with the same anxieties. The House of Lords Select Committee's conclusion that the Act had not been embedded in practice (House of Lords Select Committee, 2014) is consistent with this: a practitioner can state all five principles correctly and still let fear of a fall or a fire decide the assessment.

The opposite error is as damaging and attracts less attention. In self-neglect, the presumption and the unwise decisions principle are sometimes treated as conclusions: a person living in squalor is recorded as having capacity although nobody has assessed it, and services withdraw on the basis that the choice is theirs. Neither principle authorises that. The presumption allocates the burden of proof; it does not excuse practitioners from noticing evidence that the person cannot use or weigh information about the risks of their situation, which can be true even of someone who describes those risks fluently. Good practice keeps both errors in view. It starts from capacity, supports the person, tolerates choices others would not make, and still asks, on evidence, whether this particular choice is one the person is able to make.

Worked clinical example. Maureen Fletcher, aged 71, lives alone with two cats in a terraced house in Gateshead. For years her GP practice has worried about the cluttered house, a boiler that has not worked for two winters, and two safeguarding concerns about self-neglect that closed when she declined involvement. After a fall she developed delirium from an infection, which has

resolved during three weeks on a community rehabilitation ward. Dr Kwame Asante, the ward team's clinical psychologist, has been seeing her for low mood. On Thursday she announces that her niece will collect her on Saturday. The ward manager says she obviously lacks capacity and should be kept until a safe plan is in place. The consultant, Dr Ellen Marsh, responsible for her care and for any decision to prevent her leaving, asks Kwame to help assess her.

Kwame first defines the decision: whether to leave the ward on Saturday and return home, with or without the support on offer. The recent delirium and her low mood give a genuine reason to doubt capacity, but he notes that the riskiness of the plan is not evidence. Her hearing aid batteries have been flat for days, she is sharper in the mornings, and she distrusts anyone she associates with the earlier safeguarding concerns. On Friday morning, hearing aid working, Kwame and the occupational therapist, Priya Shah, meet her in the quiet day room. Priya shows home-visit photographs of the staircase and the unheated kitchen, and they set out the realistic options: home with carers twice a day and a key safe, home with a pendant alarm and a boiler repair only, or a further week on the ward to practise the stairs. Maureen describes the stairs and the risk of another fall in her own words and recalls the home visit from two days before. She weighs the options against what matters to her: her cats, her privacy, and a long-standing fear of being moved into a care home. She accepts the pendant and the repair but not carers in the house, and explains why. Her mood is low, but she is not dismissing the information or treating every outcome as the same, and her reasons match values she has expressed for years.

Kwame and Dr Marsh conclude that, on the balance of probabilities, Maureen has capacity to decide to go home. The team regards the choice as unwise, and section 1(4) means that view cannot decide the matter; because she has capacity, best interests and the less restrictive option are not engaged. The duty to offer help continues. With her agreement the team arranges the pendant, the boiler repair and community follow-up, and a safeguarding concern is raised with her knowledge; she agrees to a telephone call from a social worker but not a visit. Kwame records the decision as defined, the reason for doubt, each support step, the options presented, Maureen's answers in her own words, his analysis of each ability, the conclusion, who was present and the plan, noting that capacity should be revisited if her mood deteriorates. Had her depression left her unable to

weigh the options, the team would have made a best interests decision, considering home with support first, and preventing her from leaving would have required authorisation (lesson 5.2).

Common pitfalls. The first is letting the outcome trigger the assessment and then decide it, so that the thought that a client wants to do something dangerous turns into the conclusion that she lacks capacity. The safeguard is to write down the reason for doubt before assessing and to check that it is something other than disagreement with the choice. The second is treating practicable steps as a single conversation held at a bad moment, during a ward round or without a hearing aid or interpreter, and then recording incapacity; plan the support as deliberately as the assessment and record each step. The third is reaching for best interests or the less restrictive option before incapacity has been established, for example convening a best interests meeting about where someone should live when nobody has assessed whether they can decide it themselves. Keep the order fixed: assess the specific decision first, and turn to best interests only if incapacity is established. The fourth reverses the first: recording that a person who self-neglects has capacity because the presumption applies, without any assessment of the specific decision, and then closing the case. A presumption that has never been tested against evidence cannot justify withdrawing from someone at serious risk.

