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Re-thinking the Mental Capacity Act 2005: Towards the Next Generation of Law

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It is now more than a quarter of a century since the Law Commission completed its ground-breaking report on mental capacity, a report that became the Mental Capacity Act 2005. Since that time, there have been fundamental changes in the legal, social, and academic understanding of people with mental disabilities, and the pragmatics of legislative implementation have exposed difficulties that the Law Commission did not foresee. This paper considers key elements of the Act in light of those changed expectations and the experience of implementation

INTRODUCTION

The Law Commission commenced its work on reform of mental capacity law in 1989, work which was eventually reflected in the Mental Capacity Act 2005 (MCA 2005). All legal controls were made decision- and time-specific, with capacity determined according to a statutory test, and decisions made on new statutory criteria that considered matters from the perspective of the individual about whom the decision was to be taken. There is nothing in English law that corresponds to the ongoing and controlling conservatorship and tutelage administrative structures of other European jurisdictions, or the guardianships or wardships of other common law jurisdictions. Legal personhood in English law is never removed. It was a revolutionary project that still puts England near the forefront internationally of law and practice, and ground-breaking legislation of which England could be justly proud.

And proud of it we were and are. The overwhelming preponderance of evidence to the House of Lords ad hoc committee on implementation of the Act in 2014 supported the principles and overall approach of the Act as passed in 2005.[1] There were reservations about the 2007 amendments to the Act concerning deprivations of liberty, but the core of the Act garnered real enthusiasm.

That said, the bloom has at least to some degree come off the rose. Questions have been raised about how effectively implementation has occurred,[2] and there are certainly practical lessons to be learned from the MCA 2005 experience about the realities and efficacy of legal regulation in the capacity realm.

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[1] Mental Capacity Act 2005: post-legislative scrutiny, HL 139 (2014).
[2] *ibid*.

The legal context has fundamentally changed. The Disability Discrimination Act was passed only in 1995,[3] the year the Law Commission published its final report. The suggestion, now very much in the literature, that mental capacity law in itself might be inherently discriminatory has developed entirely since that time.[4] The human rights framework has completely changed, with a significant and expanding jurisprudence from the European Court of Human Rights developing almost entirely since the Law Commission report. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) has fundamentally challenged the traditional thinking on regulation of disability, with the CRPD Committee questioning whether we should be using capacity as a legal structure at all.[5] There are also conceptual issues. Related areas of law – most notably social welfare law and health law – are markedly changed. Disability studies, now an established scholarly field, had barely begun. The social model of disability that has in the last thirty years become so prevalent in England was a marginal theory when the Law Commission reported in 1995: Michael Oliver published *The Politics of Disablement*, perhaps its first foray into the mainstream, only in 1990.[6] The theorisation of the borderline between disability and vulnerability has fundamentally changed, through works by scholars such as Martha Fineman.[7] And, of course, legal theory has moved on. English socio-legal studies was in its infancy in the early 1990s, and it has since been supplemented by post-modernism and critical theory. Legal dividing lines and categories that were taken for granted in the early 1990s are now increasingly questioned.[8]

Almost a third of a century has now passed since the intellectual heavy lifting that gave rise to the MCA 2005, and the world had changed. The time is ripe for reflection, and this paper is a contribution to that process. It starts with the thinking of the Law Commission. It continues by exploring the big issues that we did not foresee: a fundamental change in how people with

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[3] North American jurisdictions were somewhat earlier than this: see for example Americans with Disability Act 1990 and the Canadian Charter of Rights and Freedoms 1982, s 15.

[4] See for example P. Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 MLR 752; B. Clough, 'New legal landscapes: (Re)constructing the boundaries of mental capacity law' (2018) 26 *Medical Law Review* 246; L. Pritchard-Jones, '"This Man with Dementia" – "Othering" the Person with Dementia in the Court of Protection' (2017) 24 *Medical Law Review* 518; M. Donnelly, 'Best interests in the Mental Capacity Act: Time to say goodbye?' (2017) 24 *Medical Law Review* 318.

[5] United Nations, Committee on the Rights of Persons with Disabilities (CRPD Committee), General comment No 1, Article 12: Equal recognition before the law, CRPD/C/GC/1 (2014).

[6] Michael Oliver, *The Politics of Disablement* (London: Macmillan, 1990).

[7] For example M. Fineman, *The Autonomy Myth* (New York, NY: New Press, 2004); M. Fineman, 'The vulnerable subject: anchoring equality in the human condition' (2008) 20 *Yale Journal of Law and Feminism* Article 2; M. Fineman and A. Grear, *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Farnham: Ashgate, 2013).

[8] Of particular relevance to the present paper is B. Clough, *The Spaces of Mental Capacity Law* (Abingdon: Routledge, 2022), probably the best legal theoretical analysis of mental capacity law currently available. Clough places mental capacity law at the intersection of a number of perceived binaries that are not, in her view, neat divisions at all: capacity/incapacity, autonomy/paternalism, empowerment/protection, carer/cared-for, disabled/non-disabled, and public/private. There are significant points of intersection between the present paper and Clough's work and elements of her analysis will be noted below, but a detailed engagement involves a discussion of the nature of law itself, and is thus beyond the scope of the present paper.

disabilities are understood, the central role of professionals in administration of the MCA 2005, and the resurgence of process and legalism in the new Court of Protection. It goes on to explore how these changes affect key terms of the MCA 2005, most notably the core concepts of 'incapacity' and 'best interests'. The final substantive section considers how all these issues come together in light of changes to the administration and legal regulation of care provision. All of these pose real challenges to the Law Commission model.

THE LAW COMMISSION REPORTS, THE MCA 2005, AND THEIR CONTEXT

The Law Commission commenced its work in 1989. The *parens patriae* jurisdiction of the Crown over adults lacking capacity had been abolished in the reforms leading to the Mental Health Act 1959, and replaced by statutory provisions. For decisions relating to personal care, these were based on existence of a mental disorder (not necessarily resulting in incapacity), and gave the guardian the powers of a father over his fourteen-year-old child.[9] These powers were significantly curtailed in 1983, when the guardian could merely determine where the individual would live (but with no power to detain him or her there), and require the individual to attend for care and treatment and to ensure access by doctors (but no power to consent to treatment on the individual's behalf).[10] This meant there was no clear legal power or authority to make many key decisions on behalf of an individual who was unable to make those decisions himself or herself. For issues of consent to medical treatment, the issue was addressed by the House of Lords in 1989 in *Re F (Mental Patient: Sterilisation)*[11] (*Re F*), where it was held that medical treatment in the best interests of a person who was unable to consent would not constitute a battery, but this was perceived as something of an ad hoc solution to a more fundamental set of problems within the legal framework. There was perceived to be a lacuna in the law.

While that provided the immediate context for the establishment of the Law Commission's work, that body also considered the law relating to financial and similar ('property and affairs') decision-making as part of the package. These were also contained in the Mental Health Act 1983. Unlike the guardianship rules, they were capacity based, but without a clear definition of capacity. They were all or nothing in their approach – a patient (to use the term of the Act) could make either all property and affairs decisions, or none – and while the decisions in question involved fairly fundamental legal rights, they were decided by administrators rather than a formal court.

The Law Commission published a consultation document in 1991 and three more in 1993, before its final report in 1995.[12] Those were followed by

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[9] Mental Health Act 1959, s 34(1).

[10] Mental Health Act 1983, s 8.

[11] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 112.

[12] Law Commission, *Mentally Incapacitated Adults and Decision-Making: An Overview* CP 119 (1991); Law Commission, *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction* CP

government green and white papers in 1997 and 1999,[13] before the MCA 2005 itself was finally passed in 2005. The Act as passed largely reflected the Law Commission's approach except on the question of public law protections for vulnerable people, which were omitted. Further, shortly prior to the passage of the Act, the European Court of Human Rights handed down its judgment in *HL* v *the United Kingdom*,[14] which found English law regarding deprivation of liberty of people lacking capacity to be in violation of Article 5 of the ECHR. The MCA as passed in 2005 did not address those difficulties; they were dealt with by amendment to the MCA in 2007 introducing the Deprivation of Liberty Safeguards (DOLS).[15] While the DOLS introduced new procedural protections in cases of deprivation of liberty, the substantive requirements reflected the existing statutory capacity and best interests tests. Those have proven notably resilient. When the government legislated to replace the DOLS with the Liberty Protection Safeguards (LPS) in 2019, it initially introduced a much more objective test of proportionality;[16] but amendments to the 2019 bill during its legislative passage saw re-introduction of key subjective elements. The result resembles the best interests tests in the original MCA 2005 much more than the government had intended.[17]

The Law Commission's approach centred on the two key concepts of incapacity and best interests. The definition of incapacity was expressly decision-specific, focusing on whether the individual (called 'P' in the Law Commission reports, a practice repeated in the MCA 2005 itself and, for convenience, in the remainder of this paper) was unable by reason of mental disability to understand and retain the information relevant to the decision, to make a decision based on that information, and to communicate that decision.

Decisions for a person lacking capacity to make the decision were to be made in P's 'best interests'. On the definition of best interests, the Law Commission debated between an objective and a 'substituted judgment'[18] approach – essentially whether the legislation should try to reach the

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128 (1993) (Law Commission (1993:128)); Law Commission, *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research* CP 129 (1993) (Law Commission (1993:129)); Law Commission, *Mentally Incapacitated Adults and Decision-Making: Public Law Protection* Consultation Paper 130 (1993) (Law Commission (1993: 130)); Law Commission, *Mental Incapacity* Law Com No 231 (1995) (Law Commission (1995)).

[13] Lord Chancellor's Department, *Who Decides?* (London: HMSO, 1997); Lord Chancellor's Department, *Making Decisions* (London: HMSO, 1999).

[14] Case 45508/99 *HL* v *the United Kingdom* (2005) 40 EHRR 32.

[15] Introduced by Mental Health Act 2007, s 50 and sch 7 and 8.

[16] Mental Capacity (Amendment) Bill, HL Bill 117 (2018).

[17] Mental Capacity (Amendment) Act 2019, see for example s 22(2), 24(3), 38(6), 52(1)), along with a process of consultation that broadly resembles the MCA 2005 best interest process (see para 23(3)).

[18] The language of incapacity has changed since the Law Commission report, and these changes are themselves significant markers of the passage of time and the development of attitudes. In modern parlance, 'substitute judgment' is taken to mean a person making a decision based on the decision-makers' views of P's objective best interests. As such it is now juxtaposed to approaches promoting P's will and preferences. For the Law Commission and other literature of the early 1990s, it meant reaching the decision that P would have made if capable, and is thus intended to reflect P's will and preferences. Because of this ambiguity, the phrase is avoided in this paper. Similarly, 'best interests' is now taken in much of the academic literature outside the MCA 2005 to mean objective best interests. As noted here, the approach developed by the Law Commission

objectively best result for P or whether it should reach the decision P would have reached if capable.

It settled on a hybrid test: P's wishes, feelings, values and beliefs would have to be taken into account in determining best interests, and P's carers were to be consulted to ascertain those. While these were to be of central concern, they were not determinative, and other factors ('all the relevant circumstances', in the language of the MCA 2005 as eventually passed)[19] also figured in the determination.

The system was to function as informally as possible. The Law Commission proposed a 'general authority', whereby anyone could make decisions in the best interests of a person lacking capacity, and (where relevant) be recompensed for the reasonable costs thereof by P. When the MCA 2005 was passed, this had mutated slightly from a positive authority into a defence in tort and crime for decision-makers acting in P's best interests, but the overall effect was similar: consistent with the decision- and time-specific nature of the capacity determination, the people making the best interests determination were to be determined in the context of the individual decision itself.

It would alternatively be possible for individuals to select who would make the decisions, by executing a Lasting Power of Attorney (LPA). Powers of attorney that could survive the donor losing capacity had been available in financial matters since 1985,[20] and the Law Commission proposed that these would be extended to health and personal welfare decision-making. Alternatively, a 'deputy' could be appointed by the court to make the decisions. For both of these options, two restrictions are significant. First, nothing in these mechanisms restricted the power of P to act on his/her own behalf: enforceability of contracts signed by P for example would fall to be determined under the regular law of contract. Nor could decision-makers make personal and welfare decisions unless they believed P lacked the capacity to make the decision himself/herself. There is thus no suggestion of a move towards incapacity as a legal status that could be declared by the court. Second, decision-makers remained bound by the hybrid best interests test. That makes the 'power of attorney' label somewhat misleading, since they are not governed solely by the agency of the donor: P's objective best interests also figure prominently in determination of the decisions to be taken.

The new legislation was to be overseen by a fundamentally redesigned Court of Protection. The previous body with that name had really been an administrative office. The Law Commission recommended that it become a proper court, staffed by High Court and lower court judges, with a broad jurisdiction to consider issues arising under the new legislation. That has happened, with judges being drawn primarily but not exclusively from the Family Court bench.

Protection from abuse was always a part of the Law Commission framework, and to this end it proposed the establishment of a range of public law measures,

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is meant to be much more nuanced, and 'best interests' has therefore become a problematic label. It is a core concept in the MCA 2005, so the term cannot be avoided in this paper, but given the current meanings in the broader literature, it is a term that must be approached with care.

[19] MCA 2005, s 4(2).

[20] See Enduring Powers of Attorney Act 1985.

intended to replace section 47 of the National Assistance Act 1948. Its proposals here considered people at risk of significant harm, and while some measures (removal from home for up to a week, for example) would apply only to people thought to lack capacity to decide issues related to their health, safety and well-being, the overall powers were not targeted specifically at people lacking mental capacity. The government did not pursue these proposals, a failure which will be relevant below.

The Law Commission also recommended reforms relating to research ethics and incapacity, and to advance decisions to refuse medical treatment. These recommendations were also implemented, but they are not discussed in the present paper. Similarly, while the DOLS, passed in 2007, and the LPS, passed in 2019 provide some helpful insights into how attitudes have changed in the last decades, their substance is not the focus here. At the core of the present discussion are instead issues concerning determination of capacity and best interests and the implementation of the statutory provisions relevant to those.

