Written Evidence NI Mental Capacity Bill

Introduction

1. This written evidence is to be read in conjunction with:

    a. The oral evidence I gave on 29 June 2015;

    b. The article "*More presumptions please? Wishes, feelings and best interests decision-making*" referred to in that evidence and submitted subsequently to the clerk to the Ad Hoc Committee;

    c. The joint paper with Professor Wayne Martin provided to the Ad Hoc Committee on 29 June 2015 suggesting amendments to certain clauses of the Bill.

2. I do not duplicate those materials. I emphasise at the outset that this evidence is focused primarily upon those aspects of the Bill concerned with mental capacity. I also emphasise that I consider that the Bill provides an important opportunity for the Northern Ireland Assembly to build upon lessons learned from experiences in other parts of the United Kingdom, and to seek to move towards compliance with the United Nations Convention on the Rights of Persons with Disabilities ('the CPRD').

The capacity test: clauses 3-5 (and clauses 13-14)

3. The NI Bill's definition of mental incapacity is found in clause 3. For comparison, I reproduce the material part of s.2 of the English Mental Capacity Act 2005 ('MCA 2005') alongside it:

NI Bill	MCA 2005
3. 1) For the purposes of this Act, a person who is 16 or over lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself about the matter (within the meaning given by section 4) because of an impairment of, or a disturbance in the functioning of, the mind or brain.	2. 1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. 2) It does not matter whether the impairment or disturbance is permanent

2) It does not matter— (a) whether the impairment or disturbance is permanent or temporary; (b) what the cause of the impairment or disturbance is. 3) In particular, it does not matter whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disorder or disability.	or temporary. 3) A lack of capacity cannot be established merely by reference to— (a) a person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity. […]

4. It will be seen that clause 3(1) of the NI Bill is materially identical to s.2(1) of the MCA 2005. Although clause 4 of the NI Bill (the equivalent of s.3 MCA 2005), defining inability to make a decision is slightly different.[1]

5. However, the NI Bill differs in making it clear that, whilst the inability to make a decision must be because of an impairment of or disturbance in the functioning of the mind or brain, the <u>cause</u> of that impairment/disturbance is irrelevant, and, in particular, whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disability. There is also no equivalent of s.2(3) MCA 2005.

6. In my view, the NI Bill moves closer to compliance with the CRPD than the MCA 2005 by making clear that incapacity can arise for reasons other than a disorder or disability.

7. However, because there remains a diagnostic element to the capacity test (in contradistinction to the purely functional test adopted by – e.g. the Assisted Decision-Making (Capacity) Bill)[2] – it seems to me that the Northern Irish Bill is still vulnerable to

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[1] Putting aside stylistic difference, the most important differences are

1. in relation to clause 4(c), which provides that a person will be considered to be unable to make a decision for him or herself if he/she "is not able <u>to appreciate the relevance of that information and</u> to use and weigh that information as part of the process of making that decision." These words do not appear in s.3(1)(c) MCA 2005.
2. There is no equivalent to s.3(3) MCA 2005, which provides that the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make that decision.

I do not address either of these differences further here, save to note that it is not instantly obvious what improvement the failure to reproduce s.3(3) MCA 2005 brings to the MCA 2005.

[2] See clause 3 of the version available on the internet as at June 2015.

3.

(1) Subject to subsections (2) to (6), for the purposes of this Act (including for the purposes of creating a decision-making assistance agreement, co-decision-making agreement or

a challenge that it indirectly discriminates against those with a disability. That challenge is essentially as formulated in the Essex Autonomy Project's Report *Achieving UNCRPD Compliance*[3] ('the EAP report'), and I do not replicate it here. If we are into indirect discrimination territory then, for essentially the same reasons as identified by the EAP in relation to the MCA 2005, it is arguable that the retention of even a watered down diagnostic threshold renders the Bill non-compliant with the CPRD.

8. It is important to note that the NI Bill goes very much further than (and in my view is a substantial improvement on) the MCA 2005 and, indeed, the AWI in terms of the requirements to ensure that support is given to a person to enable them to make a decision (clause 5; see also clauses 13 and 14 in relation to a formal capacity assessment in relation to serious interventions, clause 14 (3)(d) requiring the statement of incapacity to identify "any help or support that has been given to P, without success, to enable P to make a decision in relation to the matter"). Professor Martin and I have identified further amendments that would secure further the ability of the person whose capacity is in question to provide who is (and importantly is not) to be at that assessment; they were discussed in the oral evidence session, and are addressed further in Professor Martin's written evidence.