Reflective question. Recall a client whose choice frightened you or your team. At what point did the riskiness of that choice begin to shape your view of whether the client could make it, and what evidence, separate from the outcome, would you now want before accepting either that they had capacity or that they lacked it?

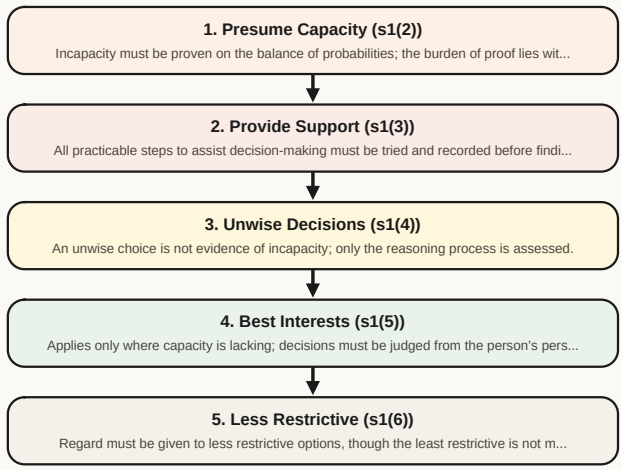



**FIGURE 2.1 Applying the Five Principles of the Mental Capacity Act**

*The five principles operate as a sequential framework where the first three establish the person's right to decide before any capacity assessment. The final two principles only become relevant if the initial steps confirm that the individual lacks capacity.*

## Points worth keeping

- Section 1(2) places the burden on whoever asserts incapacity, which must be established on the balance of probabilities with evidence about the specific decision.
- Section 1(3) makes support a precondition of any finding of incapacity: all practicable steps must have been tried without success, and each step should be recorded.
- Under section 1(4) an unwise decision is not itself evidence of incapacity, as Kings College Hospital NHS Foundation Trust v C illustrates, though the reasoning behind it may be.
- Best interests under section 1(5) applies only where the person lacks, or is reasonably believed to lack, capacity, and must be judged from their point of view.
- Section 1(6) requires regard to less restrictive alternatives but does not mandate the least restrictive option, and N v ACCG confines choices to options actually available.
- The protection imperative, warned against in CC v KK, leads practitioners to treat a risky choice as evidence of incapacity; capacity must be

assessed against realistic options.

- Treating the presumption as a conclusion in self-neglect is equally wrong, because it allocates the burden of proof and does not excuse practitioners from examining evidence.
- A section 42 enquiry under the Care Act 2014 may be required in self-neglect, but it gives no power to override a decision made with capacity.

**PRACTICE TASK**

*This week: Choose one current client whose choices concern you or others involved in their care. Write a one-page note that takes the five principles in turn: whether there is a real reason to doubt capacity for a specific decision, what support has been offered and what more is practicable, whether the concern is about the wisdom of the choice or about the person's ability to make it, and, only if incapacity has been established, how best interests and less restrictive options are being considered. Take the note to supervision and agree one concrete change, such as an additional support step, a clearer definition of the decision or a better record.*

*Study activities: The first is a reflective-practice activity of about 25 minutes, designed to make the protection imperative visible in your own reasoning. Write a brief account of a decision by a client that frightened you, then reread it and underline every sentence in which the risk of the choice is presented as evidence about the person's ability to make it. Rewrite each of those sentences so that it states evidence about understanding, retaining, using or weighing, or communicating information. The second is a skills-practice activity of about 30 minutes, designed to rehearse presenting realistic options in the way CC v KK requires. With a colleague playing a client who wants to return home against advice, prepare and present three concrete options with their likely consequences, using plain language and one visual aid, then ask the client to explain each option back in their own words. Afterwards, note which explanations worked and which needed changing.*

*Further reading:*
*Department for Constitutional Affairs, 2007. Mental Capacity Act 2005 Code of Practice. London: TSO.*

*Kings College Hospital NHS Foundation Trust v C [2015] EWCOP 80.*
*CC v KK and STCC [2012] EWHC 2136 (COP).*
*PC v City of York Council [2013] EWCA Civ 478.*