The Law Commission proposals were remarkably well-received. Academic articles of the early 1990s were notably enthusiastic.[21] There were occasional concerns that the proposed language was insufficiently robust to ensure the ends that the Law Commission wanted,[22] or that there were insufficient safeguards to protect against abuse of the new statutory provisions,[23] but the core elements of the proposal were roundly lauded. The sole exception was David Carson, who argued that the proposals would entrench rather than combat the stigma faced by people with disabilities.[24]

The legislative process was not straightforward, however. Green and white papers in 1997 and 1999 respectively were positively received, but it became clear that there were problems in the House of Lords, centering, rather improbably, on whether the Bill would facilitate euthanasia. That log-jam was eventually broken, but in the period of development of the Law Commission proposals and the slow passage through the legislature, the courts had been busy developing a parallel jurisdiction flowing from the *Re F* case noted above, and by 2002, had invented for themselves an authority to make decisions in the best interests of persons lacking capacity and to appoint alternative decision-makers to do so in the court's stead.[25] This created a system that effectively mirrored one in the Mental Capacity Bill (now the MCA 2005), then mired in the legislative process. The courts' logic in this is almost certainly wrong at every turn,[26] and it is also clear that the Law Commission expected this jurisdiction to be superseded

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[21] For example M. Gunn, 'The meaning of incapacity' (1994) 2 *Medical Law Review* 8; P. Fennell, 'Statutory authority to treat, relatives and treatment proxies' (1994) 2 *Medical Law Review* 30; K. Stern, 'Advance Directives' (1994) 2 *Medical Law Review* 57; M. Freeman, 'Deciding for the intellectually impaired' (1994) 2 *Medical Law Review* 77.

[22] Freeman, *ibid*.

[23] P. Bartlett, 'The Consequences of Incapacity' (1997) 4 *Web Journal of Current Legal Issues*.

[24] D. Carson, 'Disabling Progress: The Law Commission's Proposals on Mentally Incapacitated Adults' Decision-Making' [1993] J Social Welfare and Family Law 304.

[25] *A (A Patient)* v *a Health Authority; Re J; The Queen on the Application of S* v *Secretary of State for the Home Department* [2002] EWHC 18 (Fam/Admin); *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)* [2002] EWHC 2278 (Fam).

[26] See P. Bartlett, *Blackstone's Guide to the Mental Capacity Act 2005* (Oxford: OUP, 2nd ed, 2007) para 2.11-2.21.

by the MCA 2005,[27] but that is probably water under the bridge: the so-called 'inherent' jurisdiction now appears to be part of the legal furniture, although quite what its role is remains at best unclear.[28]

WHAT WE DID NOT SEE COMING: BIG PICTURE ITEMS

Reconceptualising autonomy and the legal character of the person lacking capacity

Re-reading the Law Commission reports from the 1990s and the contemporaneous academic literature makes clear a number of significant shifts in the analytic frameworks for capacity law, and a survey of its implementation points up unforeseen occurrences that affect a modern reading and consideration of the Act as a whole, not just its parts.

The wild card in the literature at the moment is the CRPD. This was adopted by the United Nations General Assembly in 2006, and entered into force in 2008. It is a convention intended to address the fundamental human rights deficits experienced by people with disabilities (physical and mental) in so much of the world, the relatively wealthy nations of the global north certainly included. It includes a full array of both socio-economic and civil and political rights. At its core is a fundamental shift. Prior to the CRPD, it was accepted that people with disabilities might sometimes be socially excluded and subjected to legal control, and the problem for human rights law was to delineate the procedural and substantive borders of that permissible control. The CRPD does not accept that premise: people with disabilities are not to be controlled or limited by legal measures based on disability, and to do so is viewed as discriminatory. The CRPD is based around an ethos of nondiscrimination and social inclusion, with the expectation that reasonable accommodations (a phrase with similar meaning to 'reasonable adjustments' in English non-discrimination legislation) will be provided to ensure that people with disabilities are empowered

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[27] Law Commission (1995), n 12 above, para 8.6.

[28] Extended discussion of the possible roles, if any, for this jurisdiction are outside the scope of this article. The strongest arguments for its retention concern situations where an individual is sufficiently vulnerable that their freedom of action is restricted, but where they still have capacity: see J. Herring and J. Wall, 'Autonomy, capacity and vulnerable adults: filling the gaps in the Mental Capacity Act' (2015) 35 *Legal Studies* 698; E. Cave, 'Protecting patients from their bad decisions: rebalancing rights, relationships, and risk' (2017) 25 *Medical Law Review* 527, 533; J. Munby, 'Whither the inherent jurisdiction? How did we get here? Where are we now? Where are we going?' Lecture to the Court of Protection Bar Association at https://www.cpba.org.uk/wp-content/uploads/2020/12/2020COPBA.pdf (last accessed 23 November 2021). This role may still be problematic: the jurisprudence requires a 'true mental disorder' where ECHR rights are engaged, and the definition of mental disorder is narrowing: see for example *Glien* v *Germany* App No 7345/12, judgment of 28 November 2013, § 83; *Nawrot* v *Poland* App No 77850/12, judgment of 5 March 2018 at [67]-[77]. That will be particularly problematic when a deprivation of liberty is at stake: see *Mazhar* v *Birmingham Community Healthcare Foundation NHS Trust* [2020] EWCA Civ 1377. It is also problematic when P lacks capacity, but the jurisdiction encroaches onto territory where the MCA 2005, it would seem deliberately, does not go: see *An NHS Trust* v *Dr A* [2013] EWCOP 2442 at [96]; *XCC* v *AA* [2012] EWHC 2183 (COP).

to become full and active members of society. The social model of disability is at its core: fundamentally, disability in the vision of the CRPD is a problem of society inadequately accommodating human diversity, rather than a deficiency or impairment located in the affected individuals.

For present purposes, the CRPD provisions regarding equality before the law (Article 12) are of particular relevance, since in the view of the Committee on the Rights of Persons with Disabilities, the UN body charged with the implementation of the CRPD, capacity cannot be used as a legal mechanism to regulate decision-making, at least if that determination is based in whole or in part on an individual's disability.[29] If that is correct, the challenges to the MCA 2005 would be profound. The literature surrounding the meaning and implementation of Article 12 and capacity law is of significant scale, and will not be discussed here. There is a specific literature on how the MCA 2005 relates to the CRPD that contains links to that larger literature,[30] and the present paper will not retread that ground: this is a paper about the MCA 2005, not the CRPD. The CRPD does however serve as a helpful indicator of factors that have changed. These CRPD values often reflect broader intellectual and policy shifts, and some of those cannot be ignored.

Chief among these is the understanding of P. The Law Commission was writing before the social model had established itself. For its time, the work was notably progressive. People were to be supported to make competent decisions if possible. Where decision-making by someone else was necessary, P was to be as involved as possible in the decision, and his or her wishes, values, beliefs and feelings were to form a core part of the assessment of how the decision would be taken. That said, while these controls were no doubt intended as benevolent, they were undeniably controls, and if P did not like it, it was not clear that he or she could do much about it. Certainly, the Court of Protection was established as an overseer of the Act, but there was no real discussion of how P would access it.

The Law Commission's style and the academic comments of the time focus on legal doctrine and the legal practicalities of law reform, so the social and philosophical issues are pushed out of the frame – indeed, in that regard, and to modern eyes more accustomed to interdisciplinary and social science framings of law, the analysis of the period seems peculiarly naive. While it was certainly careful to protect the competent decisions of P, its concern about decision-making was largely to create a clear set of rules so that decisions taken by professional and lay carers would have legal protection. There is no real sense in the reports that these carers and P might have conflicting views or interests: once it was reasonably believed that P lacked capacity, the decision-maker was expected to just get on with the decision-making, as defined in the law.

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[29] CRPD Committee, n 5 above.

[30] See for example P. Bartlett, 'At the Interface Between Paradigms: English Mental Capacity Law and the CRPD' (2020) 11 *Frontiers in Psychiatry* 570735, doi: 10.3389/fpsyt.2020.570735; Clough, n 4 above; Clough, n 8 above; Donnelly, n 4 above; W. Martin, S. Michalowski, J. Stavert, et al, 'Three Jurisdictions Report: Towards Compliance with CRPD Art. 12 in Capacity/Incapacity Legislation across the UK' *Essex Autonomy Project* 6 June 2016 at https://autonomy.essex.ac.uk/wp-content/uploads/2017/01/EAP-3J-Final-Report-2016.pdf (last accessed 27 November 2021).

As a marker of that, it might be noted that the word 'empower' and its derivatives occurs only seven times[31] in the five Law Commission reports, generally regarding the empowerment of carers, not of P. The exceptions are a reference to empowering people to appoint decision-makers in advance of losing capacity, and a discussion of P's empowerment as raised by a consultee in the context of a discussion of advocacy, where the Law Commission does not accept the importance of the point being raised. By 2017, the Law Commission report on reform of the DOLS referred four times to the overall ethos of the MCA 2005 in empowering P.[32] Similarly, the report of the House of Lords ad hoc committee[33] had referred to the 'empowering ethos' of the MCA 2005 twenty-three times, albeit regretting that this ethos had not come to fruition.

The degree of this shift can be overstated. The expectation among the original legal commentators was that P's wishes and feelings would be a very major factor in making decisions about him or her,[34] and that seems consistent with the Law Commission reports. The recasting of the MCA 2005 in terms of the empowerment of P is nonetheless a significant conceptual shift. It is consistent with what has been happening elsewhere in law and in society. As noted above, the Disability Discrimination Act was passed in 1995, for example, and disability studies has carved a place for itself in academe. Movements of people with lived experience of mental distress have started to be integrated into service provision, research design and development, and government policy-making. Significantly for the legal literature, the law and society, socio-legal studies, and critical legal theory movements have integrated themselves into much of legal scholarship, the present subject included, and interdisciplinarity is much more developed than it was thirty years ago. Legal capacity academics now explore theories of vulnerability and the conceptualisation of 'disability', autonomy, professional practice, rights, gender, governmentality and power, to name but a few. Legal questions and legal answers are no longer just about law. The Court of Protection, to its considerable credit, has adopted a much more open policy regarding its hearings and decisions than its predecessor, so we know far more about the people affected by the MCA 2005: they have become real people.[35] All of that affects the way we think about P, who has become theorised and acquired agency, subjectivity and identity in a way that was not foreseen thirty years ago.

A marker of that conceptual shift is the change in the attitude to advocacy. The Law Commission did not see advocacy as a pivotal or core element of

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[31] Law Commission (1993:128), n 12 above, paras 2.12, 5.3, 7.3, 7.26 and footnote 3; Law Commission (1993:129), n 12 above, in footnote 3; and Law Commission (1995), n 12 above, para 2.44.

[32] Law Commission, *Mental Capacity and Deprivation of Liberty* Law Com No 372 (2017), paras 4.13, 4.16, 4.27, 9.35.

[33] n 1 above.

[34] Seefor example Fennell, n 21 above, 43; cf Freeman, n 21 above, 84, who accepts the intent, but considers the drafting insufficient to ensure its realisation.

[35] This raises of course the question of the role of legal discourse in creating legal subjects, a topic on which academic thinking has also fundamentally shifted in the last thirty years. Whether the people created are actually any more 'real' is thus a fair question; but they are certainly discursively richer.

reform in this area. The onus to comply with the Act rested entirely with the decision-maker.[36] He or she would need to consider P's views, but P did not have a dynamic role in the process, or at least, not one that would benefit from an advocate.

That did change somewhat in the legislative process, and when the MCA 2005 was passed, independent mental capacity advocates (IMCAs) were included in the system, it would seem at the instigation of respondents to the green paper.[37] Their role was limited, however. If long-term residential care or serious medical treatment was to be provided, an IMCA was to be appointed to represent P, but only if there was no appropriate non-professional person such as a family carer to advise the decision-maker on P's best interests.[38] Family carers, if they existed, were meant to provide this advice, again with no particular acknowledgement that P's views might be at odds with those of his or her family.

Advocacy expanded further with the introduction of the DOLS. That in part, no doubt, flowed from an increasingly legal understanding of mental capacity law, a topic discussed in more detail below. Thus, as probably required by the ECHR, and reflecting the parallel sectioning regime under the Mental Health Act, non-means-tested legal aid was made available to challenge deprivations of liberty in hospitals and care homes.[39] In addition to better provision of lawyers, however, the DOLS required that an IMCA be appointed when requested by P or by P's relevant person's representative (RPR),[40] or when P or the RPR would be unable to exercise their rights without the support of an IMCA, or where they had failed to exercise those rights when it would be reasonable to expect them to do so.[41] It would seem that these provisions have had an effect. In Series's study of applications to the Court of Protection, only three per cent of general welfare applications, where there is limited right to an IMCA, were made by P; for DOLS applications, 62 per cent were by P.[42]

The phrasing of these provisions – providing P with a right to advocacy, even if an RPR has been appointed – suggests an increased acknowledgement of P's

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[36] Law Commission (1995), n 12 above, para 2.44 and, regarding public law protections, para 9.44. See also discussion papers, Law Commission (1991), n 12 above, para 6.47-50; Law Commission (1993:129), n 12 above, 1.9.

[37] Lord Chancellor's Department (1999), n 13 above, Introduction para 21.

[38] MCA 2005, s 35-41. See also Department of Constitutional Affairs, *Mental Capacity Act Code of Practice* (London: The Stationery Office, 2007) ch 10.

[39] This, sadly, takes effect only when the required assessments are complete, and the deprivation of liberty is confirmed. In 2018/19, the average time from identification of the potential deprivation of liberty to the determination under the statutory scheme was 147 days: NHS Digital, 'Mental Capacity Act (2005) Deprivation of Liberty Safeguards, (England) 2018/19, Official Statistics' Timelines, Table 1 at https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/england-2018-19#chapter-index (last accessed 19 August 2022).

[40] The 'relevant person's representative' (RPR) is an individual, often a friend or family member, is a person appointed under the DOLS, who is required to remain in contact with P, and represent and support P in matters relating to the deprivation of liberty: MCA 2005 sch A1, para 139-140.

[41] MCA 2005, s 39D.

[42] L. Series, P. Fennell, J. Doughty, A. Mercer, 'Welfare cases in the Court of Protection: A statistical overview' (Cardiff: Cardiff University Press, 2017) 48 (figure 1) at http://sites.cardiff.ac.uk/wccop/ (last accessed 27 November 2021).

identity and agency even when lacking capacity. That reflects a quite different understanding of 'autonomy' than had been the case thirty years ago. That was a time when the classic, self-governing liberal subject was the model for legal personhood, and capacity was the clear line that divided autonomous from non-autonomous decision-making, and thus decisions that warranted legal respect from those that did not. The Law Commission and the MCA 2005 went some way to addressing the starkness of that divide by including consideration of P's current wishes and feelings in the determination of best interests and requiring P to be involved as much as possible in the decision-making, and active engagement with P was also encouraged by both the MCA 2005 Code of Practice and the relevant NICE guideline,[43] but capacity still comes through as a fairly hard line of division. Thirty years later, autonomy is no longer viewed so simplistically, in law or in broader academic discourse. This is not the place to summarise a complex literature;[44] suffice it here to say that it has become very much conceptually contested territory, in ways which were not anticipated thirty years ago. The place of mental capacity in those debates, as compared to other causes of vulnerability and other influences on personal choice and behaviour, has become much more disputed. Certainly in the context of disability, the understanding is now much more of individuals in relationship with each other, rather than the atomised liberal subject.

