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ACHIEVING CRPD COMPLIANCE

IS THE MENTAL CAPACITY ACT OF ENGLAND AND WALES COMPATIBLE WITH THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES? IF NOT, WHAT NEXT?

AN ESSEX AUTONOMY PROJECT POSITION PAPER

REPORT SUBMITTED TO THE UK MINISTRY OF JUSTICE

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EXECUTIVE SUMMARY

This report is the culmination of a collaborative six-month project examining the question of whether the Mental Capacity Act of England and Wales (MCA) is compliant with the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The main findings of the report are as follows:

1. The Mental Capacity Act of England and Wales is not fully compliant with the United Nations Convention on the Rights of Persons with Disabilities, to which the UK is a signatory.
2. The definition of "mental incapacity" in s.2(1) of the MCA violates the anti-discrimination provisions of CRPD Art. 5, specifically in its restriction of mental incapacity to those who suffer from "an impairment of, or a disturbance in the functioning of, the mind or brain."
3. The best-interests decision-making framework of Section 4 of the MCA fails to satisfy the requirements of CRPD Art. 12(4), which requires safeguards to ensure respect for the rights, will and preferences of disabled persons in matters pertaining to the exercise of legal capacity.
4. MCA s.2(1) should be amended to remove the following words: "because of an impairment of, or a disturbance in the functioning of, the mind or brain."
5. The best-interests decision-making framework on which the MCA relies should be amended to establish a rebuttable presumption that, when a decision must be made on behalf of a person lacking in mental capacity, and the wishes of that person can be reasonably ascertained, the best-interests decision-maker shall make the decision that accords with those wishes.
6. The United Nations Committee on the Rights of Persons with Disabilities is not correct in its claim that compliance with the CRPD requires the abolition of substitute decision making and the best-interests decision-making framework.

This report represents the views of the authors. It should not be taken to represent the views of the Ministry of Justice, the Arts and Humanities Research Council, or other participants in the roundtable meetings that comprised an essential part of this project.

The Essex Autonomy Project is a research and knowledge-exchange initiative based at the University of Essex. Its fundamental aim is to clarify the ideal of self-determination in history, theory and practice, both for its own sake, and in order to provide guidance to those who must apply this notion—whether as care workers, as medical practitioners, as legal professionals, or simply as citizens.

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§1 INTRODUCTION:

The Mental Capacity Act of England and Wales (MCA) was adopted by Parliament in 2005 and came into effect in 2007. The MCA provides a statutory framework for both empowering and protecting adults who may have impaired decision-making capacity. In 2006, shortly following the passage of the MCA, the United Nations General Assembly adopted the UN Convention on the Rights of Persons with Disabilities (CRPD), which came into force internationally in 2008. The CRPD was ratified by the UK in 2009, and by the EU (on behalf of all member states) in 2010. In ratifying the Convention, the UK committed itself to revising domestic legislation as necessary in order to achieve compliance with its provisions. The aim of this Essex Autonomy Project Position Paper is to consider whether the MCA is compliant with the CRPD, and if it is not, what changes would be required in order to achieve compliance.

In considering the overall question of compliance, we find it useful to distinguish between remediable and structural forms of non-compliance. Remediable non-compliance is correctable through amendments to the Act and/or its Code of Practice, while still retaining the fundamental aims and legal architecture of the statute. Structural non-compliance would require a much more far-reaching change in approach. In the debates on this subject, some have claimed that the Act is already compliant with the CRPD; others have argued that it is structurally noncompliant.[1] In what follows, we argue the Act is *remediably non-compliant*. We review and assess two arguments that have been advanced for the thesis of structural non-compliance; we argue that they do not survive scrutiny. But we also show that two features of the Act in its present form fail to comply with the requirements of the CRPD, and we propose a framework for remedying this non-compliance.

The present paper constitutes the final report of a six-month project, led by the Essex Autonomy Project (EAP), with support from the Arts and Humanities Research Council (AHRC). Over the course of the project, the EAP organised a series of public policy roundtables, hosted by the Ministry of Justice (MoJ), bringing together leading

[1] The former view is implied by Office for Disability Issues 2011, para 47. The latter view is taken by a number of academic commentators and disability rights activists, whose views are discussed in detail below.

academic experts, public officials, and representatives from civil society and service-user organisations, in order to discuss the challenges and controversies associated with CRPD-compliance. In other research outputs from the project, we presented overviews of positions and arguments, but did not take a stand on the disputed issues.[2] This report is different. In it, we articulate and defend an answer to the questions posed on the title page. Our answer is informed by extensive discussions at project events, but the position defended in this paper is that of the authors, and should not be taken to be that of the AHRC, the MoJ or other partners in this project.

A final word of warning may be in order before turning to matters of substance. This report is lengthy, in part because we have devoted considerable space to exploring various lines of argument and counter-argument pertaining to the main question. We believe that this sort of attention to argumentative detail is necessary in order to arrive at an informed and considered judgement concerning the legal question that we seek to address. This is not the sort of matter that can be settled simply by invoking general guiding principles. Nonetheless, it is critical in surveying the legal minutiae that we do not lose sight of the unique opportunity presented by the CRPD. The legal matters explored in the following pages have a direct and profound bearing on the lives of persons living with disability and/or diminished capacity; the UK should use the UN engagement process as an opportunity to reflect on ways in which the treatment of such persons can meet the highest ethical and legal standards. The question of whether the MCA is compliant with the CRPD is but one part – albeit an important part – of this larger challenge and opportunity.

§2 THE ISSUES

In the debates over the question of MCA compliance with the CRPD, there have been three major points of controversy. The first pertains to the MCA's use of the so-called *diagnostic threshold*. The second pertains to the CRPD's requirement for states parties to adopt safeguards ensuring *respect for the rights, will and preferences* of disabled persons. The third, and most far-reaching, pertains to the CRPD requirement that states parties recognise the *legal capacity* of disabled persons

[2] These briefing papers can be downloaded from the EAP website at http://autonomy.essex.ac.uk/is-the-mca-compliant-with-the-uncrpd-briefing-papers.

in all matters on an equal basis with others. It will be useful to begin with a brief overview of these points of controversy.[3]

The Diagnostic Threshold: The term "diagnostic threshold" does not itself appear anywhere in the MCA, but both in court rulings and in the surrounding academic literature it has become a standard term for referring to one part of the two-part definition of mental incapacity that appears in MCA s.2(1):

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

This definition combines two discrete elements. The first part of the definition is framed in terms of a person's *decision-making ability*. A person lacks mental capacity with respect to a particular decision only if she lacks the ability to make the relevant decision for herself at the time when the decision needs to be made. In MCA s.3(1), this notion of decision-making ability is further analysed in what is known as *the functional test*. A person has decision-making ability if she has the ability to understand, retain, use & weigh information relevant to the decision, and is able to communicate a choice. Absence of any one of these abilities with respect to a particular matter can suffice to compromise decision-making ability.

But this functional test for decision-making ability is only part of the definition in MCA s.2(1). It is the second element in the definition that has come to be known as the diagnostic threshold. A lack of decision-making ability only amounts to a lack of mental capacity insofar as it is the result of an "impairment of or disturbance in the functioning of the mind or brain." The diagnostic threshold has been a flashpoint for controversy because it raises a concern about discrimination.[4] In particular, the MCA definition of incapacity seems to treat people differently

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[3] Our attention in this report is confined to the MCA as it was originally adopted by Parliament in 2005. We have not attempted to determine whether the much-criticised Deprivation of Liberty Safeguards (DoLS) are compliant with the CRPD. The DoLS were adopted by Parliament in 2007 as part of its revision of the Mental Health Act (1983), but formally have the standing of an amendment to the MCA 2005. At the time this report was being prepared, a separate process was underway to review the DoLS procedure in light of the Cheshire West decision in the UK Supreme Court (Cheshire West [2014] UKSC 19). Although we touch on the concept of "deprivation of liberty" at several points below, we believe that a separate study is required, encompassing both the Mental Health Act and the DoLS provisions of the MCA, in order to address the CRPD-compliance issues in this area.

[4] See, for example, Bartlett 2012, Flynn & Arstein-Kerslake 2014.

specifically on the basis of certain cognitive *impairments*. It thus constitutes a prima facie case of discrimination against those with disabilities that impair cognitive performance.

Respect for Will and Preferences: Art. 12(4) of the CRPD pertains to safeguarding. Specifically, it requires states parties to establish safeguards to ensure that, in matters relating to the exercise of legal capacity, the "rights, will and preferences" of disabled persons are respected. The second flashpoint of controversy concerns the question of whether the MCA meets this standard.[5] The fundamental structure of the MCA provides for a best interests decision to be made on behalf of certain persons who lack the mental capacity required to make a decision for themselves. The MCA's best interests standard has been interpreted by the courts as an "objective standard of best interests,"[6] meaning in effect that a person's best interest may under some circumstances conflict with what that person herself wishes. The second flashpoint concerns the question of whether such a provision of law is compatible with the safeguarding requirements of CRPD Art. 12(4).

Legal Capacity on an Equal Basis in All Matters: The third flashpoint pertains to the fundamental requirement of CRPD Art.12(2), which stipulates that "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." We shall return below to a consideration of the crucial notion of "legal capacity," which is not to be confused with "mental capacity." For present purposes, the crucial point is that critics of the MCA have argued that the CRPD requirements for recognition of legal capacity preclude statutory arrangements such as those found in the MCA, which allow states to find certain individuals lacking in legal capacity on the basis of a finding of mental

[5] See, for example, Bartlett 2012, Flynn & Arstein-Kerslake 2014, Lush 2011, Quinn with Arstein-Kerslake 2012, Richardson 2012.

[6] The description of the best-interests standard as an "objective test" does not appear in the text of the MCA, but only in the *Explanatory Notes* that accompanied it: "Best interests is not a test of 'substituted judgement' (what the person would have wanted), but rather it requires a determination to be made by applying an objective test as to what would be in the person's best interests" (Department of Health 2005). The term 'substituted judgement,' which appears in this passage from the *Explanatory Notes*, is not to be confused with the notion of 'substitute decision-making,' which we discuss below (§4).

incapacity. Legal capacity should be guaranteed to all persons on an equal basis, not parcelled out on the basis of one's mental abilities.[7]

In order to probe these three interrelated issues, and to lend a clear structure to our investigation, we find it useful to lay out the issues in the form of an indictment against the MCA. Accordingly, we distinguish three "counts" in the indictment.

> *Count One:* By authorising best-interest decision-making for persons who fail a functional test for mental capacity, the MCA fails to recognise legal capacity to all persons on an equal basis, as required by CRPD Art. 12(2).
>
> *Count Two:* The use of the diagnostic threshold in MCA s.2(1) violates CRPD Art. 5, which bans discrimination on the basis of disability.
>
> *Count Three:* The best-interests decision-making procedures in MCA s.4 fail to provide the safeguards required by CRPD Art. 12(4), ensuring respect for the rights, will and preferences of disabled persons.

As we shall see below, the three "counts" are interrelated in various ways, but it will be useful nonetheless to subject each to scrutiny in turn. To anticipate our final conclusion, we shall argue that the MCA is "guilty" on the second and third counts, but "not-guilty" on the first.

§3 Some Preliminary Remarks About Discrimination

Before considering the three counts of the indictment, however, we need to start with some preliminary work on the notion of discrimination. Notice, first of all, that concerns about discrimination figure either implicitly or explicitly in at least two of the three counts of the indictment. Count Two explicitly alleges that the MCA discriminates on the basis of disability. Count One alleges that the MCA fails to recognise legal capacity *on an equal basis*; so the issue once again implicates questions about discriminatory treatment. We therefore need to think first about how charges of discrimination are best assessed under the CRPD.

