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Mental Capacity Law Discussion Paper

Consensus Emerges in Consultation Roundtables: The MCA is Not Compliant with the CRPD

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Introduction

1. A panel of distinguished experts has undertaken an intensive review of the Mental Capacity Act (MCA), in order to determine whether it complies with the UK's international human rights obligations under the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The review took the form of a series of meetings funded by the Arts and Humanities Research Council (AHRC), organised by the Essex Autonomy Project (EAP), and hosted by the Ministry of Justice (MoJ). Three roundtables were organised at MoJ headquarters in May and June under the Chatham House Rule; these were followed by a one-day public conference at the Institute for Government in July. Participants in these events included leading civil servants and jurists, including the Official Solicitor and a senior judge of the Court of Protection, as well as barristers, psychiatrists, academic experts in law and ethics, and representatives from civil society and service-user organisations. The meetings were characterised by vigorous debate and some significant disagreements, but by the end of the process a broad and disturbing consensus had emerged: ***at least in its current form, the MCA is not compliant with the requirements of the CRPD***. But a framework for remedying the non-compliance also began to emerge, and many participants in the consultation were of the view that the basic architecture of the MCA was indeed consistent with the CRPD.

Background

2. The MCA was passed by Parliament in 2005 following a long consultation process, and came into effect in 2007. The CRPD was

adopted by the UN General Assembly in 2006, came into force internationally in 2008, was ratified by the UK in 2009, and by the EU (on behalf of all member states) in 2010. The CRPD does not have the force of law in UK courts, but in ratifying the Convention, the UK committed itself to revising domestic legislation as necessary to conform with CRPD standards. For an excellent overview of the relevant issues, see the article by Series *et al*. in a recent issue of this newsletter.

The questions

3. In broaching the large question of MCA compliance with the CRPD, the consultation roundtables focused on three interrelated issues. The first roundtable addressed what has come to be known as "the diagnostic threshold" in MCA §2.1. The second took up the requirements of the CRPD for safeguards to ensure "respect for the rights, will and preferences" of disabled persons. At the third roundtable, the consultation group addressed the basic legal architecture of the MCA. The MCA authorises what in international disability rights law has come to be known as "substituted decision-making." Where a person is found to be lacking in mental capacity to make a decision that needs to be made (for example about healthcare, place-of-residence, or use of financial assets), the MCA provides a legal framework for someone else to make a decision on behalf of the person lacking in mental capacity. Depending on the circumstances, that "someone else" (the best-interests decision-maker), might be a doctor or family-member or a paramedic or a judge. The MCA requires the best-interest decision-maker to act on her own judgement as to the best interests of the person lacking in mental capacity. The disputed question in the third consultation roundtable was whether this basic procedure and fundamental principle of the MCA itself constitutes a violation of CRPD Article 12.2, which requires recognition of the legal capacity of disabled persons in all matters on an equal basis with others.

The Committee on the Rights of Persons with Disabilities

4. Before broaching these specific legal questions, however, the consultation group found it necessary to grapple with two overarching issues. The first of these concerned the standing of the United Nations Committee on the Rights of Persons with Disabilities (hereafter: 'the Committee'). The CRPD established the Committee as its "treaty body," with specific responsibilities in connection with the ongoing implementation of Convention requirements and the review of progress towards CRPD-compliance by signatory nations. In signing the CRPD's Optional Protocol, the UK agreed to have its domestic law and practice reviewed regularly by the Committee. The UK's *Initial Report* was submitted to the Committee in 2011, but as yet the Committee has not undertaken its first formal review of UK compliance.

5. Earlier this year, the Committee issued its first General Comment, in which it addressed a cluster of issues concerning the requirements of CRPD Article 12, which articulates the principle of *Equal Recognition Before the Law*. Although the MCA is not explicitly mentioned in the General Comment, the Committee made clear that it considers statutory arrangements such as the MCA to be non-compliant with the CRPD. It was sharply critical of what it termed "the best-interests paradigm," with which the MCA clearly operates, and it called for the abolition of "substituted decision-making," of

which MCA §4 is an example. The General Comment was adopted by the Committee immediately prior to the initial consultation roundtable at the Ministry of Justice, and the question therefore arose as to the authority of the Committee's findings. Specifically, participants in the first roundtable debated as to whether the Committee's interpretation of the requirements of Article 12 was "binding," and whether ratification of the Optional Protocol committed the UK to abiding by the Committee's interpretation of the provisions and requirements of the CRPD.