9. However, even those steps would not suffice to cure the incompatibility with the CRPD identified above, because that incompatibility is rooted in the very definition of capacity contained in the Bill.

10. Finally, I should emphasise that from my perspective there is a <u>very</u> large question about whether a move to a purely functional test for mental capacity (or decision-making capacity) is desirable in policy terms. Most obviously, it has the potential effect of dramatically widening the scope of those who could be 'caught' by the capacity net to include those who are vulnerable by virtue of the influence of others (in English terms, it would lead to a complete conflation of the jurisdiction of the Court of Protection and the

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enduring power of attorney), a person's capacity shall be assessed on the basis of his or her ability to understand the nature and consequences of a decision to be made by him or her in the context of the available choices at the time the decision is made.

(2) A person lacks the capacity to make a decision if he or she is unable –
  (a) to understand the information relevant to the decision,
  (b) to retain that information,
  (c) to use or weigh that information as part of the process of making the decision, or
  (d) *to communicate his or her decision (whether by talking, writing, using sign language, assisted technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party.*

[3] http://autonomy.essex.ac.uk/uncrpd-report. I was a participant in the roundtable meetings; the views expressed in the report are those of the authors of the report. I am, however, entirely happy to associate myself with its conclusions on this particular aspsect.

inherent jurisdiction of the High Court to protect vulnerable but capacitous adults confirmed in *Re L (Vulnerable Adults with Capacity: Court's Jurisdiction)* [2013] Fam 1). It is important to recognise in this regard that this would enable decisions to be made on behalf of such individuals potentially against their will (the inherent jurisdiction of the High Court being generally recognised as to be deployed in a 'facilitative rather than dictatorial' fashion so as to secure their ability to make their own decisions). However, viewed strictly through the prism of compliance with the CRPD, there must be a question-mark over whether clause 2 goes far enough to overcome the difficulties identified with the MCA 2005.

Best interests: clause 7 (and clause 9)

11. I note immediately that, if one was being uncharitable, one might describe the decision to use the term 'best interests' as one that may cause unnecessary complications vis-à-vis the Committee on the Rights of Persons with Disabilities. The approach adopted both in Scotland (s.1(1) AWI and in the Irish Bill (clause 8) is one based upon interventions in respect of an adult, and both of these (the former presciently and the latter no doubt deliberately) do not use the phrase.

12. However, if it can be shown that the <u>substance</u> rather than the form of the decision-making process provides for any decisions to be taken by a substitute decision-maker appropriately to respect to the rights, will and preference of the person concerned, then it seems to me that there is a proper argument that the use of the term is not fatal here as regards compliance with the CRPD. In the amendments suggested by Professor Martin and I, we seek to 'beef up' the provisions in clause 7 (as further amplified by clause 9) so as to better to secure respect for the person's will and preferences. I do not address these further here.

Deprivation of liberty: clause 24

13. Two issues arise in relation to clause 24, which I touched upon in my oral evidence.

14. The first is the extent to which the Bill as currently drafted complies with Article 5(1)(e) of the ECHR. For my part, I have some doubts as to whether it can automatically be assumed (as it appears the draftsman does) that a person who lacks capacity for purposes of clause 2 would be said to be 'of unsound mind' for purposes of Article 5(1)(e) ECHR. The European Court of Human Rights have made clear that they consider unsoundness of mind to equate to the presence of a mental disorder, which must be capable of verification

by objective medical evidence (*Winterwerp v Netherlands* (1979) 2 EHRR 387). In the context of the English legislation, a deprivation of liberty that is to be authorised under the administrative route provided by Schedule A1 to the MCA 2005 (the so-called 'DOLS') requires that the individual in question both lack capacity to take the decision whether to be accommodated at the care home or hospital for purposes of receiving the relevant care and treatment and have a mental disorder falling within the scope of the English Mental Health Act 1983. As the Code of Practice to Schedule A1 makes clear (at paragraph 4.34):

> *A distinction can be drawn between the mental health assessment and the mental capacity assessment:*
>
> - *Although a person must have an impairment or disturbance of the functioning of the mind or brain in order to lack capacity, it does not follow that they automatically have a mental disorder within the meaning of the Mental Health Act 1983.*
> - *The objective of the mental health assessment is to ensure that the person is medically diagnosed as being of 'unsound mind' and so comes within the scope of Article 5 of the European Convention on Human Rights.*

15. An example where a person might lack the relevant decision-making capacity but not satisfy the requirement of being of unsound mind is where they are under the influence of drugs or alcohol. A stroke could also render a person without capacity to make decisions, but (unless accompanied by psychological consequences) would not constitute unsoundness of mind (and 'stroke' is not included in either of the standard diagnostic manuals for psychiatric disorder: DSM IV or ICD 10). Similarly, 'locked-in syndrome' would render a person unable to communicate (and therefore deemed to lack capacity) but would not constitute a recognised psychiatric disorder.