P thus has become a much more complex figure in our understanding of disability. He or she cannot be assumed to lack agency, but the scope and nature of that agency is contested both at the theoretical level between different scholars and at the level of individual cases and fact situations. It is now expected that support will be provided to P, through advocacy and services more generally, with the aim of increasing P's autonomy; 'empowerment' of P has, rightly, arrived as a concept in English policy-making, and there is no going back. Mapping that onto the existing law is not straightforward, particularly when the conceptual universe has become so complex and so contested.[45]

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[43] *Mental Capacity Act Code of Practice* n 38 above; National Institute for Health and Care Excellence (NICE), 'Decision-making and mental capacity' (2018), s 1.2 at www.nice.org.uk/guidance/ng108 (last accessed 12 August 2022).,,

[44] See for example Clough, n 8 above, G. Richardson, 'Mental disabilities and the law from substitute to supported decision-making' (2012) 65 *Current Legal Problems* 333; M. Nussbaum, 'Capabilities as fundamental entitlements: Sen and social justice' (2003) 9 *Feminist Economics* 33; Herring and Wall, n 28 above; R. Harding, 'Legal constructions of dementia: discourses of autonomy at the margins of capacity' (2012) 34 *Journal of Social Welfare and Family Law* 425; L. Series, 'Relationships, Autonomy and Legal Capacity' (2015) 40 *International Journal of Law and Psychiatry* 81; J. Craigie, 'A Fine Balance: Reconsidering Patient Autonomy in Light of the UN Convention on the Rights of Persons with Disabilities' (2015) 29 *Bioethics* 398; C Kong, *Mental Capacity in Relationship: Decision-Making, Dialogue and Autonomy* (Cambridge: CUP, 2018); J. Coggan, 'Mental capacity law, autonomy, and best interests: An Argument for conceptual and practical clarity in the court of protection' (2016) 24 *Medical Law Review* 396; P. Skowron, 'The Relationship between autonomy and adult mental capacity in the law of England and Wales' (2018) 27 *Medical Law Review* 32; N. Munro, 'Taking wishes and feelings seriously: the views of people lacking capacity in Court of Protection decision-making' (2014) 36 *Journal of Social Welfare and Family Law* 59; E. Jackson, 'From "Doctor Knows Best" to Dignity: Placing Adults who Lack Capacity at the Centre of Decisions about their Medical Treatment' (2018) 81 MLR 247.

[45] For an excellent theoretical analysis of this, see Clough, n 8 above.

Professionals under the MCA 2005

The vision of the Law Commission was of a system that would function on a largely informal basis. There was to be no need routinely to report decisions taken under the new law to anyone. While that made considerable practical sense, it does mean that it is difficult to get a systematic sense of how the MCA 2005 is being applied, particularly in the context of informal and family care. Certainly, it would seem that LPAs are a success: more than 898,000 were registered in 2019.[46] While that tells us that a significant number of people are planning for incapacity, it does not tell us how many of those documents are actually being used, since the advice is that they be registered immediately, rather than waiting for impending incapacity. Pivotally for purposes of the present paper, it does not tell us how good decision-makers under those documents are at gauging whether donors have capacity to make a decision, nor how they are making decisions on behalf of donors – essentially, whether they are in fact following the incapacity and best interests provisions of the MCA 2005 at all. We similarly have minimal systematic information of how decisions are taken by professionals or family carers under the general defence in section 5, when there is no LPA we have no systematic data on any differential effects on segments of the community, such as the BAME community. Given the experience of those communities with other mechanisms of state coercion,[47] that is a potentially significant silence.

What limited information there is suggests that families are largely unaware of the provisions of the MCA 2005,[48] including both the existence of the Act (and therefore in broad terms the overall rights that family members had or did not have) and the specifics of the capacity and best interests provisions, even if they were holders of LPAs. Evidence to the House of Lords committee also raised concerns that abuse (both financial and physical) by holders of LPAs was not infrequent. Even if they are aware, family and informal carers may have conflicting emotional priorities. Brown and Marchant for example note a reluctance of families in their study to take hard decisions, allowing risk to accumulate because the decision-making proved too daunting. Professionals

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[46] Family Court Statistics Quarterly, July-September 2019-20, Table 23 at https://www.gov.uk/government/statistics/family-court-statistics-quarterly-july-to-september-2020 (last accessed 19 July 2022).

[47] Regarding crime and policing, see for example A. Parmar, 'Ethnicities, Racism and Crime in England and Wales' in Sandra M. Bucerius and Michael Tonry (eds), *Oxford Handbook of Ethnicity, Crime, and Immigration* (Oxford: OUP, 2013); R. Joseph-Salisbury, L. Connelly, P. Wangari-Jones, '"The UK is not innocent": Black Lives Matter, policing and abolition in the UK' (2021) 40 *Equality, Diversity and Inclusion* 21. Regarding psychiatric detention, see 'Mental Health Act Review African and Caribbean Group – Final Report to the Review Chair' Background paper for the Independent Review of the Mental Health Act 1983 (Chair, Simon Wessely) Department of Health, 2018 at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778898/Independent_Review_of_the_Mental_Health_Act_1983_-_supporting_documents.pdf (last accessed 27 July 2022); V. Lawrence, C. McCombie, G. Nikolakopoulos, C. Morgan, 'Ethnicity and power in the mental health system: experiences of white British and black Caribbean people with psychosis' (2021) 30 *Epidemiology and Psychiatric Sciences* 1.

[48] See briefs from carer organisations, cited House of Lords post-legislative scrutiny, n 1 above, para 95, discussion at paras 179-192.

became involved when the situation became urgent.[49] It is no doubt right in principle for Brown and Marchant to say '[w]here decisions were being taken against a backdrop of family conflict this had to be factored into the decisions at hand and confronted directly instead of being used as a reason to back off',[50] but the realities of family conflict may be that this is easier said than done for people actually in those situations.[51] In retrospect it is perhaps not a surprise that the new scheme was not taken up seamlessly by family and informal carers, but it does serve as a reminder that such legal change requires cultural or social change to go along with it: just passing a law is not enough.

By comparison, professionals seem to be very much involved in the administration of the MCA 2005 – much more than the Law Commission envisaged. The House of Lords committee was critical of patchy implementation of the MCA 2005 by professionals, and systematic evidence of the use of the Act by professionals remains ambiguous.[52] They are however pivotal players in Court of Protection litigation, and it appears from the descriptions of the factual situations in those cases that doctors in cases involving medical treatment and social workers in cases involving personal care are the drivers of MCA 2005 implementation and interpretation in individual cases. The centrality of that role was not anticipated by the Law Commission, certainly as regards social care. Social care professionals are largely absent from the Law Commission discussion.

The enhanced role of social care professionals in capacity and best interest matters also no doubt flows in part from the failure of the government to enact the public law elements of the Law Commission report. This had the effect of moving protection from abuse – a classic part of the social worker's role – into

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[49] H. Brown and L. Marchant, 'Using the Mental Capacity Act in complex cases' (2013) 18 *Tizard Learning Disability Review* 60, 68.

[50] *ibid*, 68.

[51] See discussion in B. Clough 'What about us? A case for legal recognition of interdependence in informal care relationships' (2014) 36 *Journal of Social Welfare and Family Law* 129.

[52] The most recent systematic review is K. Hinsliff Smith, R. Feakes, G. Whitworth, J. Seymour, N. Moghaddam, T. Dening and K. Cox, 'What do we know about the application of the Mental Capacity Act (2005) in healthcare practice regarding decision-making for frail and older people? A systematic literature review' (2017) 25 *Health and Social Care in the Community* 295, but it is based on papers from 2005 to 2013, so is now rather dated. A recent survey by the National Mental Capacity Forum, suggests that respondents (n=1244) have the impression that implementation has significantly improved in both the health and social care sectors since the House of Lords report, but the basis of those impressions is not clear: National Mental Capacity Forum, Chair's Annual Report 2019 – 2020 at https://www.scie-socialcareonline.org.uk/the-national-mental-capacity-forum-chairs-annual-report-2019-2020/r/a116f00000UpH8PAAV (last accessed 9 August 2022). That optimism is further not wholly supported by other studies. Jenkins et al acknowledge ongoing cultural problems in implementation of the Act: C. Jenkins, N. Webster, A. Smythe, F. Cowdell, 'What is the nature of Mental Capacity Act training and how do health and social care practitioners change their practice post-training? A narrative review' (2020) 29 *Journal of Clinical Nursing* 2093, 2105. A study by Chapman et al looked at clinical staff in an LD department in one NHS mental health trust (n=262, 76 per cent of that workforce). The questions in this survey were fairly basic, but it still found a high level of variability in the knowledge of staff (with professional staff faring better than non-professional). Thus only 49 members of staff answered the questions on capacity determination correctly, and for a fairly standard question about a medical procedure, less than a quarter successfully identified the correct decision-maker (ie the person performing the procedure): A. Chapman, K. Dodd and L. Rogers, 'Knowledge of mental capacity assessment in staff working with people with learning disabilities' (2020) 14 *Advances in Mental Health and Intellectual Disabilities* 14.

the rest of the MCA 2005: if social workers were going to intervene to prevent abuse, the main MCA 2005 became a new and significant part of the arsenal, and, as a corollary, the terms of the MCA 2005 became viewed through a lens of public order and prevention of abuse.

This unanticipated colonisation has a variety of effects, some beneficial and others not. It reframes capacity away from common daily experience into the realm of experts: capacity assessment and best interest determinations become something for the professionals. Within litigation, capacity assessment becomes an event, rather than an ongoing series of micro-processes. The effect of that goes some way to undermining the time-specific nature of capacity determination, since it will not always be the case that the assessment happens at the time the decision is to be taken. It also moves the threshold for application of the Act towards more serious cases, since engaging experts is at the very least a bother, and potentially also a significant expense: it will not be done for each of the smaller decisions, many of which can be of considerable importance to a person whose life situation may be limited, and which were within the consideration of the Law Commission.[53]

It may also move the decision to a more appropriate decision-maker. For a decision as to whether a given care home remains right for P, the best interests determination under the MCA 2005 falls to the person who would be liable in tort for wrongful detention – the care home manager, or the corporate body running the care home. However, the care home may well be run by a private company paid for the care of P, resulting in a conflict of interest. It seems at least for care funded by the local authority that the decision on best interests is now in practice taken by social workers in that local authority. This makes some sense: they are not likely to have such a conflict of interest, may well have specialist training in the Act, and may know the available options better than the care home manager. This does not change the fact that it is not clear that they have the legal authority to make that decision under the Act.

This rise of the expert also brings to the fore rebalancing of power. The involvement of social workers recasts the MCA 2005 as much more of a public law statute – not what the Law Commission intended.[54] The new relationships here have proven complex, and will be explored later in this paper.

The resurgence of process?

The CRPD may have been the focus of attention in recent years, but it is the second revolution in human rights law since the early 1990s. In its initial report, the Law Commission still felt it necessary to justify its view that proposed legislation had to be ECHR compliant.[55] Only three cases from the ECtHR

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[53] See for example Law Commission (1993:128), n 12 above, 5.19-5.21.

[54] See for example *ibid*, 6.17.

[55] *ibid*, footnote to 3.12.

were cited, and only one of these, *Winterwerp* v *the Netherlands*[56] (*Winterwerp*), concerned mental disability. That is unsurprising: litigation in the ECtHR regarding capacity, conservatorships, and the conditions of life of people lacking capacity was virtually non-existent. *Bock* v *Germany*[57] addressed the length of conservatorship,[58] and some of the few ECtHR cases involving psychiatric admissions did have potential relevance in capacity contexts, but the jurisprudence was thin as to what a person with compromised capacity could expect under the ECHR. In the first decade of the twenty-first century, the ECtHR became much more engaged with this area.[59] *HL* v *the United Kingdom* was particularly influential in England, since it was a case directly about English practices. The ECHR landscape has, however, not merely changed, but really been created in the mental capacity realm in ways which the 1990s Law Commission had no reason to anticipate. At the core of that has been process, in particular appropriate judicial processes. While much of the jurisprudence so far has focused on people in institutions, it is clear that the terrain is not restricted to those situations.[60] The ECHR jurisprudence has an immediacy that the CRPD does not: since the Human Rights Act 1998 (again, antedating the Law Commission's work), the ECHR has been incorporated into English law. It has heft in policy-making as a result.

The Law Commission's vision of administration was quite different. It favoured informal processes.[61] While its reforms did call for a proper court to oversee the MCA 2005, it did not expect it to have much work: recourse to formal processes was expected to be very much the exception. As it turned out, in 2019, there were 34,445 applications to the Court of Protection, 15,514 of which were to appoint a deputy for property and affairs and another 6106 for a 'one-off' property and affairs order.[62] When the MCA 2005 was passed, it was expected that the re-vamped Court of Protection would receive roughly 200 applications relating to health and welfare per year.[63] By 2010, the Court's second full year of operation, it was receiving almost 1300 such applications

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[56] *Winterwerp* v *the Netherlands* (1979-80) 2 EHRR 387. Also cited were *Engel and Others* v *the* Netherlands *(No. 1)* [1979-80] 1 EHRR 647 and *Guzzardi* v *Italy* [1981] 3 EHRR 333, both for the proposition that deprivation of liberty is a matter of degree.

[57] *Bock* v *Germany* App No 11118/84, judgment of 21 February 1989.

[58] ECHR jurisprudence frequently uses 'guardianship' to refer to the controlling regimes to which people found to lack capacity are subject. To avoid confusion with guardianship under the Mental Health Act discussed above, this article refers to these arrangements as 'conservatorships'.

[59] See for example *HL* v *the United Kingdom* n 14 above; *Salontaji-Drobnjak* v *Serbia* App No 36500/05, judgment of 13 January 2010; *Shtukaturov* v *Russia* App No 44009/05, judgment of 27 March 2008 (*Shtukaturov*); *Stanev* v *Bulgaria* App No 36760/06, judgment of 27 March 2008 (*Stanev*); *A.-M. V.* v *Finland* App No 53251/13, judgment of 23 March 2017.