In broaching this matter, we begin by stepping back from both the MCA and the CRPD in order to review a basic distinction in discrimination law: the distinction between direct and indirect discrimination. If I advertise a job-opportunity, and specify that the job is only open to men, then I am engaged in *direct* discrimination on

[7] See, for example, Bartlett 2012, Bach and Kerzner 2010, Dhanda 2007, Flynn & Arstein-Kerslake 2014, Quinn 2010, Quinn with Arstein-Kerslake 2012.

the basis of gender. A woman who may be interested in the job is treated differently and unfavourably in comparison to the way that others in a similar situation would be treated, and the *basis* of the differential treatment is that person's gender. If I advertise for a second post, and stipulate that the minimum height of applicants is six feet, then I am open to the charge that I have *indirectly* discriminated against women. The job specification is "facially neutral." The basis of differential treatment is not gender, and some women will indeed meet the height requirement, so there is no direct discrimination. But the requirement nonetheless screens out more female than male job-seekers, and therefore impacts negatively and disproportionately on women.

Direct and indirect discrimination are treated differently under the law. My first job advert is in most instances illegal.[8] But disproportionate impact is different. Different jurisdictions handle the matter differently, but the common theme is this: practices that result in disproportionate and unfavourable impact on a protected category of persons must be subjected to careful legal scrutiny in order to assess their legality, but they are not always illegal. Crudely put: direct discrimination is generally a red light, but disproportionate impact is more like a flashing yellow. If the height requirement in the second job advert is unrelated to the tasks that the post-holder will be expected to perform, then it constitutes unlawful, indirect discrimination. But what if the height requirement is a genuine occupational requirement for the job that needs to be performed? The job specification still impacts disproportionately upon women, but it may nonetheless be lawful.

Up to this point we have been relying on a standard distinction in discrimination law.[9] But how do these matters play out in the CRPD itself? The principle of non-discrimination is one of the primary commitments of the CRPD. The Convention defines discrimination in Article 2 as follows:

> 'Discrimination on the basis of disability' means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the

[8] There are exceptions. If I am hiring prison guards in a prison for men, or football players in an all-female league, then a direct gender restriction may be legal.

[9] See for example Doyle 2007.

> political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation[.]

In Article 5(1), the Convention explicitly bans it:

> States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

What the Convention does *not do* is to provide any account of the circumstances under which differential treatment of persons with disabilities may be allowable. In other words, the CRPD provides no schema of defence against charges of indirect discrimination.

In the face of this lacuna, we have to choose between two paths. The first path would be to conclude that the CRPD allows for no such defence. On this reading, any policy that disproportionately and unfavourably impacts persons with disabilities would be prohibited under the Convention. The second path would be to look to other authorities in international law to determine when such policies may be justifiable.

At first consideration, it might seem that the text of the Convention requires us to choose the first of these two paths.[10] We note in particular that the Convention's definition of discrimination explicitly includes "all forms of discrimination"; it also makes reference to both the purpose *and the effect* of any distinction, exclusion or restriction. It is clear that this definition is intended to be highly inclusive.

But closer scrutiny serves to rule out the first path. We need to consider, first, whether the Convention's definition of discrimination really includes *all forms of disproportionate impact* on persons with disabilities. In our view, the textual argument for this interpretation is weak. As we have seen, the final sentence of the definition does explicitly include "all forms of discrimination." We agree that this sentence should be read as including both direct and indirect forms of discrimination. But not all forms of disproportionate impact constitute discrimination – direct or indirect.[11] Disproportionate impact at most constitutes grounds for an *allegation* of

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[10] This reading of the CRPD is defended in Butlin 2011; see in particular 437-438.

[11] "Differential treatment based on prohibited grounds will be viewed as discriminatory *unless the justification for differentiation is reasonable and objective*." UN Committee on Economic, Social and Cultural Rights 2009, para

indirect discrimination. It cannot in and of itself warrant a *finding* of indirect discrimination. So in banning "all forms of discrimination," the CRPD need not be read as banning all practices with disproportionate impact.

But with this sort of close textual analysis we are in danger of overlooking the elephant in the room. It is crucial to appreciate that there is *an incredibly broad array* of facially neutral state-sponsored practices that disproportionately impact upon persons with disabilities. The bar exam disproportionately excludes persons with learning disabilities from careers in the law. The test to become a frontline fire-fighter disproportionately excludes persons with mobility disabilities. These sorts of examples can be multiplied endlessly. It would be absurd to suppose that all such selection procedures are therefore prohibited under the Convention. If follows that we have to find some way of determining when these practices are lawful and when they are not.

Fortunately, there is a well-established procedure for making such a determination. The details of the procedure vary from one jurisdiction to another, but the general strategy is common ground. Since the CRPD is a UN instrument, the most appropriate place to turn for guidance is to the relevant UN authorities. The UN Committee on the Rights of Persons with Disabilities has not yet addressed this matter, so we turn instead to the UN Human Rights Committee. In its *General Comment on Non-Discrimination*, the committee writes:

> Finally, the Committee observes that not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant.[12]

In what follows, we shall adapt this guidance from the UN Human Rights Committee as our schema in assessing cases of purported discrimination against persons with

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13, emphasis added. See also the Council of the European Union's Directive 2000/43/EC, Art. 2.2(b): "Indirect discrimination shall be taken to occur where an apparently neutral provision, criterion or practice would put persons of a racial or ethnic origin at a particular disadvantage compared with other persons, *unless* that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary." (emphasis added).

[12] UN Human Rights Committee 1989/1994: para. 13. This guidance from the UN Human Rights Committee is closely echoed by the UN Committee on Economic, Social and Cultural Rights in its *General Comment on Non-Discrimination in Economic, Social and Cultural Rights* (2009), para. 13.

disabilities. Wherever a practice disproportionately impacts upon persons with disabilities, we will need to ask three questions:

> Does the practice serve a *legitimate aim* under the CRPD?[13]
>
> Does the practice use an *objective basis* for its differential treatment?
>
> Is the use of that basis of differential treatment a *reasonable means* for achieving the specified aim?

Any practice with disproportionate impact that fails any one of these three tests should be treated as unjustifiable indirect discrimination on the basis of disability, and is accordingly proscribed under CRPD Art. 5. But a practice that passes all three tests is not proscribed by the antidiscrimination principles of the Convention, even if it disproportionately and unfavourably impacts upon persons with disabilities.

Before going on to apply this test to particular provisions of the MCA, it is crucial to remind ourselves of one textual detail: *the word "disability" occurs exactly once in the MCA*. Its appearance comes in the context of MCA Schedule 6: *Minor and Consequential Amendments*, and it appears there only for the purposes of *deleting* a passage that had used the term "disability" in the *Leasehold Reform, Housing and Urban Development Act of 1993*. This may seem to be a minor and inconsequential matter, but for our purposes here it matters a lot. The crucial point to recognise is that *the MCA does not draw its distinctions on the basis of disability status*. Instead, it draws distinctions on the basis of the presence or absence of decision-making capacity, and it eschews any "status test" in assessing a person's decision-making ability.[14]

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[13] The guidance from the UN Human Rights Committee refers to "a purpose which is legitimate *under the Covenant*" (emphasis added). The Covenant in question in that instance is the International Covenant on Civil and Political Rights (ICCPR). In adapting the guidance to the present task, we propose to ask whether practices with disproportionate impact on persons with disabilities serve aims that are legitimate *under the CRPD*. This clause itself can be applied with varying degrees of stringency. On the most stringent version of the test, an aim would be legitimate only if it is an aim of the CRPD itself. A less stringent version of the test would allow as legitimate any purpose that is *not inconsistent with* the CRPD. An intermediate degree of stringency would be to allow as legitimate any aim of the CRPD *or other international human rights treaties*. The differences among these interpretations of the legitimate aim standard are for the most part not material to our analysis. Except where noted, we operate with the most stringent variant of the standard, allowing as legitimate only such aims as are themselves aims of the CRPD.

[14] It is important to be clear that our claims in this report pertain to the provisions of the MCA itself; we have not attempted any survey of its implementation on the ground. The use of status tests for capacity undoubtedly continues, and no doubt there are instances in practice where judgements of incapacity are based on age or appearance, in violation of MCA s.2(3). But these practices are illegal under the MCA, and should be addressed through training, quality control exercises, and enforcement, not through a change to the statute.

Why does this matter? The concepts of disability and the concept of mental incapacity are *not equivalent*. Most people with disabilities, even with severe disabilities, retain mental capacity, at least for some decisions. A person with dementia may be able to make her own decisions about her place of residence, her sexual partners, and most day-to-day activities, for example, despite having lost the mental capacity to make her own investment decisions. A person with paranoid schizophrenia may nonetheless retain the capacity to make decisions about treatment for a physical illness, while lacking capacity to make many other decisions. Moreover, many persons with disabilities retain mental capacity in *all* matters. Conversely, some people without disabilities lack mental capacity for certain matters. A person who has suffered a concussion, for example, or is suffering from shock following a trauma, may as a result lack mental capacity to refuse treatment for an injury, even though they do not suffer from any disability. So the two concepts are neither synonymous nor co-extensive.

We emphasise this point here because of its bearing on the contested issues about discrimination. All parties are in agreement that the differential treatment authorised by the MCA disproportionately impacts persons with disabilities. But this cannot of itself settle the allegation of discrimination. Rather it marks the point where close scrutiny of these statutory provisions should begin.

§4 The Controversy Concerning Substitute Decision-Making

With these preliminaries out the way, we can now begin to assess the three counts in the charge of non-compliance. The first count alleges that the MCA fails to recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. We begin here because this count is the most radical of the three complaints against the MCA, because the fault it alleges pertains to the fundamental architecture of the Act, and because (as we shall see) it is a matter on which the UN Committee on the Rights of Persons with Disabilities has clearly indicated its position. We therefore propose to devote close attention to this allegation in the pages that follow.

Let's begin with a brief reminder of the basic architecture of the MCA. At the risk of slight oversimplification, we can summarise its legal structure in three propositions:

> 1) An adult person (P) either has or lacks mental capacity to make a specific decision at the material time, i.e., at the time when it needs to be made.
>
> 2) If P *has* mental capacity for the decision at the material time, then P has the right to make that decision for herself.
>
> 3) If P *lacks* mental capacity to make the decision at the material time, even when support has been provided, then a decision must be made on P's behalf in P's own best interests.[15]

In virtue of this basic structure, the MCA authorises what in the disability rights literature has come to be known as *substitute decision-making*.[16] When a person is lacking in mental capacity with respect to some particular decision, some other person (the best-interests decision-maker) is authorised to "substitute" his judgement for that of the person who is lacking in capacity. Substitute decision-making is commonly contrasted to *supported decision-making*, where a designated supporter or supporters help P implement a course of action that is determined by P's own will and preferences in the matter.

Substitute decision-making is intensely controversial.[17] Among its critics, certainly the most important is the United Nations Committee on the Rights of Persons with Disabilities (hereafter: the Committee). The Committee is the formal treaty body for the CRPD, with powers and responsibilities established under the Convention itself, and under the *Optional Protocol*, to which the UK is also a signatory. At its April, 2014 meeting, the Committee adopted its first General Comment (*On Equal Recognition Before the Law*; hereafter GC1), which addresses the provisions of CRPD Art. 12. In its General Comment, the Committee states that substitute decision-making, and with it the use of best-interests decision-making, are

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[15] As noted, this three point schema is guilty of oversimplification, most notably by neglecting the possibility that P lacks mental capacity for the decision, but has a valid and applicable advance decision. In addition, the right of a person with mental capacity to make their own decisions can be Frestricted by other legal instruments, notably the Mental Health Act (1983, amended 2007).

[16] To reiterate a point we made above, the term "substitute decision-making" is not to be confused with the notion of "substituted judgement" that figures in the *Explanatory Notes* to the MCA.

[17] See Bach & Kerzner 2010, Centre for Disability Law & Policy NUI Galway, 2012, Flynn & Arstein-Kerslake 2014.

incompatible with the requirements of CRPD Art. 12. The following three passages from GC1 provide the essentials of the Committee's position.