16. In *Re X* [2014] EWCOP 25, the President of the Court of Protection held that, in any case where the Court of Protection is asked to authorise the deprivation of liberty of an individual (no matter the setting):

> *14.Compliance with the three Winterwerp [Winterwerp v Netherlands (1979) 2 EHRR 387] requirements is essential to ensure compliance with Article 5: (i) medical evidence establishing unsoundness of mind, (ii) of a*

> *kind warranting the proposed measures and (iii) persisting at the time when the decision is taken.*[4]

17. I would therefore suggest that the Bill must be amended so as to make clear that a person can only be deprived of their liberty if they are of unsound mind (and there is proper evidence of such unsoundness).

18. This amendment would, however, put the Bill into stark non-compliance with Article 14 of the CRPD which, in the view of the Committee on the Rights of Persons with Disabilities[5] provides (materially) for:

> *(1) The absolute prohibition of detention on the basis of disability. There are still practices in which state parties allow for the deprivation of liberty on the grounds of actual or perceived disability. In this regard the Committee has established that article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived disability. However, legislation of several states party, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived disability, provided there are other reasons for their detention, including that they are dangerous to themselves or to others. This practice is incompatible with article 14 as interpreted by the jurisprudence of the CRPD committee.*
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> *(2) Mental health laws that authorize detention of persons with disabilities based on the alleged danger of persons for themselves or for others. Through all the reviews of state party reports the Committee has established that it is contrary to article 14 to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or to others. The involuntary detention of persons with disabilities based on presumptions of risk or dangerousness tied to disability labels is contrary to the right to liberty. For example, it is wrong to detain someone just because they are diagnosed with paranoid schizophrenia.*
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> *(3) Detention of persons unfit to plead in criminal justice systems. The committee has established that declarations of unfitness to stand trial and the detention of persons based on that declaration is contrary to article 14 of the convention since it deprives the person of his or her right to due process and safeguards that are applicable to every defendant.*

19. Which is to take precedence as regards the obligations of the United Kingdom generally is a question of some importance, but from a strictly Northern Irish perspective the requirement that legislation passed by the Assembly complies with the ECHR would seem to dictate that the priority must be to achieve compliance with Article 5(1)(e).

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[4] The Court of Appeal held subsequently that the President's judgment was procedurally improper and therefore of no binding effect. However, no party to the appeal to the Court of Appeal or the Court of Appeal cast doubt upon these observations.

[5] Statement on article 14 of the Convention on the Rights of Persons with Disabilities (September 2014): http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E

Those under 16

20. The Committee in the evidence session on 29 June raised the issue of whether the provisions of the Bill should not apply to those under 16. There are undoubtedly arguments in favour of an approach that does not discriminate between those under and over the age of 16. However, for my part, it seems to me that one runs into a number of very profound difficulties seeking to untangle in the case of younger children whether an inability to make a decision is on the basis of a lack of capacity or on the basis simply of their (relative) stage of development.[6] The law has traditionally alighted upon the age of 16 as the age at which society assumes that a child has competence to make decisions as to their medical treatment,[7] and that principle is also enshrined in the MCA 2005 by its application to those aged 16 or above.

21. It is perhaps in this regard worth noting that the CRPD also draws a distinction between children and adults with disabilities. Indeed, in relation to children (and in stark contrast to the position in relation to adults), best interests must be "a primary consideration" in all actions concerning children with disabilities.[8]

22. None of the foregoing is intended to suggest that steps should not be taken to secure by way of amendments to the Mental Health Order that decisions as to mental health care and treatment is provided to those under 16 in a way that mirrors so far as possible the way that provided for in relation to those above 16, and in particular so as to secure their participation in decision-making to the maximum extent possible.

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4 July 2015

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[6] I note in passing that if one removed the diagnostic element from the capacity test, it would be easier to conceptualise a model that applied no matter the age of the child or young person. Query, though, whether this might not inadvertently lead to the perpetuation of the myth that adults who have impaired capacity are not simply 'big children.'