[60] See for example *A.-M. V.* v *Finland ibid.* On the ECHR and mental capacity more generally, see P. Bartlett, O. Lewis and O. Thorold, 'Mental Disability and the European Convention on Human Rights' (Leiden: Martinus Nijhoff, 2006) ch 6; O. Lewis, 'Advancing legal capacity jurisprudence' (2011) 6 *European Human Rights Law Review* 700; P. Bartlett 'Capacité juridique, limitation de liberté d'aller et venir et droits de l'homme' (2015) 6 *Revue de droit sanitaire et social* 995, Jackson, n 44 above.

[61] Law Commission (1995:129), n 12 above, 4.8.; Law Commission (1995), n 12 above, 3.24

[62] Family court statistics, n 46 above, table 21.

[63] Series et al, n 42 above, 20.

annually,[64] a figure which has been fairly stable over time. DOLS applications have been on an upward trajectory following the decision of the Supreme Court in *P* v *Cheshire West and Chester Council*[65] in 2014: in 2013 there had been 109 of these cases in the Court of Protection; in 2019 there were 5219,[66] and at least until the LPS take effect, the upward trend shows no sign of abating.

These figures show ambiguous success for the Law Commission approach. To put them in context, there are roughly 153,000 adults with learning disabilities[67] receiving long-term support from local authorities in England, and there are 676,000 people with dementia.[68] Obviously, not all these people will lack capacity, but a significant number will. Informal care is common; roughly 540,000 people in England care for someone with dementia, and 50,000 of those have given up their paid employment to do so.[69] Clearly, personal decisions are being taken for a very large number of people lacking capacity without recourse to the Court of Protection – the Law Commission's desired result. That is not the same thing as saying that the MCA 2005 is being complied with. As noted above, the consistent (but largely anecdotal) evidence suggests that families are largely unaware of the MCA 2005, and their powers and obligations under it. If that is correct, families and other informal carers may be continuing on much as they did in the unregulated days prior to the MCA 2005. That would not be so clearly a success. If they are acting in substantial compliance with the MCA 2005, their formal knowledge of the legislation is not necessarily a problem; but if lack of such knowledge means they are not complying with the Act, the objectives of the Act will not be met, and indeed liability may attach to the decision-makers.[70] Further, an objective of the Law Commission had been to simplify the processes for financial matters.[71] The statistics above suggest that there has been little change in this regard, however. Both of these interpretations remind us again that changing practice is a great deal more complex than changing law.

The Court of Protection itself seems to have developed rather differently to the Law Commission's expectation. The Commission had called for the formation of a proper court to oversee the legislation, but it seems to have expected that the court would adapt its processes to take account of the context. It was expected that P would often be in court and would make his or her views known directly, and that expert reports would be required only on an as-needed basis.[72] The court, it would seem, was expected to work very closely with the

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[64] 'Court of Protection Report, 2010' figure 2 at https://www.judiciary.uk/wp-content/uploads/JCO/Documents/Reports/court-of-protection-report-2010.pdf (last accessed 1 December 2021).

[65] *P* v *Cheshire West and Chester Council* [2014] UKSC 19.

[66] Family court statistics, n 46 above, table 21.

[67] Public Health England, 'Learning Disability Profiles' at https://fingertips.phe.org.uk/profile/learning-disabilities/data (last accessed 2 August 2021).

[68] NHS England, 'Dementia' at https://www.england.nhs.uk/mental-health/dementia/ (last accessed 1 December 2021).

[69] *ibid.*

[70] *Commissioner of Metropolitan Police* v *ZH* [2013] EWCA Civ 69.

[71] Law Commission (1995), n 12 above, 4.6-4.29.

[72] Law Commission (1995), n 12 above, 10.25-10.26.

actual litigants and often (normally?) to reach views free of experts or complex processes.

Certainly, the Court of Protection has become a recognisable court with a proper court structure, but it does not operate in a 'relaxed and non-technical' way.[73] It is a court, and it behaves like a court. This is perhaps not a surprise. The ECHR jurisprudence has given issues surrounding mental capacity a legal gravitas that was not anticipated, and the movement of professionals, particularly social work professionals, into the core of the administration of the Act similarly affects the dynamics: such professionals are used to administrative structures where courts are an accepted part of the system. It was further accepted from the beginning that if P were unable to instruct a lawyer, he or she would require a litigation friend, usually the Official Solicitor, who retains counsel. The other party, often an NHS Trust or a local authority, also retained counsel, so the Court became a place of lawyers speaking to judges, who are of course also lawyers by background. In retrospect, it is hard to see that 'relaxed and non-technical' was ever in with a chance.

That has had a number of effects. There is a rarefication of substance. Lawyers' expertise is in drawing close analysis of factual situations, statutes and cases, finding shades of meaning, engaging with legal principles, and following, applying and distinguishing precedents. This is a self-reinforcing process: each new statute and each new judgment presents a new wealth of open-textured language for debate and analysis. This is of course not unique to MCA 2005 interpretation, but it applies here as much as elsewhere, as we now debate for example about what the precise nature of the 'decision' to be made is, what sort of causal nexus is required between the mental impairment and the decision, and the intersections and interrelations between the MCA 2005 and other frameworks such as child law and mental health law.[74] Lawyers will argue, quite correctly, that these are important issues and that they are legitimately complex, but grappling with them does take us a long way from the 'plain English' approach of the Law Commission and much of the MCA 2005. The process thus becomes increasingly alienated from the people it was meant to serve.

That alienation of P in particular starts with the question of representation. If P lacks the capacity to instruct counsel, he or she must be represented by a 'litigation friend',[75] most frequently the Official Solicitor.[76] The litigation friend does not act on instructions from P, but is instead subject to the hybrid best interests test laid down in the MCA 2005.[77] Professional practice would strongly

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[73] *ibid*, 10.25.

[74] For a recent example, see *A Local Authority* v *JB* [2021] UKSC 52 regarding the overlap with criminal law, and nature of capacity for engagement in sexual relations under the MCA 2005.

[75] Court of Protection Rules 2017, R1.2 and Part 17.

[76] In Series's study, 122 of 155 litigants were represented by the Official Solicitor: Series et al, n 42 above, 54. See also Ruck Keene's study where the Official Solicitor represented in 77.5 per cent of reported cases: A. Ruck Keene, N. Kaneb, S. Kim and G. Owen, 'Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection' (2019) 62 *International Journal of Law and Psychiatry* 56.

[77] On the complexities and difficulties arising from this, see A. Ruck Keene, P. Bartlett and N. Allen, 'Litigation Friends or Foes? Representation of "P" before the Court of Protection' (2016) 24 *Medical Law Review* 333.

favour making P's views known to the Court, but the best interests criteria do not require these to be binding on P's representative, who may therefore make representations 'on behalf of' P that there is every reason to believe P would not have made, if capable of instructing. If not legally aided, P pays for this.

This is obviously problematic in terms of silencing or marginalising P, but it also limits the diversity of argument before the Court, since the other party – a local authority or health trust, for example—is also acting to ensure a decision in P's best interests as defined by the hybrid test and defined processes: in that sense, all the lawyers have the same brief. If all the lawyers are sticking to that brief, it is fair to ask how much that is new or different P's representative is bringing to the table. The professionals' characterisations of 'facts' are likely to be taken as authoritative, and the discursive structure of the case is likely to proceed on terms set by the professionals. Insofar as that occurs, this becomes an exercise in reviewing professional discretion from inside that professionalised universe.

London Borough of Brent v *SL*[78] (*Brent* v *SL*) will serve as an example. In this case, P was discharged into supported housing following psychiatric sectioning. She wanted very much to return to her own home, and the local authority made an MCA 2005 DOLS application to the court to keep her in the sheltered accommodation. Difficulties of the substantive approach to capacity determination will be discussed below. For present purposes, the point is that she did not want to remain in the sheltered accommodation, but equally accepted that to proceed would require legal representation; and looking at her finances, she was unwilling to pay for that representation. The court notes that this dilemma was frequently faced by non-disabled litigants.[79] Non-disabled litigants however can drop the case. She could not: this was an application for a DOLS order, and a court decision was therefore required. As she was held not to have capacity to litigate, however, her case would have been argued by her lawyers in her MCA 2005 best interests – a framework which would almost certainly have accepted a characterisation of her medical and self-care history with which she would have vehemently disagreed, but for which she would have had to pay, notwithstanding her concern precisely to avoid that.[80] She could reduce her financial exposure by asking to be removed as a party,[81] but this would further alienate her from the process, a bizarre result when she clearly had strong views as to what should happen.

The expectation of the Law Commission that P would generally present his or her own views to the court unless it was not 'appropriate for the person concerned to be present in court, whether because of physical or mental frailty'[82] has never been fully realized. In the early days of the court, P's attendance in court was a rarity. Since then, it would seem increasingly that P does attend, but as noted above, the processes and substance are formal and technical, and there is little by way of specialist support offered to P in light of his or her disability.

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[78] [2017] EWCOP 5.

[79] *ibid*, at [28].

[80] The merits decision appears not to be reported, but it seems likely that this is what happened.

[81] Court of Protection Rules 2017, R 9.13(3). She would still be bound by the judgment: R 9.14.

[82] Law Commission (1995), n 12 above, 10.25

Court hearings can be difficult for anyone to understand; it is fair to wonder what P makes of them.

The nature of P's involvement in the proceedings has proven doctrinally problematic. In the early days, there was serious debate as to whether the Court was *permitted* to hear from P directly.[83] That difficulty has now been addressed in the revised Court of Protection Rules 2017 rules 1.2(1)(d) and 14.2(e), but removal of the apparent prohibition does not in itself create a culture where P's direct input is the norm.[84] In recent years, it seems that judges have made increasing efforts to hear from P,[85] but if P does speak directly to the judge, it is not clear what the Court makes of the contribution. Certainly, some commentators make a forceful argument that P's contribution is not taken as seriously as other evidence.[86] There are other more positive indications, however, with some cases where for example following a meeting with the judge, P has been held to have capacity notwithstanding unanimous expert evidence to the contrary.[87]

There remains a tension in the understanding of the judicial role in such meetings: do judges perceive themselves as arbiters between witness accounts, or do they see themselves as drawing an independent assessment based on the individual in front of them. In *Re AH*[88] (*AH*), the Court of Appeal seems to have adopted the former view. The case involved the termination of life-sustaining treatment, and the trial judge had attended the hospital to speak with P about her current wishes. As a result, the Court of Appeal ordered a new trial, for two reasons. First, the actions of the judge could have been construed as a gathering of 'evidence'. While the representative of the Official Solicitor was present, counsel for the other parties were not, and were thus effectively precluded from making submissions about the information received. This went to the fairness of the hearing. Further, the disability of P meant that the judge 'was not qualified'[89] to assess her wishes from the conversation: for complex cases at least, it seems that P's statements need to be interpreted through suitably qualified professionals. Both of these reasons are revealing. The first reinforces the formalist nature of the hearing: it seems that the parties other than P are not just there to assist the Court; they have their own views and interests that they are entitled to pursue, and there is more than a hint of an adversarial framework

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[83] See for example *CC* v *KK and STCC* [2012] EWCOP 2136 at [49]; *Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1417 (COP). For further discussion, see J. Lindsey, 'Testimonial Injustice and Vulnerability: A Qualitative Analysis of Participation in the Court of Protection' (2019) 28 *Social & Legal Studies* 450.

[84] In Ruck Keene's study, P spoke to judge directly in just under one case in three: Ruck Keene, n 77 above, 65. In Series's study, P either provided unsworn testimony or met with the judge in private in seven of 260 cases, and an additional nine individuals attended the hearing in person: Series et al, n 42 above, 60.

[85] At least in cases regarding deprivations of liberty, there is ECHR jurisprudence that a face-to-face meeting is required: see for example *Shtukaturov* n 60 above. Such routine meetings are not standard in England.

[86] For example D. O'Connor, 'A Mother on Trial – Best Interests and the Conflict of Maternal Instincts' (2021) 29 *Medical Law Review* 562 at 567; Ruck Keene, n 77 above, 63.

[87] See discussions in Series et al, n 42 above, 98; Ruck Keene, n 77 above, 63 and 69; P. Case, 'Negotiating the Domain of Mental Capacity: Clinical Judgement or Judicial Diagnosis' (2016) 16 *Medical Law International* 174, 186.

[88] [2021] EWCA Civ 1768.

[89] *AH* at [71].

here. That may well reflect the dynamics between the key actors: often, it seems, there is little love to be lost either within families or between families and professional carers. It is doubtful, however, that the appropriate response to that is a reaffirmation of formalism. The second of the Court of Appeal's reasons, that communications from P require expertise to assess, reinforces the shift to professional hegemony. Both reasons risk the further alienation of P himself or herself from the process. The result is certainly a marked departure from the Law Commission approach.

The bulk of the material before the court is likely to be evidence from professionals. An assessment of capacity is required as part of the court application process; in Series's study of personal welfare applications, roughly a third of these were by social workers, a third by psychiatrists, and a third by other medical professionals or psychologists.[90] Additional expert reports may also be introduced if thought to be necessary. Some of this is inevitable, given the increasing sophistication of the legal analysis: questions of whether an impairment *causes* an inability to decide, or whether some sorts of impairments may affect decision-making capacity in ways not obvious to the casual observer, create a particular space for experts.[91] It does seem a long way from the Law Commission approach, however, where availability of expert reports seems almost an afterthought.

Commentators have criticised this as entrenching the medical model of disability,[92] and thereby continuing the narratives of disability as personal tragedy and personal limitation. That is an entirely reasonable concern. While medical experts should not be viewed as cardboard cutouts and may well be very much aware of and promoting the abilities of P, they will be doing so from a medical frame of reference. The framing of disability, a key issue for the CRPD, is not called into question. The medical framing is however imposed by the 'diagnostic threshold' contained in Law Commission reports and the MCA 2005 itself: the inability to decide must flow from 'an impairment of, or a disturbance in the functioning of, the mind or brain.'[93]

This in turn points up a collision in human rights law. As noted above, the CRPD is built on the social model of disability, and other formulations that site disability in the individual are to be eschewed. That, certainly, calls the diagnostic threshold into question. At the same time, the ECHR jurisprudence is likely to require such a diagnostic threshold when ECHR rights are engaged. The specific issue has not been litigated in a capacity context, perhaps unsurprisingly since traditional guardianship systems in Council of Europe countries contain

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[90] Series et al, n 42 above, 61 and table 25.