> On the basis of the initial reports of various States parties that it has reviewed so far, the Committee observes that there is a general misunderstanding of the exact scope of the obligations of States parties under article 12 of the Convention. *Indeed, there has been a general failure to understand that the human rights-based model of disability implies a shift from the substitute decision-making paradigm* to one that is based on supported decision-making. (GC1, para. 3; emphasis added).
>
> States parties' obligation to replace substitute decision-making regimes by supported decision-making *requires* both *the abolition of substitute decision-making regimes* and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention. (GC1, para. 28; emphasis added)
>
> The 'will and preference' paradigm *must* replace the *'best interests' paradigm* to ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others. (GC1, para. 21; emphasis added)

The first of these three passages calls for states parties to shift from substitute decision-making to supported decision-making; the second explicitly claims that substitute decision-making must be abolished. The final passage specifically rejects the use of the best-interests paradigm in actions that affect adults with disabilities. If we accept the Committee's interpretation of Article 12, then we must conclude that the fundamental legal architecture of the MCA is not compliant with the CRPD.

In assessing the Committee's position on these matters, it will be useful to begin with two initial observations. First, it is important to recognise that in ratifying the CRPD and its Optional Protocol, the UK committed itself to be *bound by the Convention*, and for its domestic practices to be *reviewed by the Committee*; it did not agree to be bound by the Committee's interpretation of the Convention. In the jargon of international law, the Committee's findings are *not binding* on the UK.[18] Of course this does not mean that the Committee's interpretation of the Convention's requirements can be lightly dismissed. The Committee is explicitly authorised to

[18] For a detailed discussion of this point see our research note on the legal status of General Comments, available at http://autonomy.essex.ac.uk/wp-content/uploads/2014/07/Legal-status-of-General-Comments-.pdf.

offer general comments and recommendations as regards CRPD compliance, and its General Comment on Article 12 will clearly provide an important part of the basis for its upcoming review of UK legislation. But it remains open to the UK to challenge or even to reject the Committee's interpretation of Article 12, while nonetheless remaining committed to the CRPD itself.

Secondly, it is important to be clear that the claims of the Committee's General Comment go beyond anything that is explicitly stated in the text of the CRPD. The CRPD itself does not actually say that substitute decision-making should be abolished. Indeed, the Convention itself makes no use of the term "substitute decision-making" at all.[19] Neither does the CRPD state that the best-interests paradigm must be replaced. Indeed the only thing that the Convention says about best interests is that the best interests of children must be a primary consideration (CRPD Art. 7.2).

These initial observations have important bearing on our assessment of the first count of the indictment. The abolition of substitute decision-making regimes would mark a radical departure from all approaches to mental capacity legislation in existence at the time of the CRPD's framing. If the CRPD was indeed intended as a call for such an abolition, then this requirement would presumably have been included explicitly in the text of the Convention itself. It was not. The Committee as well as a cohort of academics have argued that CRPD nonetheless implicitly requires the abolition of substituted decision-making. We have been able to identify two arguments – or rather, two families of argument – that purport to establish this result. In following sections we shall consider one of them, returning to the second further below (§9) in the context of our discussion of will and preference.

§5 Denial of Legal Capacity Under the MCA

The first family of arguments against substitute decision-making comprises a number of variants on one master argument, can be summarised as follows:

1) The CRPD requires states parties to recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

[19] This has been remarked upon by many. See, for example, Fennell and Khaliq 2011, Richardson 2012. See also Lush 2011.

2) Substitute decision-making regimes permit the denial of legal capacity to a disabled person in some aspects of life on an unequal basis.

∴ 3) Substitute decision-making regimes must be abolished in order to achieve CRPD compliance.

The first step in assessing this argument must be to consider more closely the meaning of the central term-of-art, *legal capacity*. Although legal capacity is a central concept within the CRPD, the Convention itself provides no definition. It is important to be clear that legal capacity is not at all the same as mental capacity, although the two concepts are sometimes linked by particular provisions of law.[20] As we have seen, the concept of mental capacity at its core refers to the ability of individuals to make decisions for themselves – either on their own or with support. The functions which comprise mental capacity (the abilities to understand, retain, use & weigh information and express a decision) are psychological abilities that vary in the human population. By contrast, legal capacity is not a psychological concept at all but a legal status or standing.

So what is that legal status or standing? As a first approximation, we can say that a person with full legal capacity enjoys the right to vote, to enter into contractual relations (including marriage), to instruct a solicitor, to participate in legal proceedings (including as a juror), etc. In short, a person with full legal capacity is a 'player in civil society.' It is important to appreciate that the foregoing list is indicative rather than exhaustive: these are *examples* of the sorts of legal agency that can be exercised by a person with full legal capacity.

Recent debates around the recognition of legal capacity have been heated and vigorous, so it is worth starting with certain points on which all parties can agree. To begin with, all parties can agree that, under the MCA, some disabled persons are not recognised as having full legal capacity in the sense specified above. Consider some examples. Under the MCA, a disabled person might be found incapable of entering into certain financial contracts. Another might be found incapable of drawing up a will. Yet another might be found incapable of consenting to marry. On the basis of such findings, particular disabled persons might find themselves 'locked out' (either

[20] On this point see Richardson 2012.

temporarily or permanently) from the exercise of full legal capacity. This is a point of general agreement.

All parties also agree on a second important point. The CRPD's requirement for recognition of legal capacity is not absolute. Specifically, the CRPD allows states parties to deny legal capacity to a disabled individual, provided that the relevant provisions of law apply to all persons on an equal basis. Consider some examples. Suppose that a disabled person were convicted of financial fraud. As part of a duly applied criminal penalty, that person might be banned from entering into certain kinds of financial contracts for a specified period. Or suppose that another disabled person were convicted of electoral fraud; she might be banned from voting as part of her criminal penalty. The key factor in these cases is that the denials of legal capacity are underwritten by provisions of law (in this case: the criminal law) that apply to all on an equal basis. They are allowable under the Convention, since they in no way single out disabled persons for differential treatment.[21]

In reflecting on these allowable restrictions on legal capacity, it is worth disentangling two elements of the standard by which the Convention permits them. The relevant provisions of law must *apply to all*, and they must do so *on an equal basis*. How does the MCA measure up against these standards? Once again, all parties should be able to agree that the MCA *applies to all* – not only to persons with disabilities. The MCA is applied on a daily basis across England and Wales. In many of those cases, the person whose capacity is assessed will have a disability, but this is by no means the only affected population. Consider the nurse who acts under the authority of the MCA when she sets up bed railings for an inpatient recovering from an accident. Consider the paramedic who acts under the MCA in overriding the refusals of a service user in an acute confusional state. The patients who receive care under these circumstances may or may not have a disability; the MCA applies to them in either case.

Having established these points of agreement, we can now bring the central disputed issue clearly into view. The issue is not whether the MCA applies to all;

[21] See GC1, para. 32: "States have the ability to restrict the legal capacity of a person based on certain circumstances, such as bankruptcy or criminal conviction. However, the right to equal recognition before the law and freedom from discrimination requires that when the State denies legal capacity, it must be on the same basis for all persons."

clearly it does. *The complaint is that the denial of legal capacity is carried out on an unequal basis*. While the MCA may indeed apply in principle to everyone, its impact is overwhelmingly on persons with disabilities. A person with a disability is far more likely than is a member of the general population to be subjected to a capacity assessment in the first place. They are also far more likely to be denied legal capacity on the basis of such an assessment.[22] So there is a *disproportionate impact* on persons with disabilities.

What this shows is that the real nub of the dispute here turns on an allegation of *indirect discrimination*. As we have seen above, disproportionate impact does not always amount to discrimination. But it does require that we subject the relevant provisions of law to careful scrutiny. In particular, as we have seen, we need to pose three critical questions: Do the relevant provisions of the MCA serve a *legitimate aim*? Is there an *objective basis* for the differential treatment? And is the differential treatment a *reasonable means* for achieving the relevant aim?

§6 The Functional Test Complies with the CRPD

These three questions are by no means straightforward to answer. As a first step in addressing them, we need to distinguish between the two components of the test for mental incapacity under the MCA. As we have seen, the MCA's test for mental incapacity combines a functional test for decision-making ability and the so-called 'diagnostic threshold.' In assessing the allegation of indirect discrimination we need to treat these matters separately. We proceed as follows. In this section we shall subject the functional test to close scrutiny. We argue that the MCA's use of the functional test as a trigger for substitute decision-making passes the threefold test for justifying a practice that has disproportionate impact on persons with disabilities. In the following section (§7) we consider and respond to five objections that have been levied against this conclusion. We return to assess the diagnostic threshold in §8.

Following the schema established above, we must first consider whether the functional test serves a *legitimate aim* under the CRPD. So what are the aims of the CRPD? In fact it has many. Among other things, the CRPD aims to:

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[22] On this issue see also Bartlett 2012.

> Recogniz[e] the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices. (CRPD, Preamble)
>
> [E]nsure [the] effective enjoyment [of the right to life] by persons with disabilities on an equal basis with others. (CRPD Art. 10)
>
> [E]nsure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters. (CRPD Art. 11)
>
> [P]rotect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects. (CRPD Art. 16)
>
> Protect the physical and mental integrity of the person. (CRPD Art. 17)
>
> [E]nsure access by persons with disabilities to health services. (CRPD Art. 25)

What is striking about this (partial) list is not only the diversity of the aims of the CRPD, but also its considerable overlap with the aims of the MCA. The central aims of the MCA are to empower people to make their own decisions wherever possible, and to protect people with impaired decision-making capacity who find themselves facing circumstances of risk.[23] These aims of the MCA are aims of the CRPD as well.

So what are the aims of the functional test? The MCA uses the functional test as a basis for differential treatment, assessing whether individuals are capable of making their own decisions in particular cases. It provides an analysis of the broader concept of decision-making ability in terms of a set of discrete abilities that can be independently assessed, and which themselves comprise real and essential components of the ability to "decide for oneself". So the aims of the functional test are the same as the overarching aims of the Act as a whole, which are themselves aims of the CRPD. It therefore passes the "legitimate aim" test.

What about the second test? Is the basis for differential treatment under the MCA an *objective* difference? There is some controversy about this matter, to which we shall return below. But there is, we believe, very good reason to answer this question in the affirmative. The basis of differential treatment under the MCA's

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[23] This summary of the MCA's aims is adapted from Lord Chancellor Donaldson's Foreword to *The MCA Code of Practice* (2007).

functional test is the presence or absence of decision-making ability. It is a plain, objective, empirical fact that some people, at some times, lack such ability. To take an extreme example, a person in a persistent coma lacks the ability to make decisions about how to spend her money, while a person in full possession of her faculties suffers no such inability. Who can deny that the difference between these two individuals is an objective difference? Or consider the difference between a patient with very advanced dementia, who has short-term memory of less than one minute, as opposed to a patient in the early stages of Alzheimer's, who may struggle with memory but can still retain information for long enough to discuss treatment options with his doctor and family. The difference between these two individuals is not a matter of subjective opinion; it is an objective measurable difference.

Granted, these examples are particularly clear and extreme; there will be other cases where the distinction between the presence and absence of decision-making ability is much more difficult to mark. But the fact of difficult or borderline cases and "grey areas" on a spectrum does not of itself impugn the objectivity of a distinction. (There is an objective difference between a day with rain and a day without rain, but on a certain day with heavy mist it may be difficult to tell on which side of the line one falls.) So pending assessment of arguments to the contrary, we hold that the basis of differential treatment employed by the MCA passes the objectivity test.

This brings us to the third and final critical question: does the functional test constitute a *reasonable* means? In approaching this question, it will be helpful to begin with an example. Suppose that two severely ill, disabled patients both protest against taking a medication that has some serious and unpleasant side-effects. Patient A understands that the medication could well cure her potentially fatal illness, but nonetheless elects not to take it. Patient B lacks the ability to understand that information, even when support is provided. In both cases we aim to foster and protect the autonomy of the patients. We also aim to protect their right to life, as well as their physical and mental integrity, and to ensure their access to health services.