[7] Section 8 Family Law Reform Act 1969 provides that "[t]he consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, should be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

[8] Article 7 CRPD.

More presumptions please? Wishes, feelings and best interests decision-making

Introduction

As the UN Convention on the Rights of Persons with Disabilities (CRPD) gains impetus, questions are increasingly being raised over the extent to which the Mental Capacity Act (MCA) complies with its key tenets. In one key regard this is especially true. Article 12(4) CRPD dictates that the "rights, will and preference" of the individual must be respected in any measures relating to the exercise of legal capacity. As set out below, what 'respect' means in this regard is hotly contested, but the working presumption is the MCA as worded fails to afford it.

In this article, though, we suggest that the way the MCA is being applied in the Court of Protection does go some significant way towards providing CRPD-compliant model of best interests decision-making (even if, for the most part, this is unacknowledged by the judges themselves). Put another way, it may be that we can, in fact, already discern from the case-law an understanding of what 'respect' might look like. Importantly, we will also suggest that approach is one that is already mandated by Article 8 of the European Convention on Human Rights (ECHR), much more familiar territory for most lawyers and judges.

We readily acknowledge at the outset that this is a very modest contribution to a debate commenced by others, even prior to the current focus on the CRPD. Two examples we would note, in particular, are the seminal article by Jonathan Herring entitled *Losing It? Losing What? The Law and Dementia* (Child and Family Law Quarterly, Vol. 21, Issue 1 (2009), pp. 3-29), and the work of Mary Donnelly (see in particular *Healthcare Decision-Making and the Law* (Cambridge University Press, 2010). We hope, though, that it is a contribution that may help bring some of the more theoretical discussions into the court room.

Background

The MCA was the result of many years of dedicated reform effort, commencing with a Law Commission Consultation Paper in 1991. While the need to have a mechanism in place to make decisions on behalf of those lacking the cognitive capabilities to do so was not seriously under debate (the wisdom of substituted decision-making was scarcely questioned until the paradigmatic shift brought about by the CRPD), the basis on which such decisions were to be made was less clear. Drawing on the frameworks in place in other jurisdictions and under the pre-existing common law, two alternative mechanisms were suggested to facilitate the making of these decisions. Substituted judgment (or surrogate decision-making) attempts to reach the decision which the person would themselves have made if they had capacity. The alternative is an objective assessment of what is in their 'best interests'. While the 'best interests' assessment had dominated healthcare decisions since the decision of *Re F: (An Adult: Sterilisation)* [1990] 2 A.C. 1, it may be noted that in at least one domain, that of statutory wills, the status quo prior to the MCA was one of substituted judgment, whereby the judge was required to consider the "antipathies" and "affections" of the particular person concerned (*Re D(J)* [1982] Ch 237).

After much consultation, it was the objective mechanism that found favour with the Law Commission, who highlighted the difficulties posed by substituted judgment when making decisions for those who have never had capacity (*Mental Incapacity*, Law Com No 231 (HMSO, 1995), 3. 25), as well as the effect it had of giving a lower priority to the person's present emotions than those anticipated in the person had they had unimpaired capacities (3.29).

The result of this long drafting process was (for these purposes) ss.1(5) and 4 MCA 2005 which provide – in combination – the requirement that decisions should be made in the person's 'best interests', taking into account a number of relevant factors. Crucially, under s4(6), the decision-maker must, 'so far as is reasonably ascertainable', consider:

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by her when she had capacity),
(b) the beliefs and values that would be likely to influence his decision if she had capacity, and
(c) the other factors that she would be likely to consider if she were able to do so.

Section 4(6) is only one of the list of factors in the 'checklist,' however. In addition, the decision cannot be made merely on the basis of the age or appearance of the person lacking capacity (s4(2)); the likelihood of the person regaining capacity must be considered (s4(3)); and the individual must, as far as is reasonably practicable, be permitted and encouraged to participate in the decision (s4(4)). The decision-maker must never be motivated by a desire to bring about death (s4(5)), and must take account 'if it is practicable and appropriate to consult them', the views of others engaged in the care of the person, or interested in their welfare (s4(7)).