[91] Re causation, see discussion in Case, n 87 above, 181, and *PC* v *City of York Council* [2013] EWCA Civ 478. Re specifics of impairment, see *A Local Authority* v *E* [2012] EWHC 1639 (COP) and *Northamptonshire Healthcare NHS Foundation Trust* v *AB* [2020] EWCOP 40, both anorexia cases, and compare with *Avon and Wiltshire Mental Health Partnership* v *WA* [2020] EWCOP 37, where the diagnosis was depression and post-traumatic stress disorder. Regarding personality disorder in this context, see K. Ayre, G. Owen and P. Moran, 'Mental capacity and borderline personality disorder' (2017 41 *British Journal of Psychiatry Bulletin* 33.

[92] For example B. Clough, '"People like that": Realising the social model in mental capacity jurisprudence' (2014) 23 *Medical Law Review* 53; Case, n 87 above; Lindsey, n 83 above; Donnelly, n 4 above; Pritchard-Jones, n 4 above, 523.

[93] MCA 2005, s 2(1); see also Law Commission (1995), n 12 above, 3.8-3.12.

a diagnostic threshold. The ECtHR has certainly never criticised that overall approach, although it has (consistent with its jurisprudence regarding mental health compulsion) made it clear that the mental disorder has to be proportionate to the guardianship imposed.[94] If it comes to be litigated, the court will be faced with the same problem faced by the Law Commission: in a guardianship system, how is the line to be drawn between beliefs and decisions warranting intervention and 'merely' eccentric behaviour?[95] The ECtHR is already relying on its mental health jurisprudence based in *Winterwerp* in its development of guardianship jurisprudence; it seems likely that they would continue this and insist on a 'true mental disorder', attested to by a suitable medical professional, as a protection against the arbitrary use of power.[96] That would seem to result in an entrenchment of the medical model.

The judicial process of course takes time. While some cases continue for years, the median time appears less. Series's study of Court of Protection files found a median time of four months for welfare and treatment cases and five months for deprivation of liberty cases.[97] That creates a challenge to a fundamental precept of the Law Commission and MCA 2005: in what sense is a capacity determination 'time specific' if it takes months to process to a conclusion? The problem is encapsulated in the following finding by Hedley J, in *A, B, and C* v *X and Y* (*A, B, and C*) regarding capacity to execute a will:

> In the event, I have concluded that I cannot make a general declaration that X lacks testamentary capacity, but that needs to be strongly qualified. There will undoubtedly be times when he does lack testamentary capacity. There will be many times when he does not do so. The times when he does lack such capacity are likely to become more frequent. It follows that, in my judgment, any will now made by X, if unaccompanied by contemporary medical evidence asserting capacity, may be seriously open to challenge.[98]

A similar finding was made in that case regarding capacity to make and revoke powers of attorney. The finding appears justified by the evidence and is very much in the spirit of the time-specific nature of capacity determination, but it did not solve the problem. The case included a dispute as to who had authority to run P's business, a matter that turned on his ability to execute powers of attorney and similar documents. The parties were left with no clarity on that point.

It is not clear how, if at all, that problem can be addressed. Many MCA 2005 issues involve fundamental rights, and so must be subject to judicial oversight,

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[94] For example *AN* v *Lithuania* App No 17280/08, judgment of 31 May 2016 (*AN*) at [122]-[128].

[95] The tenability of this line will be explored below.

[96] *Winterwerp* n 56 above at [39]. On its application in capacity settings, see for example *Stanev* n 59 above; *Shtukaturov* n 59 above; *AN* n 94 above; *DD* v *Lithuania* App No 13469/06, judgment of 14 February 2012.

[97] Series, n 42 above, 3. Her survey of local authority files suggested somewhat longer median times – nine months for health and welfare applications and seven months for deprivation of liberty. This research is prior to the 2017 amendments to the Court of Protection Rules, but comparable statistics are not yet available as to what effect, if any, those changes have made on delays.

[98] *A, B, and C* v *X and Y* [2012] EWHC 2400 (COP) at [37].

but legal processes inevitably take time. In *A, B, and C*, the situation might have changed even in the time taken to write the judgment. In this case, the court managed the problem by holding that P did not have capacity to manage his property and affairs, since unlike executing a power of attorney, this was an 'ongoing act'.[99] It is not obvious that this solves anything, however. It left open the option of appointment of a deputy.[100] While that would solve the practical problem, it did so by articulating X's capacity in terms of a package of decisions over time, moving away from the individual decision as the focus of capacity assessment. That pressure to package decisions is common in the jurisprudence – capacity to make treatment decisions, or care decisions, or decisions related to residence for example. While that has the advantage of organising decisions into administratively manageable lots, it does so by creating classes of decision rather than individual decisions as the unit of analysis – precisely what the Law Commission approach eschewed. If P were understood to remain capable of making at least some of those individual decisions, the deputy would lose the authority to make those decisions.[101] Further, the deputy could not make a decision that conflicts with that of a holder of an LPA – but the court specifically does not decide whether an LPA signed by P will be valid, so absent litigation to determine that, the powers of the deputy will be unclear. If P's capacity was wavering, as the court suggests, he could sign another LPA if the first one was struck down, hoping for better luck next time. The case arose in the context of intense antagonism between two factions of P's family, so such a chain of events is not necessarily unlikely. In any event, the result may well be correct under the Act, but seems to solve nothing.[102]

These court processes are of course expensive. For litigation relating to the property and affairs of P, the default rule is that the costs of all parties come from P's estate.[103] For cases concerning personal welfare, the general rule is that each party pays their own costs,[104] but for P this includes the cost of the Official Solicitor or other litigation friend. For cases involving serious medical treatment, the Official Solicitor's costs (and thus the bulk of the burden for P) are divided between the relevant health authority and the Official Solicitor's core budget; in these cases, P does not pay (although his or her family does, if represented separately). Legal aid is available for other cases, but is limited by both a test of merits and also means. As regards the latter, legal aid is available only if an individual's gross income is less than £2657 per month, their disposable income is less than £733 per month, and their capital does not exceed £8000, although these thresholds may still require a contribution from litigants. Full legal aid is available only if disposable income is less than £311 per month and capital less than £3000. Non-means-tested legal aid is available for appeals of deprivations of liberty in hospitals or care homes decided under Schedule A1 of the MCA 2005, but, surprisingly, not for court hearings to deprive the

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[99] *ibid* at [41].

[100] MCA 2005, s 16.

[101] MCA 2005, s 20(1).

[102] Regarding jurisdictional issues relating to fluctuating capacity see for example *GSTT* v *R* [2020] EWCOP 4.

[103] Court of Protection Rules 2017, R 19.2.

[104] Court of Protection Rules 2017, R 19.3.

individual of liberty in other contexts. The scope of non-means-tested legal aid has been construed narrowly. Whether deprivation of liberty is justified is not means tested, but once a deprivation of liberty is justified, any court challenge to the conditions under which the person is held is subject to means testing.[105]

The result of this is that the MCA 2005 can expose P and others to considerable financial risk. Series's study provides some sense of the scale: costs of a personal welfare application to local authorities were roughly £13,000; the median cost to legal aid for a medical application was £7672 and for a personal welfare application £20,874.[106] As Series notes, costs for self-funding litigants paying private rather than legal aid hourly rates to solicitors might well be significantly higher. These will be out of reach for most potential litigants, and ill-considered litigation could seriously deplete an individual's savings. For litigation surrounding property and affairs, where the costs of all parties are normally paid from P's estate, the argument is all the more telling.

All of this occurs, of course, in the context of a decade of restraint on public finances. Better legal aid, meaningful supports for P, and more user-friendly court processes would all cost money. The MCA 2005 is perhaps jinxed in this regard. The Law Commission did its work during the recession of the early 1990s, and was no doubt aware of the political realities of keeping costs down. The government green paper was explicit:

> In line with the Government's determination to contain public spending, and not to increase the tax burden, it would be necessary to recover a substantial contribution to added costs from actual or potential beneficiaries of the new procedures. The Government would therefore welcome views on the likely resource implications, and their affordability weighed against the merit of what must be issues of singular moral and ethical importance.[107]

England has now come through a decade of fiscal restraint, with major reductions in virtually all areas of government funding. The Court Service, legal aid, and local authority budgets have been particularly severely curtailed, with the latter affecting front-line programme staff and availability, but also, notably for this paper, advocacy services, and the staff required to administer the day-to-day functioning of the MCA 2005, which as discussed above had been taken up increasingly by local authorities.

At key times in the implementation of the proposals, therefore, the question has been about cost minimisation. Obviously, efficiency and financial prudence are good, but there is a difference between cost and value. There has never really been a discussion of how much we should expect to spend. By way of illustration, during the Law Commission's work on reformation of DOLS in 2016–17, it noted that proper implementation of the existing DOLS system in care homes and hospitals would cost roughly £309 million per year[108] – the

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[105] *Director of Legal Aid Casework* v *Briggs* [2017] EWCA Civ 1169.

[106] Series, n 42 above, 4.

[107] Lord Chancellor's Department (1997), n 13 above, 1.9.

[108] Law Commission, *Mental Capacity and Deprivation of Liberty Impact Assessment* 13 March 2017 at https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2017/03/lc372_mental_capacity_impact.pdf (last accessed 02 December 2021.

equivalent of roughly 1.3 per cent of the adult social care budget. The DOLS system handles something over 200,000 people a year. If it actually protects their rights, is that cost too much or not enough? At some point for MCA 2005 implementation, is it fair to ask whether everything needs always to be done on the cheap, and whether failure adequately to fund services brings into question compliance with the non-discriminatory expectations of the CRPD and the Equality Act?

Access to justice

At the core of so much of what has come before is the question of access to justice. These questions are clearest in the context of court proceedings because court proceedings are routinely reported and thus visible; but the issues are much broader: how is P to be properly engaged in the systems that affect him or her? This was not really addressed in the Law Commission reports. Their view, implicitly, seems to have been that provision of an appropriate substantive and procedural framework for decision-making would mean a coming together of the interests of P and his carers. Certainly there was little meaningful discussion of how P could access the systems off his or her own bat, or challenge decisions taken about him or her. With the rise of the ECHR jurisprudence, most directly *HL* v *UK*, that is no longer a tenable position. Processes are now required to ensure that P's situation is given active consideration when appropriate. In principle, this is obvious and important: P's rights must be made meaningful to P. Implementing that is much more problematic.

In 2011, the court in *London Borough of Hillingdon* v *Neary* imposed an obligation on public authorities to commence proceedings in serious cases where their course of action is questioned.[109] It is less obvious that they routinely do so, even when a dispute is clear.[110] Much more problematic are the cases of people who are not actively objecting and do not have persons advocating on their behalf. P is a person with a disability, sometimes a profound disability, and it cannot be assumed that he or she is able to exercise his or her rights without support. It does not follow that their care will be in their best interests (although often of course it will be). Decision-makers do not sit outside the decision-making process in a dispassionate or uninflected way. The people providing the care will be subject to an array of competing factors, only some of which focus on P. These agendas are a part of the decision-making process for these bodies,[111] and it is problematic to expect such bodies to divorce these agendas from their provision of support. Informal carers such as families are similarly bound up with the whole context of care.[112] The question for the MCA 2005 is how we ensure that best interests decisions are in fact being taken for P, and we are not looking at violation by neglect or distraction by other administrative concerns.

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[109] *London Borough of* Hillingdon v *Neary* [2011] EWHC 1377, 196.
[110] Ruck Keene, n 77 above, 69.
[111] See for example *N* v *A CCG* [2017] UKSC 22 at [36]-[37].
[112] For discussion, see Clough, n 51 above, 133-137.

The provision of support is the obvious answer, but this comes with its own complications. Who is to provide it, and on what basis? It will require a relationship between people, and one does not need to be a radical feminist or Foucauldean to see that such relationships may well import power dynamics of their own. If the support is provided by the public authority or the family, the same complications arise as noted above. The use of independent advocacy services may be helpful, but advocates are not immune from the conflicting roles and agendas. Their contract will come from the public authority, so their independence may be in part illusory, or their concerns to ensure the best results for clients overall may require them to shade advocacy in individual cases: advocates who have the reputation of 'running anything' tend to see their credibility suffer. At the very least, supporters in these circumstances are likely to find themselves restructuring and repackaging P's experience to align with the legal or administrative frameworks of the service provider. In that process P risks losing control over articulating what 'matters'. Support in itself can become alienating to P.[113] Support is also likely to be an intimate and private activity; insofar as outside oversight of these relationships to ensure their quality is appropriate, how is it to be done?

Much of this mirrors broader problems of access to justice in contexts outside disability – the lack of funding, the distant nature of court processes, the difficulty of getting good information to affected groups, and the other practical and cultural barriers to engagement. Some aspects of these may be particularly pronounced in the present context, but few are unique. There may be ways forward which may be found by exploring the similarities with these more general access problems.

A recap of the big issues

From the discussion above, it will be clear that the present context is considerably more complex than that envisaged by the Law Commission. Capacity no longer forms a neat dividing line between autonomous and non-autonomous decision-making, and P must now be considered an active stakeholder in decisions taken about him or her. At least in theory, disability law now imports an ethos of empowerment, in a way not envisaged thirty years ago.

The substantial and procedural challenges of that are significant. The Law Commission called for the redesign of the Court of Protection to be a proper court. That has happened: the Court of Protection is now behaving like a court, with the advantages and disadvantages that entails. It is transparent in its decision-making, and its decisions are well-reasoned. Based on this sort of classic legal criteria, it is notably strong. It does have significant difficulties in incorporating P into the process in a meaningful way. Some of these problems resemble the problems of access to justice of courts in broader contexts. Some are at least partly affected by limited resources. Others are result of the structuring of law by the MCA 2005 and other instruments and jurisprudence, most

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[113] For a similar point in a slightly different context, see Clough, n 8 above, 67 and passim

notably those relating to litigation friends and capacity to instruct counsel. The Law Commission had wanted their new processes to be 'quick, cheap, flexible, accessible and easy to use'.[114] At least as regards the court processes, they would seem to have failed on all counts.

Outside the courts, the picture is less clear on that score. We know that elements of the MCA 2005 have been notably popular with the general public – LPAs being the obvious example. We know much less about how the MCA 2005 is actually working in the private and informal care sectors.