Before turning to the legal issues about the MCA's functional test, let's consider first a more basic ethical question: Would it be reasonable to treat these two patients differently on the basis of the difference in their understanding of their respective situations? The answer is clearly *yes*. Indeed it would be *un*reasonable *not*

to treat them differently. Why is that? An important part of the answer is that Patient A's refusal of the medication is potentially autonomous in a way that Patient B's refusal is not. The core of the concept of autonomy lies in the notion of self-determination or (following the Greek etymology) self-legislation. Patient B is not in any serious sense capable of weighing up the options with which she is presented, so she cannot be described as autonomously refusing potentially life-saving medication. But we must also remember that protection of autonomy is not our only aim in the care of these two patients. We also seek, among other things, to ensure their enjoyment of the right to life.[24] If we yield to the protests of Patient B out of a misguided attempt to respect her autonomy, then we stand a real risk of failing to ensure that she enjoys her right to life on an equal basis with others.

We can use the lesson of this example to address the general question of law. In assessing the reasonableness of differential treatment, we are asking about the *relationship* between the basis of differential treatment and the aims it is intended to advance. Is the former a reasonable means to adopt in pursuit of the latter? In the case of the functional test for decision-making ability, the answer is *yes*. The crucial point is that autonomy is intrinsically related to decision making ability: the former depends on the latter. A person who lacks the ability to make the decisions they face in a particular domain, even when support is provided, cannot accurately be described as acting autonomously in that domain; they lack the potential for self-legislating self-determination that lies at the core of the concept of autonomy. It is therefore reasonable to use a functional test of decision-making ability as a basis for differential treatment in advancing the aim of fostering and protecting individual autonomy, particularly when this aim may conflict with the equally legitimate aims of (*inter alia*) protecting a disabled person's right to life, or ensuring their protection and safety in situations of risk. On this basis, and pending our consideration of objections below, we conclude that the functional test is aptly characterised as a reasonable means for achieving legitimate aims of the Convention.

Let's pause to take stock. The master argument purported to establish that regimes of substitute decision-making violate the Convention's requirement to

[24] Both A and B should have the right to waive their right to life, but such a choice must itself reflect an autonomous decision.

recognise that disabled persons have legal capacity in all matters on an equal basis with others. But we have now identified a fatal flaw in that argument. Recall its second premise:

> 2) Best-interests decision-making provisions permit the denial of legal capacity to a disabled person in some aspects of life on an unequal basis.

This premise is at best a partial truth; taken as a whole it is false. In the context of the MCA, what is true is that the best-interests provisions can warrant a finding of lack of full legal capacity in some disabled persons in some aspects of life. What is not true is that the MCA does so *on an unequal basis*. At least as regards its use of the functional test for decision-making ability, the relevant provision of law applies to everyone, and the disproportionate impact on disabled persons is an example of amply justified differential treatment.[25]

§7 Objections and Replies

In the preceding section we defended the MCA's use of the functional test for decision-making ability, which is itself integral to the fundamental architecture of the Act. In this section we assess the strength of our defence by testing it against the five most important objections that we have encountered in discussions by stakeholders and in the academic literature.

Objection 1: Mental capacity is not objective.

As we have seen, a practice that disproportionately impacts upon disabled persons can only be justified if the basis for the differential treatment is objective. We argued above that the functional test for decision-making ability passes this test. But this claim is rejected by the Committee in their General Comment on Article 12.[26] The Committee writes:

> The concept of mental capacity is highly controversial in and of itself. It is not, as it is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as

[25] We wish to reiterate that our argument here and throughout concerns the MCA *as written*. We have not sought to determine whether there are forms of differential treatment and disproportionate impact that derive not from the statute, but from the particular ways in which it is being implemented or distorted in practice. This is an important question in its own right, but falls beyond the scope of the present report.

[26] See also Dhanda 2007, Quinn with Arstein-Kerslake 2012.

are the disciplines, professions and practices which play a dominant role in assessing mental capacity.

This passage in the General Comment raises a number of notoriously thorny philosophical questions. What exactly is a "naturally occurring phenomenon"? What does it mean to describe a phenomenon as scientific? What is objectivity? These are deeply controversial topics to which whole books could well be devoted. We cannot hope to settle them here.

What we can do, however, is to consider the specific argument regarding objectivity on which the Committee relies in their General Comment. We have already provided an argument above in support of our contention that the difference between the presence and absence of decision-making ability is an objective difference. So what evidence does the Committee offer in support of their conclusion to the contrary? The two key premises in the Committee's argument are as follows:

A) Mental capacity is contingent upon social and political contexts.

B) The disciplines, professions and practices which play a dominant role in assessing mental capacity are contingent upon social and political contexts.

We accept both of these premises. But they are only sufficient to warrant the Committee's conclusion if an additional premise is added:

C) If something is contingent upon social and political contexts then it is not objective.

One need only state this supressed premise in order to recognise that it is not true. Think, for example, of the difference between high unemployment and low unemployment. Employment levels in a particular economy are clearly contingent upon social and political contexts (analogue of Premise A). Moreover, the disciplines, professions and practices which play a dominant role in assessing employment levels are contingent upon social and political contexts (analogue of Premise B). But it would be a blatant *non sequitur* to conclude on this basis that there is no objective difference between high unemployment and low unemployment! The Committee's objection is therefore based on a false premise and an unsound argument.

The social and political forces that bear on mental capacity and its measurement are profoundly important. On this we are in agreement with the Committee. For a disabled person, variations in those social and political forces can

make the crucial difference between having and lacking decision-making ability. Moreover, the social and political forces at work in institutions like the courts, social welfare agencies and psychiatric hospitals are matters to be taken very seriously indeed; the Committee is right to recognise that those forces can distort the assessment of capacity in particular instances. But the lesson to draw from this is not that there is no objective difference between the presence and absence of decision-making capacity. The right lesson to draw is that the marking of that objective difference must be informed by rigorous research and adequate training so as to ensure that the social and political forces in these institutions facilitate rather than undermine the objectivity of assessments.

A very different concern about objectivity is related to the fact that decision-making skills generally vary by degrees along a continuum, while the MCA operates with a "threshold concept" of mental capacity. Can the distinction between the presence and absence of decision-making ability be genuinely objective if any line drawn on the spectrum is ultimately arbitrary? (How much retention of information is enough retention to make decision-making possible? When does a misty day become a day with rain?) By way of reply, we would emphasise the importance of the presumption of capacity as a fundamental principle of the MCA. According to MCA s.1(2), "A person must be assumed to have capacity unless it is established that he lacks capacity." In conducting a capacity assessment, the assessor must look for objective evidence that suffices, on the balance of probabilities, to establish the absence of decision-making ability at the material time, for the decision that must be made. There can be no serious doubt that there are cases in which such evidence can be found. Where it cannot be found, the presumption of capacity stands. It is therefore misleading to characterise the MCA as requiring an arbitrary bright line that separates the presence from the absence of decision-making ability. The statute recognises that there may be cases where no objective determination can be made. Under such circumstances, the law in effect deems mental capacity to be present.[27]

[27] Owen, Martin and Freyenhagen (under review).

OBJECTION 2: THE CRPD REQUIRES RECOGNITION OF *ACTIVE* LEGAL CAPACITY.

We earlier provided a provisional explanation of the concept of legal capacity in terms of an indicative list of legal powers held by a person with full legal capacity. In refining this provisional definition, it is common to draw a distinction between active and passive legal capacity. The Committee explains this distinction as follows:

> Legal capacity includes the capacity to be both a holder of rights and an actor under the law. Legal capacity to be a holder of rights entitles a person to full protection of his or her rights by the legal system. Legal capacity to act under the law recognizes that person as an agent with the power to engage in transactions and create, modify or end legal relationships (GC1, para. 12).

According to the second objection, substitute decision-making cannot be allowed under the Convention, because Article 12's guarantee of legal capacity in all matters requires a recognition of active as well as passive legal capacity. Every disabled person must therefore be recognised as being "an agent with the power to engage in transactions and create, modify or end legal relationships." The substitute decision-making regime established under the best-interests provisions of the MCA can remove this power from a disabled individual and is therefore incompatible with CRPD requirements.

In assessing this objection, a first point to note is that the CRPD does not itself define legal capacity, and makes no explicit reference to active legal capacity or legal agency.[28] Secondly, we must recognise that there will inevitably be some persons for whom the exercise of legal agency (or indeed of any form of agency) is simply impossible, even when all possible forms of support are provided. (As an extreme example, think of the tragic cases of a child born with profound brain injuries, or an adult in a long term coma.) No comprehensive legal instrument in this area should be predicated on the assumption that everyone can have active legal capacity in all matters.

With these general points in mind, we can directly rebut the objection. The crucial point to remember is that CRPD does *not* require states to recognise legal capacity in all disabled persons. It requires states to recognise the legal capacity of disabled persons *on an equal basis with others*. The same point applies to active legal

[28] There was considerable debate on this point during the drafting stages of the CRPD. See Dhanda 2007.

capacity or legal agency. The CRPD does not require states to recognise active legal capacity in all disabled persons. It permits states to withhold recognition of active legal capacity from particular individuals (whether or not those persons are disabled) provided that the legal basis for doing so applies to all on an equal basis. We have shown that the MCA's functional test for decision-making ability satisfies this standard.

We agree with the Committee in holding that legal agency (being "an actor under the law") is a fundamental component of legal capacity. But it simply does not follow that every disabled person must be recognised as having active legal capacity in all matters.

OBJECTION 3: AUTONOMY DOES NOT REQUIRE DECISION-MAKING ABILITY.

We have argued that the functional test for decision-making ability is consistent with the CRPD in part because of the intrinsic connection between decision-making ability and autonomy. But it could be objected that this claim depends on an *unduly individualistic* conception of autonomy. One important trend in the recent study of autonomy has been the increased recognition of what is commonly referred to as *relational autonomy*.[29] On relational approaches, autonomy is not held to be a trait that individuals hold in isolation; autonomy is achieved instead through participation in the right kinds of supporting relationships with others. Relational models of autonomy have been influential among feminist theorists, and have a clear application in the context of disability. In keeping with the relational approach, one can develop strategies for protecting the autonomy of one person by means of the supportive actions of another. In the limiting case, it could be argued, the autonomy of P can be fostered and protected through the actions of Q, even if P herself is lacking in decision-making ability. So long as Q can identify the preferences of P and ensure that those preferences are satisfied, P's autonomy is realised in that matter.[30]

We are sympathetic to the relational approach to autonomy, although it is important to note that it remains controversial.[31] But for present purposes it is crucial

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[29] Mackenzie & Stoljar (eds.), 2000.

[30] For an exploration of this position see Bach & Kerzner 2010 and Flynn & Arstein-Kerslake 2014.

[31] Christman 2009.

to distinguish between a moderate relational theory and a particularly radical potential extension of the relational approach. The moderate relational position retains an intrinsic connection between decision-making ability and autonomy. P can only be deemed autonomous, on the moderate relational position, if P has the ability to deliberate and make decisions. What the moderate relational theorist insists is that these deliberative and decision-making abilities are characteristically possessed and exercised only in the right sorts of supportive relationships with others. Only a more radical extension of the relational approach would sever the link with decision-making ability altogether. On this approach, a person could be deemed autonomous despite lacking decision-making ability, simply in virtue of some one else identifying and acting upon that person's will or preference.

We believe that there is merit in the moderate relational position; it is also a conception of autonomy that makes a good fit with the MCA. We note in particular that the MCA clearly stipulates that mental capacity is not to be assessed by considering people in isolation. On the contrary, the Act explicitly disallows a finding of mental incapacity unless all practicable means of support have been provided. The relational approach to autonomy can also be seen reflected in judgements in the Court of Protection, particularly in cases where the courts have recognised the ways in which the decision-making capacity of one person can be decisively influenced by the actions of others.[32]

By contrast, the radical extension of the relational theory is far less plausible. Indeed arguably it leads to absurd consequences. To see why, suppose for a moment that P is a mouse. Q determines that P has a preference to be fed, and acts so as to fulfil P's preference in this matter. Would it follow that the mouse is autonomous in this matter? Clearly not. Autonomy requires some form of self-determination and self-legislation. These activities are often carried out in partnership with others; that is the plausible point made by the moderate relational theorist. But it would be an abuse of language to describe a mouse as autonomous in the absence of even shared decision-making abilities, simply on the grounds that its preferences were satisfied.