On the face of the statute, no one of these factors is to take priority, indeed, the Report of the Joint Committee on the Draft Mental Incapacity Bill (HL 189-1, HC 1083-1 (TSO, 2003)) was clear that this was deliberate: determining the best interests of the individual "required flexibility" best achieved by "enabling the decision-maker to take account of a variety of circumstances, views and attitudes which may have a bearing on the decision in question." It was for this reason that they did not recommend any weighting or giving priority to the factors involved in determining best interests. [89] In a similar vein, as the Government identified, there was a deliberate policy decision that "a prioritisation of the factors would unnecessarily fetter their operation in the many and varied circumstances in which they might fall to be applied" (Government Response to the Scrutiny Committee's Report on the Draft Mental Incapacity Bill (February 2004) Cm 6121).

This approach was carried through into the Code of Practice accompanying the MCA. While the individual's wishes and feelings, beliefs and values "should be taken fully into account", they will "not necessarily be the deciding factor" (paragraph 5.38).

Notwithstanding the Law Commission's insistence that, "the two tests need not be mutually exclusive", instead pushing for a compromise "whereby a best interests test is modified by a requirement that the substitute decision-maker first goes through an exercise in substituted judgment" (*Mental Incapacitated Adults and Decision-Making: A New Jurisdiction*, Law Com No 128 (HMSO, 1993), 2.4), the approach adopted in the MCA did, in the view of Lewison J, 'mark a radical change in the treatment of persons lacking capacity' (*Re P* (*Statutory Will*) [2010] Ch 33, [2009] COPLR Con Vol 906, at para 36).

Such a change was not unanimously accepted – indeed, that approach was heavily criticised by the Scottish Law Commission as not giving "due weight to the views of the adult, particularly to wishes and feeling which he or she had expressed while capable of doing so" (Report on Incapable Adults, Scottish Law Commission Report No. 151 (1995), 2.50), and the Adults with Incapacity (Scotland) Act 2000 was very deliberately framed around the principles of benefit, not best interests.

The court record may however demonstrate this concern should be seen as more theoretical than real.

The case-law evolution

Given the decision not to prioritise any of the factors in s.4, it is of little surprise that the case-law on the relative weight that should be ascribed to a person's wishes and feelings superficially lacks coherence.

We suggest, however, that a dialogue can be seen emerging in the case-law between two lines of thought: on the one hand that a rebuttable presumption exists in favour of giving effect to a person's wishes and feelings; and on the other that the individual's wishes and feelings represent just one factor in the balance sheet which should not receive special consideration.

This dialogue found its roots in *Re S and S (Protected Persons), C v V* ([2009] W.T.L.R. 315, [2008] COPLR Con Vol 1074) where talk of 'presumptions' first emerged. HHJ Marshall QC forcefully remarked:

> '… where P can and does express a wish or view which is not irrational (in the sense of being a wish which a person with full capacity might reasonably have), is not impracticable as far as its physical implementation is concerned, and is not irresponsible having regard to the extent of P's resources (ie whether a responsible person of full capacity who had such resources might reasonably consider it worth using the necessary resources to implement his wish) then that situation carries great weight, and effectively gives rise to a presumption in favour of implementing those wishes, unless there is some potential sufficiently detrimental effect for P of doing so which outweighs this.'[57]

It would, in HHJ Marshall's view, take significant detriment to P to be sufficient to outweigh the 'sense of impotence' and 'frustration' of having one's wishes overruled. [58]

> "What, after all, is the point of taking great trouble to ascertain or deduce P's views, and to encourage P to be involved in the decision making process, unless the objective is to try to achieve the outcome which P wants or prefers, even if he does not have the capacity to achieve it for himself?" [55]

HHJ Marshall's conclusions at paragraph 57 could be criticised for the apparent ease with which the presumption she identified could be rebutted on grounds reflecting the concerns of others. However, her approach nonetheless represented a serious attempt to grapple with the balance between empowerment and protection contained in the MCA. As she noted, the empowering ethos underlies much of the Act, including the presumption of capacity in s1(2); the duty to support the person in making their own decision (s1(3)); and the duty on the decision maker to involve the individual in decisions (s4(4)). We will return to HHJ Marshall's judgment in our concluding section.