Professionals, particularly social workers in local authorities, do seem to be a great deal more pivotal in the use of the MCA 2005 than anyone had anticipated. That would seem to be the case in the general usage of the Act; it seems certainly to be the case for the court processes. Combined with the issues of representation, this casts the substance of the hearing into a professionalised space. This is reflected in the apparent logic of the applications. Series notes that the MCA 2005 personal welfare applications seem to be about enforcing P's best interests onto P, in the face of objections from P or his or her family.[115]

That in turn raises two significant departures from the Law Commission vision. First, it casts the MCA 2005 in a controlling light: in this vision, the MCA 2005 is about the local authorities taking action to control P. This is not necessarily simplistically bad: even people with limited paternalist instincts might agree that there are times when decisions which P may find intrusive or disagreeable may need to be made. That is consistent with the view of the Law Commission, that the protection of P was one reason why reform was needed.[116] It does however point up that the MCA 2005 is, in much of its application, about doing things to P that P does not want. In this sense and consistent with the ethos of the time the Law Commission was writing, it is not a statute that empowers P.

Second, this role of the professionals was not anticipated by the Law Commission, and it significantly alters the characterisation of the statute. The Law Commission had viewed the elements of the current MCA 2005 as a matter of private law. While it allowed that public bodies could avail themselves of these powers, they had expected that such bodies would normally use the proposed public law powers relating to protecting vulnerable adults.[117] These latter proposals were not in the end enacted, and the 'private law' powers became increasingly integrated into the work of public authorities. In that sense, the private law characterisation of these powers is much more ambiguous: at least as regards health and welfare applications, the MCA 2005 would seem to be about the functions of public authorities.

The changes in the contextualisation of mental capacity law in the last decades affect the conceptualisation of its two key concepts, incapacity and best interests. It is to those issues that this paper now turns.

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[114] Law Commission (1993:128), n 12 above, 1.2.

[115] Series, n 42 above, 5.

[116] Law Commission (1995), n 12 above, 2.42-2.43, 2.46.

[117] Law Commission (1993:128), n 12 above, 2.7, 5.17; Law Commission (1993:130), n 12 above, 5.6-5.12.

INCAPACITY

When the Law Commission did its work, capacity was considered almost exclusively in a rationalist framework. The debates concerned what an individual needed to know, and what sort of intellectual manipulation he or she could perform on that information. Was evidencing a choice enough, or were rational reasons required? What degree of understanding would be needed?[118] It is therefore unsurprising that the Law Commission adopted an essentially rationalist test: P would lack capacity to make a decision if 'he or she is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision; or he is unable to make a decision based on that information'.[119]

Even if one were not prepared to jettison the concept of capacity completely, as orthodox interpretations of the CRPD would require, the passage of time means that this approach requires re-thinking on a number of grounds. Theory of decision-making has moved on significantly since that time. Emotions[120] and cognitive biases[121] are now understood as being highly significant in how we all make decisions: decision-making is not just about cognitive ability narrowly defined. That raises the initial question of why the gateway to decision-making should be determined by a set of criteria that does not reflect the decision-making used by the rest of us. That is to some degree reflected in the capacity literature. The Law Commission in the 1990s spoke of both the conceptual elusiveness and the importance of a 'true choice'.[122] The more recent literature tends to use other terms such as 'authenticity' applied either to the decision or to the "self" of P,[123] placing the issue in conceptualisations of autonomy that have moved on a great deal from those of thirty years ago. Those discussions tend to focus on values and factors relating to personal relationships rather than cognitive abilities as the Law Commission would have understood them.

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[118] L. Roth, A. Meisel and C.W. Lidz, 'Tests of Competency to Consent to Treatment' (1977) 134 *American Journal of Psychiatry* 279. For a detailed discussion in the context of the MCA 2005, contemporary with the Law Commission deliberations, see Gunn, n 21 above.

[119] Law Commission (1995), n 12 above, draft bill cl 2(1); essentially adopted into the MCA 2005 as s 3(1).

[120] See for example A. Damasio, *Descartes' Error* (London: Papermac, 1994); A. Damasio, *The Feeling of What Happens* (London: Vintage, 2000).

[121] In general, see M. Haselton, D. Nettle and D. Murray, 'The Evolution of Cognitive Bias' in D. Ross (ed), *Handbook of Evolutionary Psychology* (New York, NY: Wiley, 2nd ed, 2016). Regarding such bias in medical decisions, see S. Ozdemir and E. Finkelstein, 'Cognitive Bias: The Downside of Shared Decision Making' (2018) 2 *Clinical Cancer Informatics* 1. For legal decisions, see S. Charman, A. Bradfield Douglass and A. Mook (eds), 'Cognitive Bias in Legal Decision Making' in N. Brewer and A.B. Douglass (eds), *Psychological Science and the Law* (New York, NY: Guilford Press, 2019).

[122] Law Commission (1995), n 12 above, 3.15.

[123] For example K. Wilson, 'The Abolition or reform of mental health law: How should the law recognize and respond to the vulnerability of persons with mental impairment' (2019) 28 *Medical Law Review* 30; C. Kong, J. Coggon, M. Dunn, and P. Cooper, 'Judging Values and Participation in Mental Capacity Law' (2019) 8 *Laws* 3; Herring and Wall, n 28 above; Case, n 87 above; Harding, n 44 above; Cave, n 28 above; Skowron, n 44 above; Richardson, n 44 above.

The question of 'belief' brings some of these issues together. The common law had required that P believe the relevant information provided to him or her in order to have capacity.[124] The Law Commission did not include that as a requirement expressly, although the requirement that P understand 'the reasonably foreseeable consequences of deciding one way or another'[125] perhaps comes close, and this phrasing is contained in the MCA 2005.[126] 'Belief' was reintroduced almost immediately by the court.[127] This falls nicely into the way court processes work: first 'the facts' are determined, and then the behaviour of the relevant actors is assessed in terms of those facts. It becomes very difficult for the court to engage with P, if P does not accept those 'facts' as found. As discussed earlier, professional evidence is likely to be central in determining what 'the facts' are.

This is problematic given the developments in understanding of autonomy and the role of P that have occurred in recent decades. Certainly, even on a conservative analysis, it cannot be required that P simplistically agree with his or her advisors. As a simple example, consider the case where a clinician changes his or her diagnosis. If P considers the previous diagnosis more convincing, he or she may be wrong, but surely does not necessarily lack capacity. However, a move away from 'objective' facts determined by the experts creates practical problems. What if the 'fact' in issue is frequently not believed? For example, what if P is refusing a Covid vaccination because Covid does not really exist, the vaccines are not safe, and are ineffective anyway. None of these bear objective scrutiny; does it follow here that P lacks capacity, even though these beliefs are held by a sizeable minority of the population? Even more complex, what if P is refusing the vaccine from a belief that if she gets Covid, God will cure her. To atheists, this view will be equally false and at least as incomprehensible as the bad science approach, but since if it actually flows from a religious belief, it is taken to warrant particular protection in human rights law. That is particularly problematic since religious elements arise so frequently in psychosis.

The technical legal answer from the courts is based on causation: if the incorrect belief flows directly from the disability, then P lacks capacity; otherwise not.[128] That raises problems of its own, however. The first is practical: peoples' lives do not fall into convenient boxes, and it may well be unclear whether the incorrect belief flows from the disorder, or from some other source. There may be no exclusive cause, and the causes may be intermingled.[129] Is it enough that

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[124] *Re C* [1994] 1 WLR 290

[125] Law Commission (1995), n 12 above, 3.16

[126] MCA 2005, s 3(4).

[127] *A Local Authority* v *MM* [2007] EWHC 2003, 81. For detailed discussion, see also N. Allen, 'Is Capacity Insight?' (2009) *Journal of Mental Health Law* 165; P. Case, 'Dangerous liaisons? Psychiatry and law in the Court of Protection – Expert discourses of "insight" (and "compliance")' (2016) 24 *Medical Law Review* 360.

[128] MCA 2005, s 2(1); *PC* v *City of York Council* n 92 above. For further discussion, see Clough, n 8 above, 60-63.

[129] Cases involving anorexia and similar conditions provide a helpful example here. People with anorexia tend to be held not to have capacity to make decisions about their treatment by force-feeding, even when they state that their decision to refuse such treatment flows from their view,

the disability is a contributing factor? If so, how significant does its role have to be, and how can this possibly be ascertained with any certainty?

The use of disability as a factor here is further theoretically problematic. False beliefs are held for diverse reasons, but many will be as indefensible as the influence of disability. Why would one set of indefensible reasons – mental disability – result in a decision not being respected, while other seemingly equally indefensible reasons – for example 'I read it on the internet' – result in the decision being respected? If, as it seems, both reasons are equally indefensible, is this a case of the imposition of control based on disability, precisely the discriminatory approach that the CRPD is meant to preclude?

The psychological discussion of emotions and bias and the philosophical discussion of values cited above make it clear that these apply to all human decision-making, albeit in varying ways. The use of capacity in the MCA 2005 creates a hard line, when the complexities of individual cases are anything but clear cut. The academic literature highlights quite rightly the marginalising effect of that on people who are considered incapable, but the situation of people who may be vulnerable but are considered capable also warrants concern. While the MCA 2005 requires support to be provided so an individual may make a competent decision,[130] no provision is made for support if an individual has capacity but still requires support. It is perhaps arguable that this is not the role of capacity law, but that suggests a legal distinction that is not reflected in individuals' experience. The examples above may be black and white, but decision-making ability is in infinite shades of gray.[131]

Theoretically, it does not follow from this that all decisions must be respected, but it does require re-thinking of the meaning of 'true choice'. If it is understood that the line is not strictly cognitive, but referring to consistency of approach with the individual's longer-term values, how is that to be articulated in legislation? And if it is accepted that cognitive biases and emotions are an integral part of decision-making, how can or should we take account of those when deciding whether a decision is sufficiently 'authentic' to be accorded legal weight? And how will these apply in the context of long-standing and profound disabilities, where the subsisting characteristics of the individual may be difficult to ascertain? People do change, and significant life events such as those which will occasion disability might be expected to affect the individual's view of their situation and the decisions affecting them. People should not be imprisoned by an idealised past self who no longer exists, but if an individual-specific view of authenticity is called for, how is it to be assessed without at least some reference to the individual's previous values? How do we ensure the agency of the individual is maintained throughout this process, consistent with the expectations regarding the personhood of P articulated earlier in this paper? As Gibson says, if capacity determinations are not to be based on the wisdom of P's

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consistent with the objective facts, that their disorder has fundamentally diminished their quality of life and their expectations: see for example *A Local Authority* v *E* n 92 above, where refusal of treatment was not given effect.

[130] MCA 2005, s 1(3), 3(2).

[131] This point is at the core of Clough, n 8 above.

decision, the alternative criteria have to be clear and workable[132] Human rights law also requires that they be sufficiently clear that decisions taken using them are consistent between assessors and avoid arbitrariness. It is not at all clear how legislation could be drafted based on a 'true choice' approach that would meet these thresholds.

Assessment of capacity in the MCA has from early on been criticized by commentators for what Williams calls the 'concertina effect'[133] that is, that the assessment of capacity is inextricably bound up with the assessor's view of the outcome of the decision being taken. That is not meant to be the case: a person is specifically not meant to lack capacity merely because his or her decision is unwise.[134] This is further reflected at the court level. There are certainly cases where the court takes hard decisions that allow P to take risks or indeed that will result in P's death,[135] but they are not routine.

This is not surprising. As noted, the government did not proceed with the public law elements of the Law Commission proposals. While amendments to the Care Act 2014[136] gave adult safeguarding tribunals a statutory base, it did not give them any real power, so any proactive intervention needs to come from either the MCA 2005 or the inherent jurisdiction. The scope of the latter remains amorphous; it is unsurprising that the MCA 2005 has expanded into this role.

The Law Commission did foresee this, at least to some degree, for risks to P himself or herself: one of their objectives from the beginning of their deliberations was to protect P from exploitation.[137] They did not anticipate that the processes would be used to protect others, however: the expectation was that if public safety was at issue, the Mental Health Act would be used.[138] That is now problematic. The role of the Mental Health Act has itself been undergoing reconsideration, based on many of the same changing factors as are relevant to the MCA 2005. This is not the place to explore these developments in detail, but changes to the legislation in 2007 introduced treatability requirements for detentions beyond twenty-eight days:[139] dangerousness is now not enough. That may particularly affect people with dementia or serious learning difficulties – two of the main groups that overlap with MCA 2005 clients, but for whom there may be no curative medical treatment for their mental disorder. Further reforms are on the cards. A government-appointed committee

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[132] D. Gibson, 'Conceptual and Ethical Problems in the Mental Capacity Act 2005: An Interrogation of the Assessment Process' (2015) 4 *Laws* 229, 230.

[133] V. Williams, G. Boyle, M. Jepson, P. Swift, T. Williamson and P. Heslop, *Making Best Interests Decisions* (Bristol: University of Bristol, 2012). See also for example Cave, n 28 above, 530 and passim; Case (2016) n 128 above, 377.

[134] MCA 2005, s 1(4).

[135] For example *King's College Hospital* v *C* [2015] EWCOP 80. On a similar point when best interests were at issue, see *Wye Valley NHS Trust* v *B* [2015] EWCOP 60.

[136] Care Act 2014, s 43.

[137] Law Commission (1991), n 12 above, 1.9, 1.15, 2.27, 4.27; Law Commission (1993:128), n 12 above, 1.2, 1.9; Law Commission (1993: 130), n 12 above, passim; Law Commission (1995), n 12 above, 2.34, 2.42-2.44, ch 9.

[138] Law Commission (1995), *ibid*, 2.46.

[139] Mental Health Act 2007, s 4, amending MHA 1983, s 3(1)(d).

advising on reform reported in 2018; a white paper[140] and draft bill[141] have been published, and legislative reform is expected soon. While it seems likely that a dangerousness standard will remain a part of the Mental Health Act detention criteria, there does seem to be some movement away from viewing this legislation as a dangerousness statute. There is also a practical difficulty: the number of overnight mental health beds fell by 73 per cent between 1987/88, when the Law Commission started its work, and 2019/20.[142] It is therefore not obvious that it would be practical to use the Mental Health Act even if it were desirable. This serves as a helpful reminder: just as mental capacity law has moved on, so has much of the law around it.

Notwithstanding the Law Commission approach, the Supreme Court has now determined that the ability to understand likely adverse effects of a decision and risks to others does form a part of the test of capacity.[143] Whatever the merits of that decision given the changing context of mental health law, it does reinforce a characterisation of the MCA 2005 as being about control rather than empowerment.