6. After some initial debate about this matter, a clear consensus emerged. A review of a wide variety of sources indicated clearly that the Committee's interpretation of the Convention is *not binding* on signatory nations. In signing the Convention and its Optional Protocol, the UK committed itself to comply with the CRPD, and to be reviewed by the Committee; it did not commit itself to be bound by the Committee's interpretation of the Convention. 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 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.

Discrimination

7. A second general matter that arose during several of the consultation roundtables was the issue of discrimination. One of the basic principles of the CRPD is the principle of non-discrimination. In Article 2, the CRPD includes an explicit definition of discrimination on the basis of disability; in Article 5 it requires states parties to prohibit such discrimination. Inevitably, disagreements arise as to what constitutes discriminatory treatment. One widely accepted distinction in discrimination law is the distinction between direct and indirect discrimination. If a job advert concludes with the sentence, "No women need apply," then the employer is engaged in direct discrimination on the basis of gender. If a different job advert requires the postholder to be at least six feet tall, then it indirectly discriminates against women. The second advert does not explicitly mention gender, and some women will certainly satisfy the criterion. But the requirement disproportionately and adversely affects women who may be interested in the job, insofar as more women than men will be screened out by the height requirement.

8. The distinction between direct and indirect discrimination is important in assessing the MCA. The MCA does not draw its legal distinctions explicitly in terms of disability status. Indeed the word "disability" appears only once in the whole statute, and the Law Commission report that led to the Act explicitly eschewed "status tests" for mental incapacity. Most persons with disabilities will retain decision-making capacity for many matters; some will retain decision-making capacity in all matters. Conversely some persons lacking in disabilities will, at some point or another, lack decision-making capacity as regards at least some decisions. So the MCA's concept of mental incapacity and the concept of disability simply do not coincide. Nonetheless, the provisions of the MCA do disproportionately affect persons with disabilities, particularly those with mental disabilities or psychiatric disorders. A person with learning disabilities or dementia or schizophrenia is far more likely to be found lacking in mental

capacity than is a member of the non-disabled population. So the issues about indirect discrimination loom large. But how, if at all, should the concept of indirect discrimination be applied in connection with the CRPD's ban on discrimination against persons with disabilities?

9. On this matter there was no consensus among the participants in the roundtable meetings, and it seems clear that further work will be required in this area. Some participants in the consultation process emphasised that the CRPD requires states parties to prohibit *all forms* of discrimination on the basis of disability. (See the definition of "discrimination" in Article 2.) Moreover, in contrast to many other legal instruments, the CRPD itself includes no clear legal schema for justifying and defending practices which may adversely and disproportionately affect groups against whom discrimination is prohibited. Other participants in the consultation roundtables insisted that some state-sanctioned practices will inevitably have a disproportionate impact on certain classes of disabled persons, so it is crucial to establish a clear legal framework for distinguishing the conditions under which disproportionate impact is lawful.

10. In looking for guidance on this issue, one helpful source is the UN Human Rights Committee (UNHRC). In its General Comment on Non-Discrimination under the International Covenant on Civil and Political Rights, the UNHRC 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." This suggests one possible approach for considering the force of the anti-discrimination provisions of the CRPD. If a particular set of practices has a disproportionate impact on persons with disabilities, then three questions need to be asked: (i) Does the relevant practice serve an aim which is legitimate under the CRPD? (ii) Does the practice make use of a criterion of differentiation that is objective? (iii) Is the differential treatment rationally related to the legitimate aim? This schema of reasoning is not uncontroversial, to be sure, but it proved to be a useful framework for reflecting on issues about discrimination and differential treatment under the MCA.

The diagnostic threshold

11. With these general matters in hand, we can turn to the specific legal issues enumerated above. The first question, and the topic of the first roundtable meeting, concerned the diagnostic threshold. As readers of this newsletter will know, the MCA defines mental incapacity in MCA §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.*

12. It is important to distinguish two discrete elements in this definition. The first part of the definition characterises mental incapacity in terms the absence of decision-making ability. This "functional test" is then elaborated in MCA §3.1, which unpacks the concept of decision-making ability in terms of the fourfold test: understand, retain, use and weigh, express a choice. But MCA §2.1 also includes a second requirement. In order to be deemed lacking in mental capacity, an individual must not only be lacking in decision-making ability; that ability must itself be lacking *because of an impairment of, or a*

disturbance in the functioning of the mind or brain. It is this second component of the definition that has come to be known as the diagnostic threshold. (Several participants in the roundtable questioned the use of the term, "diagnostic threshold;" but we use it here simply as a well-established shorthand.)