The approach espoused by HHJ Marshall was however, short-lived. No sooner had the judgment been handed down in *Re S and S,* than Lewison J responded in *Re P* ([2009] EWHC 163 (Ch), [2009] COPLR Con Vol 906), that HHJ Marshall 'may have slightly overstated the importance to be given to P's wishes' [41]. Lewison's approach found favour with Munby J in *Re M (Statutory Will), ITW v Z and others* ([2009] EWHC 2525 (Fam), [2009] COPLR Con Vol 828) the latter specifically endorsing the 'compelling force' of the judgment at [28]. Relying on the drafting of the Act, Munby J was clear that: "[t]he statute lays down no hierarchy as between the various factors which have to be borne in mind" [32], and while "P's wishes and feelings will always be a significant factor to which the court must pay close regard", "the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific" [35]. Munby J indicated that the important considerations in determining the weight to be ascribed to the wishes and feelings of the individual were:

> "a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings…
> b) the strength and consistency of the views being expressed by P;
> c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to;
> d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and
> e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests."

The case law that follows is largely characterised by a dialogue between these two competing views: while *VAC v JAD & Ors* [2010] EWHC 2159 (Ch) and *NT v FS and others* ([2013] EWHC 684, [2013] COPLR 313) faithfully reiterate the words of Munby J in *ITW,* giving no especial weight to the person's own wishes, other judgments are more sympathetic in this regard. *Re G(TJ)* ([2010] EWHC 3005 (COP), [2010] COPLR Con Vol 403) is a powerful example. Drawing on the previous case law, and the work of the Law Commission pre-MCA, Mr Justice Morgan concluded that the best interests assessment *can* encompass substituted judgment, and absent any countervailing factors, respect for what the Court can identify to have been P's wishes *can* define what would be in her best interests. While the "court is not obliged to give effect to the decision which P would have arrived at" [37], they are obliged to consider it, and it may be that it is in the best interests of P for the court to give effect to the wishes which P would have formed on the relevant point, if he had capacity. While talk of 'presumptions' is notably absent, the approach initially espoused by HHJ Marshall certainly seems to underpin the general tenor of the judgment.

It was against this backdrop, that the MCA first came before the Supreme Court in *Aintree University Hospital NHS Foundation Trust v James* ([2013] 3 WLR 1299,

[2013] COPLR 492). A crucial decision in many respects, the scrutiny given to the MCA has, we suggest, redefined the role of wishes and feels in the best interests calculation. The purpose of the best interests test was, in the view of Lady Hale, ‘to consider matters from the patient’s point of view’:

> “Insofar as it is possible to ascertain the patient’s wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.” [45]

In placing the emphasis on the patient’s <u>own</u> views, and by stressing the importance of considering decisions from the perspective of the individual concerned, the Supreme Court lent powerful support to the view of HHJ Marshall in *Re S and S,* and more recently, Morgan J in *Re G(TJ).* It confirmed the place of the individual at the centre of the assessment, recognising the subjectivity that any assessment of an individual’s best interests much inevitably entail.

At almost exactly the same time as the judgment in *Aintree* was handed down, an almost quintessentially ‘*Aintree*-compliant’ judgment was given in *Re M (Best Interests: Deprivation of Liberty)* ([2013] EWHC 3456 (COP), [2014] COPLR 35), where Peter Jackson J had to decide whether it was in the interests of the individual to be forced to reside in a care home against her wishes to return home, in order to ensure the management of her diabetes. In deciding that she should be entitled to return home, Peter Jackson J acknowledged that “the court must surely have regard to the person's own assessment of her quality of life”, rather than tirelessly striving to prolong life at all costs (see paragraph [38]).

Re M is not alone in this regard. Decisions in *Westminster City Council v Sykes* [2014] EWCOP B9, and *Newcastle-upon-Tyne Foundation Trust v LM* [2014] EWHC 454 (COP) show the individual increasingly taking centre stage in determinations about their best interests. Hayden J’s scrupulous search to identify the wishes and feelings that the individual would have had as to the continuation of artificial nutrition and hydration (ANH) in *Sheffield Teaching Hospitals NHS Foundation Trust v TH & Anor* [2014] EWCOP 4 was remarkable. No less remarkable was the criticism in the same case of the approach of the Official Solicitor. Hayden J felt constrained to record that “the Official Solicitor’s lawyers appear not to share my analysis of the cogency and strength of TH's wishes regarding his treatment”:

> “54 [..] I confess that I have found this surprising. If I may say so, they have not absorbed the full force of Baroness Hale's judgment in Aintree and the emphasis placed on a 'holistic' evaluation when assessing both 'wishes and feelings' and 'best interests'. They have, in my view, whilst providing great assistance to this court in ensuring that it has the best available medical evidence before it, focused in a rather concrete manner on individual sentences or remarks. To regard the evidence I have heard as merely indicating that TH does not like hospitals as was submitted, simply does not do justice to the subtlety, ambit and integrity of the evidence which, in my judgment, has clearly illuminated TH's wishes and feelings in the way I have set out.