[32] A Local Authority v Mrs A and Mr A (2010) EWHC 1549; V v R (2011) EWHC 822 (QB).

This is not the place to undertake a systematic assessment of the problems and prospects for relational theories of autonomy. For the purposes of the present objection, it suffices to note (i) that our defence of the MCA's use of the functional test is consistent with moderate relational theories, where a link between autonomy and (shared) decision-making ability is retained, and (ii) that nothing in the CRPD can be plausibly construed as requiring the UK to predicate its legislation on the radical extension of the relational theory of autonomy, which is controversial and beset by serious difficulties of principle.

OBJECTION 4: A LESS RESTRICTIVE ALTERNATIVE IS AVAILABLE.

In our defence of the MCA's use of the functional test for decision-making ability, we have argued that the functional test is a reasonable means to adopt in the service of aims that are themselves legitimate under the CRPD. But the MCA's use of the functional test is reasonable only if there is no alternative means that would provide the same benefits while being less restrictive of fundamental rights and freedoms. In this case, it might be objected, there is indeed a less restrictive means that should be preferred.

What is the less restrictive means? Drawing on the language of CRPD Article 12(3), the means that many disability-rights activists point to is a regime of *supported decision-making*.[33] As we have seen, the strategy of the MCA is to advance its various aims in part through a method of *substitute* decision-making. Decisions on behalf of persons who lack mental capacity are taken by someone else, following the best-interests decision-making procedure. The use of the functional test for decision-making ability lies at the heart of this procedure, and is integral to the MCA's strategy of achieving the fundamental aims of empowerment and protection: empowering those who can make decisions for themselves and protecting those who lack decision-making ability.

The proposed alternative would effectively shadow the MCA for persons who are able to make their own decisions (whether with or without support): such individuals would have the right to make their own decisions. But where decision-

[33] Art. 12(3) reads as follows: "States Parties shall take appropriate measures to provide access by persons with disabilities to the *support* they may require in exercising their legal capacity" (emphasis added).

making ability is lacking (even when support is provided), the two approaches diverge. The supported decision-making approach would *not* be to make a best-interests decision on behalf of the person. Instead, a supporter would be assigned the role of identifying and giving effect to that person's will and preference in the matter at hand – regardless of whether it was deemed to be in the individual's best interests to do so. Programmes of supported decision-making along these lines have been proposed in the academic literature, and have been trialled on a limited basis in some jurisdictions around the world.[34] The basic principle of the supported decision-making alternative has been strongly endorsed by the Committee, which holds that the CRPD itself requires this approach.

Assessing the adequacy of this objection introduces a number of complexities. As a preliminary point, it is import to disambiguate some of the relevant terms. The MCA itself incorporates both a principle of support and the principle of the less restrictive option.

> MCA s.1(3): A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> MCA s.1(6): Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

These principles are important elements of the MCA's approach to the protection of both autonomy and liberty. But we need to be clear about the scope and content of these principles. The force of MCA s.1(3) is in effect negative: it *precludes* a finding of incapacity if practicable support for decision-making has not been provided. Once a person is found to be lacking capacity, however, the decision is to be made in the person's best interests, not through supported-decision making. MCA s.1.6 stipulates that the best-interest decision-maker must *have regard for* the possibility of using less restrictive means. But this does not entail that the best interests decision-maker

[34] Again, see Bach & Kerzner 2010, Flynn & Arstein-Kerslake 2014.

should *always adopt* the least restrictive intervention.[35] A less restrictive option is only to be adopted insofar as it is in the overall best interests of the person lacking in capacity. This is itself one of the features of the MCA that has been most controversial among critics of substituted decision-making.[36] The MCA allows the liberty and freedoms of a disabled person to be limited based on someone else's judgement as to their best interests.

In order to assess the adequacy of the objection, we need to consider whether a regime of supported decision-making would really achieve the aims of the MCA (which we have seen to be legitimate under the CRPD) by a less restrictive means. Here it is important to be clear about the aims that the MCA's regime of substituted decision-making is intended to serve. One *part* of its aim is to foster and protect the autonomy of individuals (including disabled individuals), by empowering those with the ability to make their own decisions. As MCA s.1.6 makes clear, it also aims to avoid unnecessary restrictions of liberty. But as we have seen, the MCA's substituted decision-making regime serves other aims which are also legitimate under the CRPD. It aims to protect individuals (including disabled individuals) who may lack decision-making capacity in circumstances of risk; it aims to ensure the enjoyment of the right to life by individuals (including disabled individuals) who may lack decision-making capacity; and it aims to protect individuals who may lack decision-making capacity from abuse, violence and neglect.

The overall aim of the MCA is therefore best understood as a complex combination of all these aims. Its use of the functional test as a trigger for substituted decision-making is itself a principled means of balancing these sometimes competing aims in a reasonable way. It defers to an individual's autonomy where it is possible to do so – that is, wherever the potential for autonomy is present in the form of the ability to make decisions with support. And it then seeks a balance between liberty and protection where the conditions for autonomous self-determination are absent.

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[35] "[S]ection 1 (6) is not a statutory direction that one 'must achieve' any desired objective by the least restrictive route. Section 1 (6) only requires that before a decision is made 'regard must be had' to that question. It is an important question, to be sure, but it is not determinative." Re P [2009] EWHC 163 (Ch) (Lewison J) para. 41.

[36] See, especially, Quinn with Arstein-Kerslake 2012, Flynn & Arstein Kerslake 2014.

Would a regime of supported decision-making achieve the same aim by a less restrictive means? It is far from clear that it would. In the first place, we cannot assume that greater deference to the will and preferences of a person lacking in decision-making abilities will result in a net increase in autonomy or liberty. In some instances it may have exactly the opposite effect. (Sometimes the overall liberty and autonomy of a person is *enhanced* by a strategic and timely restriction of liberty.) Furthermore, even in those cases where net liberty *is increased* by deference to will and preferences, the cost of this increase in liberty may be a significant reduction of the degree of *protection* afforded to particular disabled persons in situations of risk, in circumstances where their right to life is threatened, and in circumstances where there is a danger of neglect, violence or abuse. Arguably then, the supported decision-making model *fails to achieve the same end by a less restrictive means*. It seeks rather to achieve a *different end* (maximising autonomy and liberty) by a *different means* (deference to the will and preferences of persons lacking in capacity).

Ultimately, our response to Objection 4 must be to insist that the crucial point has not been proven. A policy which disproportionately impacts persons with disabilities constitutes indirect discrimination if a less restrictive means is available for achieving the intended aim. But it is not enough to *say* that there is a less restrictive means; such a claim must itself be substantiated. We welcome the experiments in supported decision-making that are underway in various jurisdictions around the world. There is much that the UK can learn from these experiments and incorporate into its practise. But we are aware of no experiments anywhere in the world that have *abolished* substituted decision-making altogether in order to *replace* it with supported decision-making procedures. Until there is compelling evidence that a comprehensive system of supported decision-making is indeed a less restrictive alternative that provides equally effective means for achieving the aims of the substitute decision-making regime under the MCA, the UK cannot be under an obligation to adopt such a policy.

OBJECTION 5: PROTECTION IS NOT A GENERAL AIM UNDER THE CRPD

One final objection merits discussion here. As will have been clear in the foregoing, our defence of the MCA's use of substituted decision-making rests in part on the claim that *protection of disabled persons in situations of risk* is itself an aim of

the CRPD. We have on occasion encountered resistance to this claim. The objection runs as follows: The CRPD does indeed say that states parties have an obligation to protect disabled persons in situations of risk, but this obligation is strictly circumscribed under the CRPD. Specifically, it is an obligation that arises only in the context of humanitarian emergencies, situations of armed conflict, and natural disasters.

This objection does not survive a close reading of the text of the Convention. The textual basis of this objection is CRPD Article 11, which does indeed concern humanitarian emergencies. But notice first of all the title of Article 11: "Situations of Risk *and* Humanitarian Emergencies" (emphasis added). The word "and" here is a first clear indication that the scope of Article 11 is not *restricted* to humanitarian emergencies. It pertains to situations of risk more generally, *including* humanitarian emergencies. This clue from the title is strongly reinforced by the text of the Article itself, which obliges states parties "to ensure the protection and safety of persons with disabilities in situations of risk, *including* situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters" (emphasis added). The use of the word "including" clearly indicates that states obligations in this matter are not restricted to the three enumerated circumstances. It therefore cannot plausibly be claimed that the CRPD aims to protect disabled persons in situations of risk only when the risk arises from humanitarian emergencies, situations of armed conflict, or natural disasters.

But it would be a mistake to focus too narrowly on Article 11 in replying to this objection. Article 11 is far from the only place where the CRPD exhibits its commitment to the aim of protecting persons with disabilities. Other circumstances explicitly enumerated in the Convention include circumstances that threaten enjoyment of the right to life, as well as circumstances where there is a risk of neglect, violence or abuse. Article 17 calls for protection of the physical and mental integrity of persons with disabilities. In sum, the need to protect persons with disabilities is one of the animating aims of the CRPD when read as a whole. Of course this does *not* mean that the CRPD provides a blanket warrant for every possible paternalistic intervention. Like the MCA, the CRPD has multiple aims, and a reasonable means must be found for balancing them in order to achieve the best overall result.

§8 THE DIAGNOSTIC THRESHOLD DOES NOT COMPLY WITH THE CRPD

In the preceding sections we showed that the MCA's use of a functional test for decision-making ability is compatible with the recognition that disabled persons enjoy legal capacity on an equal basis with others in all aspects of life. But we need now to consider the second component of the MCA's test for mental capacity: the diagnostic threshold. Our procedure shall be the same as in the preceding section, but the outcome is different. As we show below, the diagnostic threshold does not survive the close scrutiny that is required where a provision of law has a disproportionate impact on persons with disabilities.

Imagine two disabled persons, P and Q. Both P and Q lack decision-making ability in a particular matter, for example about deciding on their place of residence. Suppose that both are incapable of using and weighing information about the risks presented by a particular place of residence. But the underlying explanation of this inability is different. P is unable to use and weigh information about the risks *because of an impairment of, or a disturbance in the functioning of, the mind or brain*. Perhaps P suffers from a learning disability or delusions associated with a psychiatric disorder. Q is unable to use and weigh information about the risks for some other reason. The law treats P and Q differently. P satisfies the diagnostic threshold, and lacks decision-making capacity for the decision he faces. He will therefore be eligible for substitute decision-making under the best-interests paradigm. As a result P may enjoy certain protections against a risky housing situation; he may also suffer a loss of legal capacity in matters pertaining to his accommodation. But none of this will be true of Q. Because Q fails to meet the diagnostic threshold, she will neither be eligible for the protections offered to P, nor suffer the loss of legal capacity that P suffers.

It could be argued that the diagnostic threshold is an instance of *direct* discrimination on the basis of disability. After all, in treating people differently on the basis of the presence or absence of a mental impairment or disturbance, are we not explicitly using a disability status as the basis of differential treatment? This is a matter about which one might come to different conclusions, but in the last analysis it does not much matter. Whether or not it meets the standard for direct discrimination, the diagnostic threshold certainly has a disproportionate impact upon persons with

disabilities in a way that can affect their ability to exercise fundamental rights and freedoms. So we must subject it to close critical scrutiny. As we shall show presently, the diagnostic threshold fails to survive such scrutiny. So one way or another, we shall argue, the diagnostic threshold is non-compliant. It is unlawful either as direct discrimination on the basis of mental disability (impairment) or as indirect discrimination.

We turn now to make out this case in detail. The procedure for doing so should by now be familiar. We will need to address three questions: Does the diagnostic threshold serve a *legitimate aim* under the CRPD? Is the difference marked by the diagnostic threshold an *objective basis* for differential treatment? And is the use of this threshold a *reasonable means* for achieving the relevant aim? As we will see, there is a fair bit of fine-grained work involved in addressing these three questions, but the bottom-line position turns out to be clear.