13. It is worth pausing to reflect on the legal and logical significance of this feature of the MCA's definition of its master concept. Consider two individuals, P and Q, both of whom lack decision-making ability. Let's suppose that they both lack the ability to use and weigh information with respect to a decision to be made about a mortgage or a risky relationship. But there is an important difference between P and Q. P lacks this ability because of an impairment of or disturbance in the functioning of his mind or brain. Perhaps P has a learning disability, or dementia. Q lacks this ability for some other reason. Notice that the MCA treats P and Q differently. In P's case, the law provides for a best-interest decision to be made on P's behalf in P's own best interest – even if P himself is not at all happy with the outcome. But the MCA does not sanction this kind of interference in Q's case, since his inability to make decisions does not have its basis in a mental impairment or disturbance. Remember: both P and Q lack decision-making abilities, but Q is left to make his own mistakes on his own terms, while P is given no such opportunity.

14. Does the diagnostic threshold constitute a form of discrimination against persons with disabilities? It would certainly seem to be a provision of law that will disproportionately affect persons with disabilities, and it could well interfere with their ability to exercise fundamental rights and freedoms. Although one need not be disabled in order to suffer from an impairment or disturbance in the functioning of the mind or brain (someone who has had too much to drink on a Saturday night might suffer such an impairment, but this of itself does not constitute a disability!), persons with disabilities are far more likely than are the general population to be "screened in" under this test. So there is at least a prima facie case of indirect discrimination.

15. But differential treatment does not of itself constitute unlawful discrimination, if we follow the schema outlined above. In order to determine the lawfulness of the diagnostic threshold, we would need to determine whether it passes the threefold test delineated by the UN Human Rights Committee. This is not the proper place to apply that test in all its detail. But on the basis of an analysis prepared by the EAP research team, the overwhelming majority of participants in the roundtables concluded that the diagnostic threshold was indeed a form of unlawful indirect discrimination against persons with (mental) disabilities. There is in fact quite a detailed history about the purposes for which the diagnostic threshold was originally introduced in legislation. (The purposes were surveyed by the Law Commission in 1993 in its *Consultation Paper 128*.) But it is hard to see how any of these purposes satisfy the threefold test deriving from the UN Human Rights Committee's schema. For example, one reason cited by the Law Commission for the inclusion of the diagnostic threshold was to "increase the involvement of people with suitable specialist qualifications" in the assessment of mental capacity. But the criterion used as the basis for differential treatment does not seem to be rationally related to this aim, since appropriate experts could be involved in the assessment of decision-making ability whether or not the diagnostic threshold is included in the legal definition.

Respect for rights, will and preferences

16. The second roundtable consultation focused on the CRPD requirement of "respect for the rights, will and preferences" of disabled persons. In short, the CRPD requires states parties to ensure that legal principles and practices affecting the legal capacity of persons with disabilities are devised so as to provide safeguards that ensure such respect. This principle has direct bearing on the MCA, particularly in connection with the best-interests decision-making procedures of MCA §4. The MCA does not define the concept of "best interests," but it does specify a procedure to be followed in determining the best interests of an incapacitated person when a decision needs to be made on his behalf. One of the requirements in this procedure (MCA §4.6) is that the best-interests decision-maker "consider, so far as is reasonably ascertainable, the person's past and present wishes and feelings … [and] the beliefs and values that would be likely to influence his decision if he had capacity." The question before the second roundtable was whether these requirements of the MCA were sufficient to satisfy the safeguarding requirements of the CRPD.

17. Once again, the answer to the question is far from straightforward. Much comes to turn on what is meant by the term "respect" in the phrase "respect for rights, will and preferences." In ordinary usage, "respect" has a variety of meanings and rather divergent dictionary definitions. It seems clear that the MCA requires the best interest decision-maker to "have regard for" the will and preferences of a person lacking in mental capacity. But the MCA's best-interests provisions have in some instances been applied in ways that override those preferences in the objective best interests of a disabled individual. If "respect" means "always be bound by," then the MCA does not always respect the will and preferences of disabled persons.

18. In the end, participants in the second roundtable were not able to agree on a positive definition of the elusive concept of "respect." Neither of the standard dictionary definitions (either "have regard for" or "be bound by") seem to suffice. But a very broad consensus emerged that the provisions of MCA §4 do not suffice to fulfil the safeguarding provisions required under the MCA. The smoking gun can be found in the verb that figures in the crucial sentence of MCA §4.6. What the statute in its present form requires is that the wishes and feelings, beliefs and values of the incapacitated person be "*considered*." This seems too weak a requirement to satisfy the CRPD safeguarding provisions. Respect may be an elusive legal concept, but whatever it means, it is possible to *consider* a person's rights, will and preferences without thereby affording them *respect*. After all, a tyrant might *consider* his subjects' preferences, but then simply brush them aside.