Hayden J concluded his judgment by making the important point that:

> 55. […] whatever the ultimate weight to be given to TH's views it is important to be rigorous and scrupulous in seeking them out. In due course the clarity, cogency and force that they are found to have will have a direct impact on the weight they are to be given. 'Wishes' and 'best interests' should never be conflated, they are entirely separate matters which may ultimately weigh on different sides of the balance sheet."

Although, as Hayden J – entirely properly – indicated in *TH*, wishes and best interests are not synonyms, we would suggest that it would be quite possible to contend that the courts are increasingly narrowing the distinction (or, putting it another way, moving towards substituted judgment).

The recent decision of Pauffley J in *United Lincolnshire NHS Trust v N* ([2014] EWCOP 16, [2014] COPLR 660), and its striking contrast to the approach previously adopted by Baker J in the case of *W v M* ([2011] EWHC 2443 (Fam), [2012] COPLR 222), encapsulates this shift in attitude. Both cases concerned the continued treatment of patients in a Minimally Conscious State (MCS). Whilst there are grounds to distinguish the two, in both the ultimate question was the same, namely whether the continued provision of ANH was in the patient's best interests. In *W v M*, Baker J held that the 'conventional' balance sheet should be applied to determining where a patient's best interests lay in continuing life-sustaining treatment. Despite accepting evidence from her family that she would not wish to live like that, even having been presented with details of a specific incident where M expressed views to the effect that it would be "better to let Tony Bland die", Baker J ultimately concluded that "it would in my judgment be wrong to attach significant weight to those statements made prior to her collapse". As there was no evidence that she had specifically considered the question of withdrawal of ANH, or the continuance of treatment when in an MCS, the sanctity of life should prevail [249].

It is not clear that N's comments in *United Lincolnshire* were any more carefully considered than those of M when it came to determining what she would have wanted in the position she now found herself. The evidence, centering around a single conversation N was reported by her daughter to have had had with a friend, where both professed they would not wish to live with a reduced capacity if they were involved in a car accident, was scarcely more convincing, yet Pauffley J appeared to accord much greater weight to it than Baker J was prepared to do. While setting out the strong presumption in favour of life that *W v M* adhered to, she went on to draw heavily from the judgment of Lady Hale in *Aintree,* highlighting the need for the court to "put themselves in the place of the individual patient and ask what his attitude is or would be likely to be". For all that she followed the balance sheet approach of *W v M*, her approach was markedly different: even in the absence of an applicable advanced decision, "what the views of the patient might be, and what the views of the family are, are highly material factors when considering best interests, although not determinative" [58], drawing on the dicta of Waller LJ in the pre-MCA authority of *An NHS Trust v (1) A and (2) SA* [2006] LS Law Medical 29. In the circumstances, Pauffley J was "utterly convinced" [66] that continued treatment would not be in her best interests, and accordingly sanctioned not only the decision not to seek to restart ANH, but also the withdrawal of intravenous fluids and dextrose.

We could give further examples where courts have sought loyally to put themselves in the shoes of P – that of Cobb J in *An NHS Trust v Ms X* [2014] EWCOP 35, [2015] COPR 11 – being one (see paragraphs 58 and 59). However, we must certainly acknowledge that there are clearly outliers to the trend identified above. In *The Mental Health Trust & Ors v DD & Anor (No 1)* [2014] EWCOP 11, for instance, Cobb J was forced to decide whether to accede to DD's wishes and allow for a home birth without social or health care assistance, despite an 'extraordinary and complex' obstetric history including three caesarean sections and thrombo-embolic disease. Having adopted the approach of Hayden J in *Sheffield Teaching Hospital NHS Trust,* and quoted extensively from *Aintree,* Cobb J nonetheless held that "while giving due weight to her wishes, and her fundamental rights… I nonetheless come to the clear conclusion that it would be in her best interests that she should be delivered of her baby by caesarean section." Cobb J in subsequent judgments (the last being [2015] EWCOP 4), authorised a series of increasingly draconian measures including, ultimately, forced sterilisation of DD.

Cobb J in DD's case was confronted with a series of dilemmas that we would suggest would sorely tax the Committee on the Rights of Persons with Disabilities (the CPRD being noted in passing in his judgment, but not addressed directly by him, being an unincorporated international instrument with no direct effect [2015] EWCOP 4 at [102]). His analysis can be criticised in many ways, but not – we suggest – for its lack of rigour.