The first step, then, is to identify the *aim* of the diagnostic threshold. Why was it included in the statute at all, and what function is it intended serve? This is in large part a historical question; fortunately there is a clear and carefully documented historical record available in answering it. The MCA was a statute long in the making. The parliamentary process that led to its adoption was informed by a detailed study by the Law Commission. The Law Commission proposed the inclusion of the diagnostic threshold, and its advice on this particular matter was subsequently followed by Parliament. The detailed reasoning behind the Law Commission's recommendation is recorded in Law Commission Paper 128: *Mentally Incapacitated Adults and Decision-Making – A New Jurisdiction*.[37]

Looking to this historical record, we find that there were five considerations advanced in support of the diagnostic threshold. Inclusion of the diagnostic threshold in the definition of mental incapacity would:

A. Avoid 'distress caused by overuse of protective powers.'

B. Facilitate involvement of appropriate experts in applying the functional component of the capacity test.

[37] Law Commission 1993, Part III. For an early criticism of the paper's reasoning see Carson 1993.

C. Compensate for an intrinsic difficulty with the functional element of the test, which enumerates abilities that vary as a matter of degree along a continuum.

D. Maintain compliance with Article 5 of the European Convention on Human Rights.

E. Avoid improper interference in the lives of those whose perceived decision-making inabilities were 'attributable merely to a lack of inclination or eccentricity.'

In what follows, we consider each of these five aims of the diagnostic threshold. In each case, as we shall see, they fail at least one element in our threefold test.

Start with the aim of avoiding distress caused by overuse of protective powers. Let's allow that this is a legitimate aim under the CRPD. Overuse of protective powers can be suffocating, so it is indeed important to insure again it. Moreover, an important aim of the Convention is to protect the autonomy of disabled persons; in order to do so, it is imperative to prevent undue infringement of individual autonomy through the use of unwarranted or excessive paternalistic interventions. The problem with (A) is not the legitimacy of the aim; it is the unreasonableness of the means. If we are seriously concerned about distress caused by overuse of protective powers, it is not reasonable to adopt a strategy that by intent only serves to protect persons without an impairment or disturbance of the mind or brain. Persons with these forms of impairment can also be distressed by overuse of protective powers; indeed they are particularly vulnerable to this sort of intervention and the distress associated with it. It is not reasonable to adopt a means that fails to protect to this part of the population, simply on the basis that they suffer from a mental impairment or disturbance! So the diagnostic threshold is not a reasonable means for achieving a legitimate aim. It only really serves to protect the healthy population from the overuse of protective powers. That is unjustifiable discrimination.

Aim B also straightforwardly fails the reasonableness test. It is perfectly proper to involve appropriate experts in the assessment of mental capacity, particularly in difficult cases. But expert involvement is possible whether or not the

diagnostic threshold in included in the statutory definition. There is therefore not a reasonable relationship between the aim and the means adopted to achieve it.[38]

When we come to Aim C, matters become somewhat more complicated. A number of experts who participated in the Law Commission consultation were concerned about an intrinsic weakness in the functional test for decision-making ability. The four functions included in that test vary along a continuum in the general population. They are 'analog' rather than 'digital.' But the concept of mental capacity must serve as a threshold concept: any person either has it or lacks it at the material time as regards a particular decision. So there is an intrinsic challenge in deciding where to 'draw the line.'

Aim C fails to survive critical scrutiny on several counts. First of all, it arguably fails the legitimate aim test. Suppose that we adopt the least stringent interpretation of the legitimate aim test, and require of an aim nothing more than that it is *not inconsistent* with the CRPD. Would Aim C pass the test? It might not. It could be argued that the drawing of an arbitrary digital distinction on an analog spectrum of decision-making abilities is exactly the sort of red-lining that the Convention seeks to consign to the dustbin of legal history. However this matter is decided, the more important point is that diagnostic threshold once again fails the reasonable means test. After all, it cannot be a reasonable means to compensate for a weakness in one test by bolting on an unrelated test, simply on the grounds that it makes it possible to draw distinctions that would otherwise be difficult or impossible to draw. If we were to accept such a rationale, then *any* test could be bolted on to the functional test, provided that it made it easier to draw an up-or-down judgement in particular cases. To make matters worse, it is far from clear that the diagnostic threshold delivers even this much. The notion of an impairment or disturbance in the mind or brain is itself a vague category, which can be expected to vary by degrees along a spectrum. (Where along the spectrum of cognitive performance in a variety

[38] We have heard some clinicians argue that the diagnostic phase of a capacity assessment is critical in providing a context in which psychiatric expertise can be deployed in the assessment of capacity. Where there is no impairment or disturbance in mental function, it could be argued, psychiatric expertise is irrelevant. It falls beyond our purposes here to assess this general thesis about psychiatry. Even if it were conceded, however, it still leaves open the possibility of involvement by other experts with specialist knowledge of decision-making processes.

of tasks does learning disability begin?) So the diagnostic threshold does not even manage to deliver the dubious good that was promised under Aim C.

With Aim D we come to a difficult area of international law.[39] As well as being a signatory to the CRPD, the UK is a signatory to the European Convention on Human Rights (ECHR), which itself has been incorporated into domestic law in the UK under the Human Rights Act (1998). Article 5 of the ECHR prohibits the deprivation of liberty, except under certain enumerated conditions. Since a best-interests decision under the MCA will in some instances result in depriving someone of their liberty, issues pertaining to Article 5 are engaged. It is clear from the history of the MCA that the diagnostic threshold was included in the definition of mental incapacity in part in order to ensure compliance with the ECHR. By restricting any possible authorisation of deprivation of liberty to those who suffer from a mental impairment of disturbance, the intent was to bring the MCA under ECHR Art. 5.1.e, which permits "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants."

Compliance with international human rights obligations is certainly a matter of paramount importance, and is in general a legitimate aim for Parliament to pursue. So much should go without saying. But care must be exercised here. Compliance with the ECHR passes our legitimate aim test only insofar as the ECHR is itself compliant with the CRPD. But such compliance cannot simply be assumed. Some have argued that Article 5 of the ECHR is itself non-compliant with the CRPD, since it explicitly allows unsoundness of mind to be used as a basis for the deprivation of liberty. This seems to be the view of the Committee.[40] But there is also an independent failing of Aim D. Aim D could at most justify the use of the diagnostic threshold in cases where a best-interests decision results in a deprivation of liberty. But not all best-interests decisions lead to such an outcome. The diagnostic threshold is therefore not the least restrictive means of realising Aim D, and accordingly fails the reasonable means test.

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[39] On this point see also Fennell 2011.

[40] "The CRPD (Article 12) now makes it clear that 'unsoundness of mind' and other discriminatory labels are not legitimate reasons for the denial of legal capacity (legal standing and legal agency)." GC1, para 13.

We are left to consider Aim E. We wholeheartedly accept the idea that protection of eccentricity is a legitimate aim under the CRPD. Eccentricity is not only a celebrated trait in British cultural life; respect for eccentricity is also closely related to the valuing of individual autonomy. If we wish to respect the autonomy of individuals, then we need to leave wide berth for individuals to pursue their own projects within the boundaries of the law, even if these projects look odd or nonsensical to others. So Aim E satisfies the legitimate aim test.

Where Aim E fails is with respect to the reasonable means test. An eccentric who has decision-making abilities but fails to exercise them does not need the protection of the diagnostic threshold. For if I pass the functional test, the MCA allows me to pursue my eccentric projects even at risk to my life or health, and even if I elect not to exercise my decision-making abilities due to disinclination or myopic commitment. So the only eccentrics whose eccentricity is really protected by the diagnostic threshold are those who lack decision-making ability, but for some reason other than an impairment of or disturbance in the functioning of the mind or brain. It is hard even to imagine who this vanishingly small tribe of incompetent eccentrics might be. To make matters worse, the diagnostic threshold fails to protect the eccentricity of the much larger class of disabled persons who may suffer from such an impairment or disturbance. If we are serious about the valuing of eccentricity – and we should be – then we need to be serious about the protection of disabled eccentricity as well. So as a means for protecting eccentricity, the diagnostic threshold is a dismal failure.

What this survey shows is that none of the original grounds for introducing the diagnostic threshold survive the appropriate legal scrutiny. None can therefore be used to justify the disproportionate impact of the diagnostic threshold on persons with disabilities. If there is some other justification for the inclusion of the Diagnostic Threshold then this should be produced and assessed. But on the basis of the foregoing survey, we conclude that the diagnostic threshold is inconsistent with the UK's commitment to the CRPD.

§9 RESPECT FOR WILL AND PREFERENCES

Article 12(4) of the CRPD requires states parties to adopt safeguards in matters pertaining to the exercise of legal capacity by persons with disabilities. One particular safeguarding requirement has been the topic of extensive discussion and debate: the requirement for safeguards that "shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person." In this section we consider how this provision of Article 12 applies in the context of the MCA.

In addressing this matter, we will need to consider two distinct questions. Some have argued that the principle of respect for will and preferences precludes substitute decision-making altogether.[41] We shall argue that this conclusion is not warranted by a reasonable interpretation of the safeguarding requirements of Article 12(4). But there is a separate question about whether the MCA's best interests provisions in their present form contain sufficient safeguards to satisfy the CRPD requirements. We shall argue that they do not, and that a more robust form of safeguarding is therefore required. We take these two matters in turn.

It has been argued that the CRPD principle of respect for the will and preferences of disabled persons itself precludes substitute decision-making. The key point here is that statutory regimes like the MCA require a substitute decision-maker to make an independent determination of the best interests of a person lacking in capacity, and this decision may diverge from the person's known will and preferences. In short: action in the best-interests of P sometimes requires action contrary to P's wishes.

This outcome is not simply a theoretical possibility. In one case, the Court of Protection ruled that it was in the best interests of a woman with severe anorexia nervosa to be treated involuntarily for a period of up to two years, using all necessary means of physical and/or pharmacological restraint to overcome her resistance. The Court ruled that this coercive course of action was in her best interests, notwithstanding the fact that she had repeatedly stated that she did not wish continued

[41] Flynn & Arstein-Kerslake 2014, Centre for Disability Law and Policy NUI Galway 2012.

treatment.[42] In another case, an adult with severe learning disabilities and epilepsy wished to remain in residence with his adoptive mother, who shared his preference in this matter. A best-interests assessment by the Courts nonetheless resulted in his being moved into an independent living arrangement; contact with the adoptive mother was restricted by court order.[43] In cases of financial best-interests decisions, it is not at all uncommon for the courts to order a course of action that diverges from the preferences of the person lacking in capacity. A few of these cases receive publicity, but it is important to realise that best-interests decisions are made on a daily basis in care homes, hospitals, private homes, etc. Inevitably, the result in some cases is action that is contrary to the known will and preference of a disabled individual.

Critics of substitute decision-making cite cases like these in support of their contention that substitute decision-making is not compliant with CRPD Article 12(4). Where the known wishes of a disabled person are over-ridden on the basis of a substitute best-interests decision, these critics argue, there is a failure to respect that individual's will and preferences. Since this possibility derives from the logic of substitute decision-making under the best-interests standard, these critics characteristically go on to call for a "paradigm shift" to a regime of supported decision-making, in which the will and preferences of the disabled person will be the decisive factor.[44] This is the position that has been taken by the Committee:

> All forms of support in the exercise of legal capacity, including more intensive forms of support, must be based on the will and preference of the person, not on what is perceived as being in his or her objective best interests[.] (GC1, para. 29)

Note the way in which the Committee's conclusion on this point involves an exclusive disjunction between a "will and preference" approach and an "objective best interests" approach.

In assessing this line of argument, much comes to turn on the meaning of the language in Article 12(4). What exactly does the CRPD require in calling for *respect* for will and preferences? Article 31 of the *Vienna Convention on the Law of Treaties*

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[42] *Re E (Medical Treatment Anorexia)* [2012] EWHC 1639 (COP).

[43] *Re M; W v M* [2011] EWHC 2443 (Fam).