19. On the basis of the results of these first two consultation roundtables, a broad (though not unanimous) consensus began to emerge. By including the diagnostic threshold, and by failing to include stronger safeguards to ensure respect for the rights, will and preferences of disabled persons with impaired mental capacity, the MCA fails to comply with the requirements of the CRPD. These forms of non-compliance are comparatively "shallow" and in principle remediable. The diagnostic threshold could in

principle be rescinded, leaving the functional capacity test and the remainder of the statute intact. And either the Act itself or the Code of Practice could in principle be amended to ensure a stronger form of respect for the will and preferences of incapacitated persons in the context of best-interests decision-making. One possible form of strengthening would be to adopt or adapt a framework of interpretation of MCA §4.6 proposed by Judge Hazel Marshall in Re: S and S (Protected Persons). Marshall in effect proposed a defeasible presumption that actions taken in the best interests of P requires making decisions that achieve the outcome that P would prefer. Marshall's schema was criticised in subsequent judgements in the Court of Protection, and was not uncontroversial among participants in the second roundtable. But there was a broad consensus that some form of strengthening of current safeguards is required, falling short of an absolute deference to the preferences of persons lacking in mental capacity. Marshall's schema seems a good point of departure for further reflection on these matters.

The functional test

20. There remains the possibility that the MCA suffers from a much deeper, and non-remediable form of non-compliance with the CRPD. It was this matter which occupied the attention of the third and final consultation roundtable, and the July conference. One way of framing the issue here is to focus on the functional component of the MCA definition of mental incapacity in MCA §2.1, and on the role this plays in the overall legal and ethical architecture of the Act.

21. As we have seen, the MCA standard of mental incapacity combines two elements. A person suffering from an impairment or disturbance in the functioning of the mind or brain lacks mental capacity if that impairment results in a loss of decision-making ability. We have already seen how the so-called diagnostic element in this definition falls foul of the CRPD anti-discrimination requirements. But what about the functional component? Under the MCA, an adult can be denied the legal authority to make their own decisions if they lack the ability to understand, retain, use and weigh information, and to express a choice. In the language of the CRPD, such an individual would lack full legal capacity. Critics of substituted decision-making and "the best-interest paradigm" have argued that this fundamental feature of the MCA must be abandoned in order to comply with the CRPD. The objection is that this sort of statutory arrangement disproportionately and adversely affects persons who suffer from disabilities. Persons who do not suffer from disabilities would be rightly appalled (according to this objection) to have their decision-making abilities questioned and assessed and second-guessed on grounds that they need to be protected from their own poor decision-making. But persons with disabilities are regularly subjected to this form of differential treatment. Proponents of this line of objection argue that a fundamentally new approach is required – a "new paradigm" that will provide support to persons with disabilities to give effect to their own will and preferences, rather than stepping in to make decisions on their behalf where decision-making capacity is deemed to be lacking.

22. The issues raised by this more fundamental criticism of the MCA were the most contentious in the proceedings, and could not be fully resolved in the course of the consultation process. However, a broad consensus did emerge around two important points. Firstly, it was broadly agreed that the MCA

in its current form fails to go far enough in ensuring support for persons who may lack decision-making capacity. The MCA itself provides at the outset that "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 §1.3). But little is said either in the Act or in the Code of Practise about what form this support should take, or who has the legal obligation to provide it. These issues have not to this point been adjudicated by the courts. Compliance with the CRPD requires that this "support principle" within the MCA be strengthened and developed.

23. Secondly, it was broadly agreed by the participants in the consultation process that there will always be a class of cases where persons with disabilities cannot make their own decisions, even when all possible forms of support have been provided. If we are nonetheless to recognise legal capacity in such individuals, that recognition cannot take the form of allowing such individuals to exercise active legal capacity, since such individuals simply cannot make decisions for themselves (even with support). Safeguards should be in place to ensure respect for the rights, will and preferences of such individuals, but the hard fact is that someone other than the disabled individual will be required to make decisions in such cases. It was the view of many participants in the roundtables that this required the retention of some form of substituted decision-making, despite the Committee's insistence that it be abolished.

Next steps

24. A fuller report on the consultation project will be submitted to the MoJ in August in the form of an Essex Autonomy Project position paper, which will be posted in due course on the EAP Website. A draft of the position paper will be presented for discussion at the upcoming EAP Summer School.

Note

25. Readers should note that the views expressed in this article should not at this time be ascribed to the Government, notwithstanding the Ministry of Justice's hosting of and participation at the round table meetings and conference.

Author biography

Professor Wayne Martin is the director of the Essex Autonomy Project, a multi-disciplinary research and public-policy initiative 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. The project has been funded by major grants from the Arts and Humanities Research Council.