The use of capacity law as a surrogate for safeguarding and public protection legislation creates an upward pressure on the threshold of capacity. Such upward pressures are endemic in capacity in any event: once capacity is called into question, the individual is assessed with reference to technicalities of the assessment criteria, and in practice may well have to demonstrate considerably higher capacity than is required of other decision-makers. The *Brent* v *SL*[144] case, described above regarding the processes of litigation capacity, provides a good example. In that case, we are told by the expert psychiatrist that SL did not 'understand the basis of such proceedings, as she is preoccupied by the fact that she would prefer to live at home'.[145] The court, quite properly given the jurisprudence on capacity to litigate, explored whether SL really understood the factual background to her situation, and her own previous behaviour that had led to these difficulties. It noted the potential complexity of proceedings, before concluding that SL did not have capacity to litigate this matter. It does not seem likely that these questions would be asked of non-disabled litigants whose homes were at risk. Tenants facing eviction or homeowners facing foreclosure are not normally expected to have an untainted understanding of the conditions that brought them to this state of affairs or of the intricacies of proceedings in order to litigate. Asking the questions raises the bar.[146]

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[140] Department of Health, *Modernising the Mental Health Act: Increasing choice, reducing compulsion* Final report of the Independent Review of the Mental Health Act 1983 (Chair: Simon Wessely) (London: Department of Health, 2018); Department of Health, *Reforming the Mental Health Act* White Paper (London: TSO, 2021).

[141] https://www.gov.uk/government/publications/draft-mental-health-bill-2022 (last accessed 25 July 2022).

[142] King's Fund, 'NHS hospital bed numbers: past, present, future' at https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers (last accessed 21 August 2021). General and acute hospital beds fell by 41 per cent in the same period.

[143] *A Local Authority* v *JB* n 75 above, 92-93.

[144] n 79 above.

[145] *ibid*, 6.

[146] For discussion of a similar point in a different context, see O'Connor, n 86 above.

Questions of safeguarding and public safety further those pressures.[147] It is now almost trite to say that society is risk averse, and when the mechanism to intervene is mental capacity law, it seems inevitable that pressures will be brought to make the control mechanism accessible. Baroness Hale, in a case regarding Mental Health Act compulsion, stated: 'Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify.'[148]

Consistent with this, the Law Commission thought that it was recommending a low standard of capacity. Whether that was ever correct is a fair question,[149] as is whether it has and can remain low, given the pressures in the system.

These difficulties are reflected in the conflicting agendas and frames of reference of care professionals.[150] Professionals will view situations through the lens of their professional training, and rejections of that framework are likely to trigger concerns about lack of 'insight', which in turn are interpreted as an inability to use or weigh information in the capacity determination.[151] This is buttressed by a set of administrative concerns that are unavoidable. Some of these are laudable: the professional ethos of medical and social work professions is meant to encourage real concern over the well-being of people cared for by those professions. Others are implied threats in the system. If P dies unexpectedly on the doctor or social worker's watch, for example, administrative enquiries will place the professional's practice under intensive and intrusive scrutiny, which may in turn lead to public criticism in the press. For the capacity assessor, therefore, at least for serious decisions, the context of the assessment will often not just be about the MCA 2005.[152]

In many (most?) cases, there will also be an issue of what the decision is that is at issue. In *A, B, and C*, discussed above, which distinguished between P's capacity to litigate, to make a will, sign an LPA and manage his property and affairs overall (even though each of these had significant effect on the others) is an example of a broader problem: P's life is unlikely to separate off into the nice little packets that a decision and time-specific capacity law would seem to require,[153] and the blurring of these lines makes capacity determination complex and almost certainly inconsistent as between assessors. The courts themselves occasionally recognise the artificiality of this, creating yet another pressure to combine decisions into bigger packets. That in turn, though, complicates the

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[147] See further discussion in J. Fanning, 'Continuities of risk in the era of the Mental Capacity Act' (2016) 24 *Medical Law Review* 415 and O'Connor, n 86 above.

[148] *R (Wilkinson)* v *Broadmoor Special Hospital* [2001] EWCA 1545.

[149] See Fennell, n 21 above.

[150] See A. Keeling, '"Organising objects": Adult safeguarding practice and article 16 of the United Nations Convention on the Rights of Persons with Disabilities' (2017) 53 *International Journal of Law and Psychiatry* 77.

[151] Cave, n 28 above, 530; Case, n 12 above, 377.

[152] This difficulty also arises regarding best interests determination, and will be discussed in more detail in that context.

[153] As the court sometimes recognises: see for example *Liverpool CC* v *CMW* [2021] EWCOP 50 at [15]. See also Clough, n 4 above; Brown and Marchant, n 49 above. The Supreme Court discusses the complexities of determining the 'matter' of the decision at some length in *A Local Authority* v *JB* n 74 above, 67-77, 86-96.

array of factors by which capacity is determined, and creates yet another pressure to raise the threshold of capacity.

These difficulties are arguably unavoidable in the current system. The MCA 2005 places the initial assessment of capacity with the person who is directly engaged in the care or treatment of P. Even if the professionals making the front-line capacity assessments view themselves as supporting decision-making in CRPD terms (and many of them will), the problems that were identified in the last section as arising with people providing support will apply here as well. The assessors are not disinterested automata. As Banner points out,[154] capacity determinations involve normative judgments, and any move towards further subjectivisation of the criteria to take into account innovations in autonomy theory are likely to complicate rather than simplify those determinations.

All of that suggests a marked difference from the approach envisaged by the Law Commission, when it was accepted relatively uncritically that the objective assessment of capacity would be possible.[155] Certainly, there are examples in the Court of Protection[156] and no doubt in professional practice as well where real attempts are made to protect the objective integrity of the assessment, but systemic factors militate against it. The MCA 2005, much more than was ever anticipated, needs to be considered as part of a much bigger contextual tapestry.

BEST INTERESTS

Incapacity was meant to be the gateway to the MCA 2005; 'best interests' were how decisions were to be taken once a decision was to be taken under the MCA 2005. It will be clear from the previous section that this is not the clear line that was anticipated: it is often professional plans, developed presumably in P's best interests, that P has capacity to consent to or not, and P's receptiveness to the plans does seem to affect the professionals' view of his or her capacity. The complexity of factors identified in capacity determination will apply equally to best interests assessments: the agency of P and the meaning of autonomy, the role of emotions and biases in decision-making, the difficulty of dividing complex lives into MCA 2005-convenient decision packets, and the complex agendas of decision-makers (most visibly professional decision-makers), for example.

Consistent with the Law Commission approach, best interests decision-making is a core principle of the Act,[157] but the definition of best interests in the Act is flexible. Decision-makers must consider P's past and present wishes and feelings, and the beliefs and values that P would have brought to the decision, and must consult with a range of carers to ascertain these. But the decision-maker is to consider 'all relevant circumstances',[158] not further defined. This was referred to earlier in this paper as a 'hybrid' test, with subjective and

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[154] N. Banner, 'Unreasonable reasons: normative judgements in the assessment of mental capacity' (2012) 18 *Journal of Evaluation in Clinical Practice* 1038.

[155] See Gunn, n 21 above, 21.

[156] See Ruck Keene, n 77 above.

[157] MCA 2005, s 1(5).

[158] MCA 2005, s 4(2).

objective elements. The test does not provide guidance as to the weighting of the factors. As Taylor puts it, 'whilst the legislation explains what must be done in pursuit of best interests, it provides no further insight into what is actually being pursued.'[159]

Unsurprisingly, the relative roles of the subjective and objective elements have provoked considerable discussion in the last decades. Changing conceptions of disability, and the move away from a bright line of capacity as the marker of autonomy and where P's agency, even if lacking capacity, is taken more seriously, mean that this was bound to be a contested area. The court is, at least to some degree, responding to that. Early on, it had been held that there was 'no relevant distinction' between the objective test of capacity developed by the courts for purposes of the inherent jurisdiction and the MCA 2005 test,[160] effectively marginalising P's subjective views. While it is difficult to see this as consistent with either the Law Commission reports or the MCA 2005 itself, it is an approach that continued for some time. In Series's study of files from 2015, it was not possible to determine how frequently best interests were consistent with P's wishes and feelings, because it was too often not possible to ascertain from the court files what P's wishes and feelings were.[161] That is no longer the case. P's wishes and feelings, values and beliefs do seem to be taking a larger place in best interests determinations in court (although, consistent with the legislation, they are not always determinative).[162]

A related but distinct tension has been the subject of less academic debate: what is the nature of the decision being taken by the court or other decision-maker? Is it to come up with a form of words or views that take the place of the decision P would make if he or she had capacity, or is it a determination by the decision-maker of what is actually going to happen to P? If Series is right that 'the personal welfare application process does appear to be mainly a vehicle for public authorities to seek authority for, or overcome objections to, interventions which they feel are in Ps best interests',[163] that suggests a much more extensive role for the judicial decision than merely making a decision analogous to one P would make if capable. If that is the nature of the best interests determination, the question becomes what factors can and should be taken into account in determining the course of action to which P will be subjected. And if the issue is compulsion of P by public authorities, then this is presumably a set of issues in public law (as compared to determination of P's wishes and feelings, which sounds more in private law).

The jurisprudence is problematic in this regard. The first appearance of the MCA 2005 in the Supreme Court is in *Aintree University Hospitals NHS*

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[159] H. Taylor, 'What are "best interests"? A critical evaluation of "best interests" decision-making in clinical practice' (2016) 24 *Medical Law Review* 176, 182.

[160] *MM, A Local Authority* v *MM and KM* [2007] EWHC 2003 (Fam) at [92].

[161] Series, n 42 above, 6.

[162] For fuller discussion, see A. Ruck Keene and M. Friedman, 'Best interests, wishes and feelings and the Court of Protection 2015-2020' [Winter 2020] *Journal of Elder Law and Capacity* 31; Jackson, n 44 above. See also for example *North West London Clinical Commissioning Group* v *GU* [2021] EWCOP 59.

[163] Series, n 42 above, 5.

Foundation Trust v *James*,[164] (*Aintree*) a case concerning the provision of life-sustaining treatment to a very ill man. The court holds that the MCA 2005 'is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further.'[165] While it emphasised that the matter was to focus on P 'as an individual, rather than the conduct of the doctor',[166] this remains a long way from making P's wishes determinative. Indeed, the bulk of the discussion was about broader policy factors and guidance concerning life-sustaining treatment and, while the evidence regarding P's views was not challenged, the eventual decision was not consistent with those views. The court is clear that it could not question a doctor's decision that a treatment was not clinically warranted, continuing

> Of course, there are circumstances in which a doctor's common law duty of care towards his patient requires him to administer a particular treatment, but it is not the role of the Court of Protection to decide that. Nor is that Court concerned with the legality of NHS policy or guidelines for the provision of particular treatments. Its role is to decide whether a particular treatment is in the best interests of a patient who is incapable of making the decision for himself.[167]

Aintree was followed by *N* v *A CCG*[168] (*N*), to similar effect. In that case, P was of very limited mental abilities and was affected by extensive physical disabilities as well. He lived in a care home and received extensive care. The issues were whether some of this care such as intimate washing could be performed by his mother, and whether day visits to the family home could be organised occasionally. The background to the case was complex, but the upshot was that the CCG refused to facilitate either of these. The Supreme Court took the view that the Court of Protection could decide only between 'available options';[169] and as the public authority was not prepared to provide the services desired by P's parents, a best interests determination of those options would serve no purpose.

What does this say about best interests under the MCA 2005? Presumably, P's objective best interests will have been considered in the development of the care plan; what does re-considering them in the context of an MCA 2005 hearing add? On that basis, if the court's remit is limited to what P *could* have decided if capable, what is the argument for not reaching the decision that P *would* have decided if capable? At least that would give P a veto: if the finding is that he or she would not agree to the proposed services, they would not proceed, much as if a competent service user refused a proposed programme of care. Alternatively, if additional factors can be introduced so that the decision is not one P would not have wished to make, why should the same approach not bite on the service providers, particularly if there are significant questions for example about the legality of the provider's decision? Why should P be forced,

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[164] [2013] UKSC 67.

[165] *ibid*, 18.

[166] *ibid*, 24.

[167] *ibid*, 18.

[168] [2017] UKSC 22.

[169] *ibid*, para 35.

but service providers not? Particularly when P's legal team will be acting on statutory best interests rather than on instructions, an approach which as noted above already favours the professionals, the law as we have received it is starting to look a great deal more controlling than enabling of P.

Does it matter why the service provider is declining to provide the service? In *N*, until the night before the first instance hearing, the CCG's position was simply that the care proposed was not in N's best interests. At 11.32 pm on the night before the hearing, the CCG introduced its position that the case should not proceed because the matters at issue 'were "not on the table" given that the CCG had said that it was not willing to allow or to arrange them, or to commission staff or to fund the necessary resources.'[170] It is fair to ask whether in at least some cases of this type, the public authority's funding decision would have been different if it had thought the service provision was in fact in P's best interests. If that is correct, then the debate would seem to be about P's best interests, and the proper place for that to be determined is the Court of Protection. If that is correct, the Court's decision does appear in such a case to render the service provider's view of what is in P's best interests unchallengeable. That would significantly undermine the utility and credibility of the MCA 2005, and risks marginalising P.

In practice, of course, decisions will rarely be so clear cut. The development of a service plan will involve a great deal more than just a consideration of P's best interests. For the CCG in *N*, for example, implementing that decision would also involve financial and staffing decisions (including both the provision of staff and the scheduling of staff), health and safety concerns, negotiation and liaison with the parents, and organising a range of practical details such as transportation for the home visits. These factors, it would seem, are why the Supreme Court ruled them out of the MCA 2005 remit:[171] on that analysis, these are public law decisions that should be dealt with, if at all, by judicial review. In developing the plan, however, the range of factors get considered as a package, and the role of best interests is likely to be difficult to disaggregate from the rest of that package. Creating jurisdictional dividing lines between MCA 2005 and other elements of that decision-making risks artificiality.[172]

The court's view seems based on the uncontroversial point that the MCA 2005 does not create rights to services that others in the community do not have. The inverse of this point must also be true, however: just because P lacks capacity, he or she must not lose rights to services possessed by others in the community. The Court seems content with that; there is no suggestion that N could not seek judicial review of the CCG's funding decision.

It is not clear how such a judicial review would work, however. In other cases of this sort, the applicant is either competent himself or herself, or is a person with decision-making authority over the relevant individual (for example the parent of an ill child). Either way, the court hearing an application for judicial review can be reasonably sure that, if the applicant is successful, the treatment would be consented to or the social service taken up: a decision for the claimant

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[170] *ibid*, 11.