[44] On the language of a "paradigm shift" see Glen 2012, Quinn 2010.

specifies that a treaty should be interpreted "in accordance with the ordinary meaning given to the terms of the treaty in their context and in light of its object and purpose." We adopt that approach here. As a first step, let's look to the dictionaries to find the ordinary meaning given to the term, "respect." In *The Oxford English Dictionary*, the first non-archaic definition of "respect" as a verb is "to regard, consider, take into account." *Webster's Tenth Collegiate Dictionary* defines "to respect" as "to consider worthy of high regard." The definition in the *Oxford Dictionary of English* is also revealing: "to have *due* regard for" (emphasis added). On any one of this trio of definitions, a requirement of respect falls short of a requirement of absolute deference or non-interference.

On the basis of this first dictionary definition, it would be fair to say that the MCA best-interests decision-procedure *already* requires respect for a person's will and preference. The best-interests provisions of the MCA are spelled out in section 4 of the Act. No definition of "best interests" is provided, but the Act prescribes a procedure to be used in determining best interests in any particular case. The legal specification of this procedure does not use the CRPD terminology of "will and preference," but it does explicitly require the best-interests decision-maker to consider, in so far as they are reasonably ascertainable, the "past and present wishes and feelings" of the person lacking in capacity, as well as "the beliefs and values that would be likely to influence his decision if he had capacity." In short, if "respect" means "regard, consider, take into account," then the MCA best-interests procedure is predicated on the principle of respect.

But the MCA's principle of respect itself has principled limits. Firstly, its best-interests decision-procedure allows that there may be circumstances when it is either not possible, or not reasonable, to determine the will and preferences of a person lacking in capacity. Where emergency action is called for and information is lacking, for example, the MCA does not require the initiation of an investigation of the wishes and feelings of an incapacitated individual; immediate action can be taken. But the more important limit is that the wishes, feelings, beliefs and values of the person lacking in capacity *need not be decisive*. They must be *considered* by the best-interests decision-maker, but the best-interests decision-maker is *not bound* by them.

If they conflict with the overall best interests of the person lacking in capacity, then the best-interests decision-maker is legally obliged to override them.

At this point we must return to the dictionaries. As we have seen, *one* definition of "respect" is "regard, consider, take into account" or "have due regard for." But there are other definitions which make the requirement of respect much more stringent. Definition 4c in OED is "to refrain from interfering with." The same meaning is given as the second definition in *Webster's*. The last definition in *The Oxford Dictionary of English* is "to agree to recognise *and abide by*" (emphasis added). If "respect" means "agree to abide by," then the MCA *fails* to ensure respect for the will and preferences of disabled persons. Why? Because the best-interest decision-maker can and indeed must in some circumstances override a known will and preference that he has taken into account.

What we have learned so far is that the crucial language in CRPD Art 12(4) is beset by ambiguity. And the ambiguity matters. Depending on which dictionary definition of "respect" is adopted, the force of the required safeguards will vary dramatically. If "respect" means "have regard for" then the MCA best-interests procedure clearly complies with the provisions of Art. 12(4). If it means "agree to recognise and abide by" then it clearly fails to comply. In what follows, we argue that neither of these dictionary definitions can suffice in interpreting Article 12(4). The first definition of "respect" is too weak, while the second definition is too strong. We take these two points in reverse order.

Should we understand the principle of respect for will and preferences to require the state and care-providers to refrain from *any* interference in the exercise of will and preferences by persons with disabilities? In one sense the answer is obviously *no*, as all parties can agree. As we have emphasised above, a disabled person is constrained by the same provisions of law (including the criminal law) that apply to everyone; this places obvious limits on any commitment to non-interference. In order to feel the sharp point of the problem, however, we need to consider examples where the relevant will and preferences fall inside the broad compass of the criminal law, but are severely self-destructive or imprudent. Suppose that the person in question is disabled, and lacks decision-making ability as regards the decisions he

faces. Does the principle of respect for will and preference preclude *all paternalistic interventions* contrary to his will and preferences?

Consider a case. An adult male receives a large financial settlement following a head injury at work. One of the symptoms of his brain damage is a lack of any settled awareness of the extent of his own deficits. He insists that he is fine, and does not need help from others. Those around him know that this is not the case. The man receives his financial pay-out from the insurance company; the amount is calculated to take account of a lifetime of care needs consequent upon his injury. But the man insists that he has no such care needs, and proposes to spend his financial windfall on a Rolex watch, a fast car, and a luxury holiday villa instead. Can the state interfere with the exercise of these potentially self-destructive and imprudent preferences?

The posing of these questions may sound rhetorical, in part because the ethical answers may seem obvious. Persons suffering from these kinds of conditions are profoundly vulnerable, and one of the threats they face derives from fact that they have strong desires that are not informed or constrained by decision-making abilities. We arguably have an ethical *duty* to come to their aid. Fulfilling that ethical duty will in some instances require that we interfere with their ability to exercise their own will and preferences. But this is to answer the question from the perspective of ethics. How should we answer the question in terms of law? Does the Convention forbid what ethics requires?

We believe it does not. In order to see why, we need to expand our semantic analysis. So far we have focused on the term "respect." As we have seen, the Vienna Convention directs us to the ordinary meaning of terms *in their context*. So what about the rest of the phrase in which that term occurs? What does it mean to respect *the rights, will and preferences* of a disabled person? As we shall see, the fact that the verb governs three grammatical objects establishes constraints on its possible meaning.

Start with the phrase "will and preferences." In the discourse surrounding Article 12, this phrase is often used as if it were a single semantic unit: *will-and-preferences*. But we should recognise that "will" is not the same as "preference," and that preferences themselves often conflict. I might *prefer* to go to the beach today, but my *will* is to go to the dentist instead. Since will and preference can diverge,

circumstances arise in which it is *impossible* to respect the will *and* the preferences -- if indeed "respect" means "agree to abide by."

Consider the case of a woman in labour who suffers from a very severe needle phobia.[45] She is told that the baby is breech, and that the safest way forward is to have a C-Section. She is profoundly concerned for the health of her baby and herself and she consents to the procedure. In the language of moral philosophy: she *wills* that it take place. But upon being taken to theatre for the surgery she comes face-to-face with a needle. Sampling of the mother's blood is an essential part of the preparations for the C-Section. Upon seeing the needle she is overwhelmed with fear and very strongly expresses her preference that the nurse take the needle away. In such a situation, the medical staff face a dilemma. They can either honour the patient's will (the birth of a healthy baby by the safest means possible) or they can honour the patient's preference ("get that needle away from me"); they cannot do both.

This conceptual point has direct consequences for the interpretation of Article 12. If we interpret "respect" as meaning "recognise and abide by," then the requirements of Article 12 would be strictly impossible to enforce in the case of the needle phobic mother. For the facts on the ground require the medical staff to choose: they can either abide by the will or they can abide by the preference; they cannot be bound by both.

The case of the needle phobic mother can also serve to illustrate a second ground for rejecting this interpretation of "respect." Suppose that the mother's life is at risk in this situation, and the risk itself comes from the confluence of two factors. The potential traumas associated with a breech birth is one factor; the second factor is the needle phobia. Taken together they have the potential to be fatal. As we have seen, one of the aims of the CRPD is to ensure that disabled persons enjoy the right to life on an equal basis with others (Art. 10). If we are to avoid a conflict between Articles 10 and 12 of the Convention, "respect" must be interpreted as requiring something less than absolute deference to will and preferences.

Should we conclude on this basis that "respect" in Article 12(4) means nothing more than "have regard for" or "take into account"? No. One way to see

[45] The example is based on Re MB [1997] EWCA Civ 3093.

why not is to consider the last semantic unit in the clause we have been analysing. It calls for respect for the *rights*, will and preferences of disabled persons. The principle of respect for human rights is a fundamental plank of both international and domestic law. In calling for human rights to be respected, we are not simply calling for them to be *considered* or *taken into account*. Such a protection would be far too weak. It would leave the rhetorical door wide open to any tyrant (petty or otherwise) who insists that he has *respected* the human rights of the people he oppresses. After all, he *considered* them; he *took them into account* – all on his way to trampling them out of corrupt self-interest! Because "respect" is the operative verb in the phrase that includes "respect for rights," it *has* to mean more than merely "have regard for."

In the last analysis it would be a mistake to expect any dictionary definition of "respect" to fix the meaning of CRPD Article 12(4). The word has a meaning that resists strict definition, and lies somewhere in the essentially contested semantic space between the two dictionary definitions that we have considered and rejected. From a legal perspective, one might say that "respect" means "refrain from interfering with – *except when interference is properly justified*." But this by itself is enough to establish an important conclusion. For we are now in a position to see that the best-interests provisions of MCA s.4 do *not*, in their present form, comply with the safeguarding requirements of CRPD Article 12(4). The smoking gun can be seen in the verb in MCA s.4(6). As we have seen, the requirement there is that the best-interests decision-maker *CONSIDER* the wishes and feelings, values and beliefs of the person lacking in capacity. But Article 12(4) requires *RESPECT* for the will and preferences of disabled persons. Whatever "respect" means in this context, it must be something stronger than "consider," even though it is less than "be absolutely bound by." For it is possible to *consider* someone's rights, will and preferences without *respecting* them. The safeguards in the MCA's best-interests provisions must therefore be strengthened in order to achieve compliance with the CRPD.

Allow us to sum up our two major findings regarding will and preferences. We have shown, firstly, that the safeguarding requirements of CRPD Article 12(4) do not preclude substitute decision-making under the best-interests paradigm. Critics of substitute decision-making argue that the best interests framework is inconsistent with the CRPD requirements pertaining to respect for will and preference. But this

argument is predicated on an understanding of "respect" that is not the primary dictionary definition of the term, is implausibly stringent in the present context, and would lead to incoherent policy injunctions and conflicts of rights within the CRPD. But we have also shown that the MCA requires stronger safeguarding provisions to ensure respect for the rights, will and preferences of disabled persons who may be lacking in decision-making capacity. It is not enough to require that their wishes, feelings, values and beliefs be considered. Steps must be taken to ensure that their will and preferences are duly respected. In the next section we consider what steps would satisfy this requirement.

§10 REMEDIES

We have shown that the MCA in its present form fails to comply with the requirements of the CRPD. Its non-compliance pertains not to the basic structure of the Act but to particular details of its provisions. So what remedies would bring the statute into full compliance?

One answer is at least superficially straightforward: the diagnostic threshold must be excised from the statutory definition of "mental incapacity." Specifically, this would require amending MCA s.2(1) as follows:

> For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter ~~because of an impairment of, or a disturbance in the functioning of, the mind or brain~~.

Such a revision of the statute would leave its other provisions unchanged. In particular, the functional test for decision-making ability could remain, and would operate as it does presently. Substitute decision-making would remain for persons who lack decision-making ability even after support has been provided.

There is, however, a serious legal complexity associated with this seemingly straightforward remedy. The risk is that the change required for CRPD compliance would in turn result in a violation of Article 5 of the European Convention on Human Rights. The UK finds itself in the difficult position of having to satisfy two international human rights requirements which pull in opposed directions.[46] The

[46] On this point see Fennell and Khaliq 2011.

challenges associated with inconsistent international legal obligations fall beyond the scope of this report. Our aim was to determine whether the MCA is compliant with the CRPD, and what remedies are required where it is non-compliant. It is perhaps nonetheless worth offering a few provisional observations about this broader dilemma.

One proposal that could be considered would be to invoke the principle of the more recent instrument. Since the CRPD is the most recent international human rights convention, it could be argued that it takes precedence over earlier instruments in cases of conflict. But this strategy faces a number of obstacles. It is complicated, firstly, by the fact that the CRPD is a UN instrument, while the ECHR is not. The principle of the more recent instrument is therefore not as straightforward to apply as it would be in the case of two instruments with the same provenance. The international complexity is in this case compounded by a domestic complication. The ECHR has the force of domestic law under the Human Rights Act (1998). If Parliament were to consider changes to the MCA, then Article 19 of the Human Rights Act would require the Secretary of State to issue a written statement regarding the compliance of the amended statute with Convention rights. Given the conflict with Article 5 that would be generated by rescinding the diagnostic threshold, it is doubtful that a "Statement of Compatibility" could be issued.

A second strategy would be to seek to disarm the conflict between the two instruments. As we have seen, the conflict arises in cases where a best-interests decision under the MCA results in a deprivation of liberty. Under the ECHR, such a deprivation would need to fall under Article 5.1.e, which permits a deprivation of liberty in accordance with a procedure prescribed by law for persons of unsound mind. The term "unsound mind" has never been defined, and the European Court of Human Rights has recognized that it is "a term whose meaning is continually evolving."[47] If the UK were to rescind the diagnostic threshold, and subsequently deprive a person of liberty on the basis of their lack of decision-making ability and a determination of best interests, a challenge in the European Court of Human Rights is to be expected. Could the UK respond to the challenge by arguing that a lack of decision-making ability *is itself tantamount to unsoundness of mind*?

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[47] *Winterwerp v Netherlands* (1979) 2 E.H.R.R. 387, para. 37.

Once again, serious obstacles lie along this path. The European Court of Human Rights has never defined "unsoundness of mind," but a substantial history of Article 5 case law has established a set of strict conditions under which unsoundness can be used to justify a deprivation of liberty. Particularly important in the present context are the following: (a) a finding of unsoundness of mind must be informed by objective *medical* evidence; (b) the unsoundness itself must be of a form that warrants compulsory confinement; (c) the confinement itself must be effected in a hospital, clinic or other appropriate institution.[48] Arguably, deprivations of liberty under the MCA often fail to satisfy these conditions. If this is indeed the case, then it could be argued that the MCA fails to comply with ECHR Art. 5 – with or without the diagnostic threshold.

In light of these difficulties, it is worth considering the possibility of a compromise measure. In our survey of the aims and purposes of the diagnostic threshold, we found that the aim of avoiding conflict with the ECHR failed the reasonable means test. The potential conflict with ECHR Article 5 pertains to best-interests decisions *that result in a deprivation of liberty*; it is therefore not justified to make use of the diagnostic threshold across the board, even where no deprivation of liberty is involved. In light of this, one strategy would be to retain the diagnostic threshold, but only for cases where a deprivation of liberty is involved. Where no deprivation of liberty is involved, the functional test for decision-making abilities would stand alone. Of itself this would not resolve the issue of compliance with the CRPD, but it would constitute a step towards compliance.

In addition to the legal obstacles connected to this first remedy, there are also a variety of potentially significant *political* obstacles. A change to MCA s.2(1) would require action by Parliament, and this in turn presupposes a political will to make the requisite change. It is not our purpose here to enter into an analysis of the political prospects for such a legislative initiative, but one important point is pertinent to our analysis. As we have seen, one of the original aims of the diagnostic threshold was to "avoid distress caused by overuse of protective powers." At least some of the participants in the Law Commission's original consultation process were concerned

[48] European Court of Human Rights 2012: 16.

about subjecting members of the general public to the kinds of capacity assessments faced by persons who suffer from impairments of or disturbances in the functioning of their mind or brain. Those same concerns might well prove to be a political obstacle in seeking to rescind the diagnostic threshold.

We take note of this potential political obstacle because it bears on the fundamental legal and ethical choice faced by the UK, its citizens, and their representatives in Parliament. There are, we submit, two options. One is to retain a test for decision-making ability as a condition on the exercise of full legal capacity, and to apply it to all on an equal basis. That requires elimination of the diagnostic threshold. If the resulting policy is thought to be too intrusive and distressing for members of the non-disabled public, then the alternative is to eliminate the test for decision-making ability for everyone. But the choice must be made one way or the other. What cannot be countenanced is retention of the test, but application of it in such a way that is tantamount to indirect discrimination against persons with disabilities.

Let us now turn to the second respect in which the MCA currently fails to comply with the CRPD: the matter of ensuring respect for the rights, will and preferences of disabled persons in matters pertaining to the exercise of legal capacity. As we have seen, compliance with the CRPD requires that the MCA include stronger safeguards to ensure such respect, specifically in the context of best-interests decision-making under MCA s.4. The requirements for compliance are in this instance far less determinate than in the case of the diagnostic threshold. Because the term "respect" lacks a precise legal definition, the requirement to ensure respect is open to a variety of possible fulfilments. The one point that is clear is that the relevant safeguards must go beyond the current MCA standard, which requires only that the wishes, feelings, beliefs and values of a person be *considered*.

We believe that the best general strategy for achieving compliance on this matter would be to establish a hierarchy among the various factors that are considered in assessing best interests. MCA s.4 operates with a "checklist" of factors to consider in a best-interests assessment, but the courts have ruled that there is no hierarchy

among the items on the list.[49] The wishes and feelings of the person have been deemed by the court to be "always be a significant factor to which the court must pay close regard,"[50] but that does not entail that they are given precedence over other considerations. A promising approach to the challenge of establishing stronger safeguards in compliance with CRPD Article 12(4) would be to incorporate a principle of precedence into the best interests assessment.

What form should such a principle of precedence take? A useful point of departure in considering this question can be found in a proposal due to HH Judge Hazel Marshall QC.[51] On Marshall's approach, a best-interests decision-maker operates with a *rebuttable presumption* that it is in the best interests of P to bring about the course of action that P prefers. Marshall's judgement includes a proposal about how such a presumption might work in detail. We find it useful to summarise Marshall's test as follows:

> Suppose a person (P) faces a decision but lacks capacity to make it himself. Nonetheless P has a reasonably ascertainable wish (W) as to what course of action should be taken. The best-interest decision-maker should deem it to be in P's best interests that W be fulfilled provided that the following conditions are met:
>
> 1. W is a wish which a person of full capacity might reasonably have.
>
> 2. W is physically implementable.
>
> 3. A person with full capacity having resources such as P's might reasonably consider it worth using the resources necessary to fulfil W.
>
> 4. There is no potential sufficiently detrimental effect that would provide a strong and cogent justification for overruling P's wishes.

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[49] "[T]he statute lays down no hierarchy as between the various factors which have to be borne in mind, beyond the overarching principle that what is determinative is the judicial evaluation of what is in P's 'best interests'." *Re M, ITW v Z and others* [2009] WTLR 1791, [2009] EWHC 525 (Fam), para. 32.

[50] *Re M, ITW v Z and others* [2009] WTLR 1791, [2009] EWHC 525 (Fam), para. 35.

[51] *Re S and S (Protected Persons), C v V* [2009] WTLR 315; see in particular paras. 57-58.

Marshall offers no strict principle to determine how to decide when this fourth condition is met. But she offers the following illustrative examples of cases where P would fail to meet the fourth condition:

> a) There is a factor which is either unknown to P or unappreciated by P, but that, if known and appreciated by P, would have led P to abandon W.
>
> b) Fulfilment of W will have a detrimental effect on P that is greater than the detrimental effect on P of having W overruled.

We take the following to be examples of circumstances where Marshall's approach would warrant overturning the will and preference of P:

> Case A: A person under the influence of a hallucinogenic drug has an insistent wish to leap from a height, irrationally believing that he has the power of flight.
>
> Case B: A person with severe dementia wishes intently to leave her care facility, but her preference is based on her wish to return to the family home, which has long since been demolished.
>
> Case C: A person who has suffered a brain injury insists that he wants to spend the money from his insurance settlement now, but cannot take into account the significant ongoing costs associated with his care, lacking awareness of the extent of the deficits associated with his injury.
>
> Case D: A person in an acute confusional state wishes to consume a certain substance, thinking it is food or medication, but is unaware that it is in fact a toxic substance.
>
> Case E: An elderly person in a care home regularly expresses resistance to getting out of bed or going for garden visits. But the wish to remain inside is usually ephemeral, and she consistently gives signs of appreciation once she has passed the initial hurdle, whereas she often remains grumpy and depressed if allowed to remain indoors or in bed.

Cases A-E are all cases where Marshall's approach would justify overriding the known will or preference of the individual. Case A fails to meet Marshall's first condition: the wish is not one that a person of full capacity might reasonably have.

Case B fails to meet Marshall's second condition: it is physically impossible in these circumstances to fulfil the wish to return to the family home. Case C fails to meet Marshall's third condition, supposing indeed that the wish to spend all the money now is not one that a person with full capacity could reasonably act upon. The final two cases illustrate how Marshall's approach copes with potential detrimental effect. P's wish is overridden in Case D because there is good reason to suppose that P's wish to consume the substance would not survive his learning that it is toxic. In Case E, the moderate costs associated with overriding P's wishes (not capitulating to her desire not to go out) is justified by avoiding the larger detrimental effects of allowing her to fret in bed all day.

The sheer variety of different routes whereby P's wishes can be overridden on Marshall's approach may lead some to object that her approach does not go far enough in ensuring respect for the will and preferences of persons lacking in capacity. Indeed some have complained that Marshall's reliance on terms such as "reasonable," "responsible" and "full capacity" mean that Marshall's test would be no different in effect than the current best interests standard.

These are matters that merit further debate and research. It is important to appreciate that Marshall's approach is conceptually different from the best interests standard as currently interpreted by the courts. On the current standard, the preference of P will be determinative *only if it happens to coincide* with the independent judgement of the best-interest decision-maker as to what is in P's best interests. Marshall's approach is different: P's preference will be determinative provided that it falls *within a range of options* that meet Marshall's four conditions. While the current approach instructs the best-interests decision-maker to look for the *uniquely best course of action*, Marshall's approach sets some outer boundaries of choice, but stipulates that P's preference should prevail provided that it falls within those boundaries.[52]

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[52] Suppose that P is severely ill, and that his doctors recommend a medical procedure to which P objects on religious grounds. Suppose that P lacks capacity to make the decision for himself. The judgement of the best-interests decision-maker might be that P's religious convictions are false and his objections to the medical treatment are misguided. Her own judgement is that it would clearly be in P's best-interests is to proceed with the medical treatment, overriding P's known wishes. On Marshall's approach, P's wishes would be determinative, since P's preference falls within the range of options that a person with full capacity might reasonably choose.

Nonetheless, it can be argued that the details of Marshall's approach would still make it too easy to override P's will and preferences. Here it is worth noticing that there is a significant difference in principle between Marshall's two examples of circumstances under which a potential detrimental effect might justify a paternalistic overriding of P's wishes. Recall that the first example involved a circumstance where there is a factor unknown to P or unappreciated by P, and there is strong reason to believe that knowledge and appreciation of that factor would have sufficed to alter P's wishes. In an extended sense, an intervention in such circumstances can be said to be based on P's wishes, even if the attribution of wishes is in this case somewhat idealised.

Marshall's second example is very different in form. Rather than being based on an interpretation of what P's wishes would have been with better information, it is based on the best-interests decision-maker's weighing of what can be quite incommensurate factors: the possible detrimental effect associated with action based on P's ascertainable wishes, as opposed to the possible detrimental effect associated with overriding those wishes. This may be a step too far. If P meets the first three conditions in Marshall's test, then it follows that P's wishes are already within the bounds of risk that a person of full capacity might consider worth taking. If there is no additional factor of which P is unaware, it can be argued that P's wish should be determinative.

Marshall's approach could also be modified by removing or modifying the first condition. Marshall proposes that deference to the wishes of P should reach its limit if P's wish is not one that a person of full capacity could reasonably have. Although this requirement is conceptually different from the best-interests standard currently used by the courts, it might still be thought too restrictive. Should the reasonable wishes of a person with full capacity be used as a standard for constraining the liberty of a person lacking in capacity?

We shall not seek to settle these questions here. The feature of Marshall's approach that we endorse is the adoption of a principle of precedence in the best-interests decision-making process, where the principle of precedence takes the form of a rebuttable presumption that P's wishes, where reasonably ascertainable, should be decisive. There remains the challenge of agreeing on the conditions under which

such a presumption can be discharged. Marshall's proposal provides an excellent point of departure for further research and reflection, but in our view this is precisely the sort of matter that needs to be settled by democratic discussion and debate. For the challenge is to agree a framework whereby the competing values of liberty and protection can be reasonably balanced for all on equal basis.[53]

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