[171] *ibid*, 36-37.

[172] See further Clough, n 8 above, particularly ch 5.

would have practical effect. Since the best interest determination takes the place of a capable decision by P, this cannot be assumed for a judicial review involving a person lacking capacity. The first question from the judge on such an application is likely to be whether, if the judicial review is successful, the treatment or service would be in P's best interests, and after *N*, the only answer counsel can honestly give is that this is as yet unknown. The judicial review court has case management powers very similar to those of the Court of Protection, and parallel to the decision in *N*, might well view the judicial review application as academic, and dismiss it accordingly. The result would be a catch-22: P cannot get judicial review because there is no best interests judgment, and cannot get the best interest judgment because there is no judicial review.

At the present time, the difficulty can be solved by P launching separate applications under the MCA 2005 and for judicial review, and applying to have the two cases heard together by a judge authorised to sit on in both the Court of Protection and the Administrative Court. However, that may change. As Baroness Hale notes,[173] the Care Act 2014 envisages formal tribunal appeals of local authority decisions on care services.[174] If that is brought into effect, differing membership rules would mean that the applications could not be joined: the adjudicators would be different. That is currently the position under the Children and Family Services Act 2014, an act which can provide services to people with special educational needs up to the age of twenty-five, so with concurrent jurisdiction to the MCA 2005 for people over sixteen. The relevant regulations give the appeal rights to the parent of young adult lacking capacity.[175] The relevant code of practice acknowledges the importance of the MCA 2005 within the decision-making process as to what services are to be offered,[176] but in the event that service provision is disputed, it is not clear how jurisdiction will work. Will the best interests elements be determined in the appeal before the tribunal (the forum in which the parent has authority under the regulation) or in a separate application to the Court of Protection (where best interests issues are meant to be determined)? The significant point for present purposes however is that the jurisdictional distinction is inherently problematic. If capacity law is to be integrated into service provision more generally, as the policy seems to be, it makes no sense to separate it out for purposes of court review.

As the court in *N* notes, the Law Commission took the view that mental capacity law should not challenge care planning by local authorities.[177] That is correct, but once again, times have moved on. The review structure in the early 1990s was relatively rudimentary: key cases in challenging failure to provide services such as *R (Barry)* v *Gloucestershire*[178] were still in the future. Whether *Barry* went far enough in protecting the rights of people requiring care was

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[173] n 168 above, 37.

[174] Care Act 2014, s 72. Not yet in force.

[175] The Special Educational Needs and Disability Regulations 2014, R 2014, No 1530, part 6.

[176] Department of Education and Department of Health, *Special educational needs and disability code of practice: 0 to 25 years* (London: Department of Education and Department of Health, 2015) ch 8 and appendix 1.

[177] Law Commission (1995), n 12 above, 8.19; cited in *N* v *A CCG* n 168 above, 30.

[178] [1997] 2 ALL ER 1 (HL).

contested at the time[179] and since,[180] but it did provide a firm foundation on which care decisions could be challenged.[181] Whether because of shortages of services (relevant to social housing, for example, and other services in times of restraint) or because of the same rearticulation of rights flowing from changes in the social view of people with disabilities, challenges to provision are now very much part of the social welfare context. DOLS (and soon LPS, with a broader reach than DOLS) are bringing service provision increasingly into the legal arena. Both the NHS and local authorities have established non-statutory complaint and appeals mechanisms to address grievances in service provision.[182] We are also increasingly in a world of guidance and league tables: policy documents from government, NICE, the NHS, Public Health England, or the CQC are rife, telling people what services they can expect and whether their hospital trust or care home is up to snuff. The official discourses are about what citizens can reasonably expect; it is unsurprising if they take legal action when those expectations are not met.[183]

The characterisation of the relationship between service providers and service users in health and social care law has also moved on. The general point is made expressly by the Supreme Court in *Montgomery* v *Lanarkshire Health Board*: 'One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services.'[184]

That is reflected in the provision of social care services, and health services to people with mental disabilities. The Care Act 2014 requires service providers to take account of the user's views, wishes, feelings and beliefs, and involve the user as far as possible in the decisions taken under the Act (with support if necessary).[185] This is entirely consistent with the discussion of best interests in the Mental Capacity Act Code of Practice,[186] which envisages the MCA 2005 and its best interests test as integral to all decision-making regarding people lacking capacity. Consistent with that, just as consultation with a competent patient is normally required prior to a do not resuscitate (DNR) order being put into place, so the best interests factors and consultation fulfill a similar role

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[179] See for example E. Palmer and M. Sunkin, 'Needs: Resources and Abhorrent Choices' (1998) 61 MLR 401.

[180] See for example dissenting judgment of Baroness Hale in *R (McDonald)* v *Kensington and Chelsea* [2011] UKSC 33 (*R (McDonald)*).

[181] For a recent application, see *R (on the application of Davey)* v *Oxfordshire County Council* [2017] EWCA Civ 1308. While unsuccessful in the result, the decision engages with the detail of the applicant's situation to a degree that would have been unthinkable thirty years ago.

[182] In 2018-19, the Local Government and Social Care Ombudsman dealt with 713 complaints (60 per cent upheld) regarding assessments and care planning, 568 (73 per cent upheld) regarding residential care provision, and 337 (72 per cent upheld) regarding home care provision: see Local Government and Social Care Ombudsman, Review of Adult Social Care Complaints 2018-2019 at https://www.lgo.org.uk/information-centre/reports/annual-review-reports/adult-social-care-reviews (last accessed 21 November 2021).

[183] See for example *R (Rose)* v *Thanet Clinical Commissioning Group* [2014] EWHC 1182.

[184] *Montgomery* v *Lanarkshire Health Board* [2015] UKSC 11, 75.

[185] Care Act 2014, s 1(3) and passim.

[186] n 38 above, ch 5.

for people without capacity.[187] There is a space and a need for the MCA 2005 to fulfil that sort of subjective role.

Just as the relevant ECHR jurisprudence regarding mental capacity law has been transforming since the Law Commission project, so it has on social welfare rights. In 1996, the ECtHR held that state disability pensions could be included in the protection of 'property' in ECHR Protocol 1, Article 1.[188] That jurisprudence applies only to financial benefits based on contributions, but in *Botta* v *Italy*, in 1998, the ECtHR held that Article 8 could impose positive obligations on states to adopt measures to secure respect for private life.[189] Enforced relocation because of closure of a care home,[190] and the indignity resulting from a failure to provide required assistance in using the toilet[191] have been held by the ECtHR to engage Article 8, for example, and it has been accepted by the Supreme Court that this can impose an obligation to provide community care services in some circumstances.[192] The state action will be consistent with the ECHR if it is proportionate to the attainment of a legitimate aim under Article 8(2), but that still leaves a good deal of scope for debate in individual cases.

In cases like *N*, courts are still trying to hold the line, but legal challenges to care provision seem the way of the future, in ways the Law Commission cannot have imagined. Whether that is desirable or not misses the point: the genie is unlikely to be pushed back into the bottle. If that is correct, a serious conversation needs to be had about the interface between those developments and mental capacity law.

The approach in *N* has its problems, but a combined forum that can deal with both the service provision questions and the mental capacity/best interests also raises difficulties. As discussed above, the formulation of service or treatment plans flows from a range of factors that merge into each other. If P is to be acknowledge as an autonomous or semi-autonomous agent, his or her decision (or the best interests determination that takes its place) warrant real and formal respect. At the same time, none of the discussion here will make the other real challenges faced by social services or the NHS go away – things such as budgets, administrative demands and staffing, as well as a range of less easily defined factors about what the professionals believe in good faith, rightly or wrongly, is best for P.[193] In that complex space, how do we ensure that P's will and preferences really will matter?[194]

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[187] *Winspear* v *City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB), 45-47.

[188] *Gaygusuz* v *Austria* App No 17371/90, judgment of 16 September 1996. For a summary of the development of that jurisprudence, see *Béláné Nagy* v *Hungary* App No 53080/13, judgment of 13 December 2016 (GC).

[189] (1998) 26 EHRR 241 at [33].

[190] *Watts* v *The United Kingdom* App No 53586/09, judgment of 4 May 2010.

[191] McDonald v *the United Kingdom* App No 4241/12, judgment of 20 August 2014. While Article 8 was engaged, on the facts there was held to be no violation.

[192] *R (McDonald)* n 180 above. Such an order was not made on the facts of the case.

[193] For a case where this proved particularly problematic, see *London Borough of Hillingdon* v *Neary* n 1 above.

[194] The difficulty here closely parallels those within shared decision-making systems in medicine, and in the 'recovery' movement, a movement originally intended to allow psychiatric service users to be more central to their care and treatment, but arguably co-opted and captured by professional cultures: see for example Barlott et al, 'Destabilising social inclusion and recovery,

One could expand potential compulsion to cover service providers, as it now covers P: if P can be forced to make decisions we have every reason to believe he or she would not make if competent, why should service providers not be subject to the same compulsion? This would allow the full range of issues to be considered by a court actually able to provide a meaningful remedy. In principle, there would be a logic to that, but it must have limitations. If a doctor is honestly and reasonably of the view that a drug will injure a patient, he or she must be able to refuse to give the patient the drug, whether the patient wants it or not. That said, it seems in practice unlikely that a court would require a doctor to do that, absent truly extraordinary circumstances. From the perspective of P, the greater risk is that care plans flow from administrative convenience rather than the real best interests of P.[195] In that event, the case for a system of greater compulsion on service providers seems a great deal more convincing. Applying such a system to specific factual contexts would no doubt prove challenging – decisions are complex – but courts are meant to be able to deal with complex factual situations. This might perhaps be a way forward?

The underlying question in much of this is how the agency of P is to fit into the planning and provision of care and services, a space increasingly occupied by diverse professionals, regulatory structures and administrative and judicial processes. None of this could reasonably have been foreseen by the Law Commission. It is clear though that the best interests approach as currently articulated in the MCA 2005 cannot really cope with the complexity of that changed and changing environment.

CONCLUSION: TOWARDS THE NEXT GENERATION OF LAW

The work of the Law Commission was impressive and laudatory. It fundamentally changed progressive thinking about mental capacity, and the MCA 2005 which eventually resulted from it remains far in advance of much of the comparable legislation internationally. Its work commenced more than thirty years ago, however, and it is fair to ask what we have learned, how has our thinking changed, what did we not see coming, and where should we take the next generation of thinking.

The context has fundamentally altered since the early 1990s. As discussed, the way we think about disability and about people with disability is unrecognisable relative to thirty years ago. Capacity no longer forms the neat dividing line between autonomous and non-autonomous self. The rise of the social model of disability means that we ask much more profound questions about how society is organised to create disablement, rather than placing disability uniquely as a limitation of and within the disabled person. The legal context is also different. The ECHR jurisprudence has changed beyond all recognition, both as regards capacity and as regards rights to welfare and social services, from what the Law

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and pursuing "lines of flight" in the mental health sector' (2020) 42 *Sociology of Health and Illness* 1328.

[195] See for example *Hillingdon* v *Neary* n 10 above.

Commission could have envisaged. And however one reads the CRPD, it is the clearest of markers that things really have changed.

Some of the subsequent events might have been foreseen thirty years ago, but were not. The Court of Protection is behaving very much as a court. It is hard to criticise that – it is what the Law Commission asked for. The Law Commission however anticipated a place in which P's voice would routinely be heard, a place of simple processes and informality. That is not what has happened. The Court of Protection is a place of legal argument by barristers, buttressed by testimony of experts. That has its advantages – the legal standard of decision-making is by and large very good – but it becomes hard to map onto the decision- and time-specific framework of the MCA 2005, and the expectation that P would be involved in decision-making.

As far as one can tell, usage of the MCA 2005 divides into two categories. There is the army of private decision-makers appointed through LPAs, where the objective would seem to be to fence out state intervention. It is not really clear how far the holders of those documents, like the private carers who continue to make ad hoc care decisions for their family members, are aware of the requirements of the MCA 2005. The best guess seems to be that their knowledge and overt compliance is at best limited. There is a salient reminder here: however law is taken forward in this area, implementation in society broadly poses administrative challenges. Care decisions within families are cultural, and cultures can be hard to shift.

The second set of users are professionals, using the MCA 2005 to regularise provision of a care plan that may or may not include P's deprivation of liberty. Best practice is to include MCA 2005 factors at all stages of care, from planning to execution, but the jurisprudence has emphasised a divide in judicial oversight that is problematic. Following *N*, once the plan has been developed, there may be few (if any) alternatives available at the time the MCA 2005 come to judicial notice. If the MCA 2005 is going to bring much by way of empowerment of P in these cases, that division needs to be re-thought.

Some of these problems are endemic. The matters at issue do engage the rights of P, and as such must be subject to court oversight. The problems described in this paper that flow from court processes will continue, whatever system of law is adopted in the future. Problems of P's representation, procedural complexities, and the difficulties of delay are not going anywhere.

As we turn to the future, some fundamental questions will need to be revisited. Is capacity the gateway concept we want to use? On one hand, it does have some common cultural understanding, and if one is in fact taken to have capacity, it does provide a real bulwark against unwanted intrusions. On the other, as discussed here and elsewhere, it does seem to impose a rigid line in sets of facts that may much better be understood in shades of gray. Would we be better starting with a different framework, such as 'vulnerability'?[196] While this can provide a more multi-faceted analytic structure, its purview is unclear – it may

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[196] See B. Clough, 'Disability and Vulnerability: Challenging the Capacity/Incapacity Binary' (2017) 16 *Social Policy & Society* 469.

mean whatever the speaker wants it to mean, and in a system that determines rights, that is problematic.

If the system is triggered, how are decisions to be taken? Should they reflect the decision P would have made (and if so, how is that to be determined)? If a decision is reached which P would not have reached, presumably on the basis that leads to a better result for P, should there be a corresponding flexibility in the system to enforce decisions onto providers that they would not have wished to make? Otherwise, does this become simply a statute by which people with disabilities are controlled – a result that would be difficult to defend in the new social and political climate articulated above. And how, in all of this, are decisions to be linked to care planning, since if P's involvement is really going to be meaningful, it is going to need to happen at that stage?

Thirty years on, it is time for a rethink. The MCA 2005 was world-leading in its time, and we should reflect on it, build on its strengths, and learn from our experience of its implementation. But a lot of water has flowed under a lot of bridges since the intellectual heavy lifting of the Law Commission. We need to take that into account too.