We perhaps cannot be so charitable about the other major outlier, *RB v Brighton and Hove Council* [2014] EWCA Civ 561. The case concerned – in form – a challenge to a standard authorisation under Schedule A1 granted in favour of a man in a care home who wished to leave to resume independent living, and, in particular to continue drinking. In substance, it concerned the question of the justification for preventing an individual continuing to live in the same fashion that they had prior to any doubts being raised as to their capacity, in circumstances where it was clear that his wishes remained entirely consistent pre- and post- the contended loss of capacity to make the decision.

The Court of Appeal's analysis of the place of RB's wishes and feelings was scant in the extreme:

> "The MCA section 4(6)(a) requires both the Council and the court to take those wishes into account. I do so. Unfortunately it is not possible for the time being to comply with those wishes." [81]

Their analysis as to the balance between protection and empowerment in the Act was even shorter:

> "Without proper safeguards a regime of compulsory detention for medical purposes would be unacceptable, indeed Orwellian. However, the carefully drawn provisions of the MCA together with the reviewing function of the court ensure that the power to detain is not misused. <u>In the present case deprivation of liberty is necessary in order to protect RB from seriously injuring himself. That must be in his best interests</u>." [83].

It will, of course, be the case that judges to some extent reverse-engineer the weight to be placed on wishes and feelings depending on what may result. They are, after all, only human: while the judge may comfortably hand back the decision over where to reside to the incapacitated individual, a potentially self-destructive choice – especially one that may involve more than one life (as in *DD*) may lie less comfortably within a moral framework that will be acceptable to most judges. The decision in *RB v Brighton and Hove Council* however, remains hard to explain, and we await with very considerable interest the views of the Strasbourg court upon the application outstanding to that court on RB's behalf.

Although we accept that some may consider that we are seeking to impose an artificial coherence upon case law (and there will always be anomalies), we suggest that a trend is readily discernible: greater emphasis is undoubtedly being given to identifying the wishes and feelings of the individuals concerned (in particular those wishes identified prior to the loss of capacity); these wishes are taking on a much higher priority in the assessment of the best interest; and clear and convincing justification is required before they are departed from.

Nowhere is this perhaps more evident than the recent decision in *Re DT* [2015] EWCOP 10, where the Public Guardian sought to remove DT's sons as his EPA's, against his express wish to retain them as attorneys. Senior Judge Lush felt little hesitation in allowing himself to be reminded of the presumption set out by Judge Marshall in *Re S and S* (making no reference to Lewison J's qualification in *Re P,* or the subsequent decision of Munby J in *ITW*). In the absence of anything "irrational, impracticable or irresponsible in DT's wish that his sons should continue to act as his attorneys", Senior Judge Lush found, there was nothing to "justify overriding his wishes."[46]

Where are we going from here?

This is not the place to engage in a detailed discussion of the requirements of the CRPD (ably covered by Lucy Series in *Comparing Old and New Paradigms of Legal Capacity* [2014] Eld LJ 62). As noted at the outset, one particular flashpoint however, is as to the meaning of the requirement in Article 12(4) of the Convention, which requires states to "ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person." Strictly interpreted, this may be taken to rule out substitute decision-making altogether. By its nature, a decision taken on behalf of someone may well conflict with, or override, the wishes of that individual. Certainly this is the position adopted by the UN Committee on the Rights of Persons with Disabilities:

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

As the Essex Autonomy Project (EAP) have identified in their report *Achieving UNCRPD Compliance* (summarised in Wayne Martin's article *The MCA under Scrutiny: Meeting the Challenge of CRPD compliance* [2015] Eld LJ 32), the definition of “respect” – the word in the Convention – is ambiguous. However, it would seem to fall somewhere short of a requirement that one “complies” or “adheres to” the individual’s wishes. Nonetheless, the EAP suggested that the current requirements of s.4(6)(a) MCA 2005 do not go far enough. The EAP has proposed that the MCA be amended to establish a rebuttable presumption that, when a decision must be made on behalf of a person lacking in mental capacity, and the wishes of that person can be reasonably ascertained, the best interests decision-maker shall make the decision that accords with those wishes. We would certainly agree that such would be an improvement, although we would also add that (a) the MCA should make clear that rebutting that presumption requires justification; and (b) even if what is required to rebut that presumption need not be set out expressly in statute, the principle must be that, the further the departure from P’s wishes, the more compelling the justification required.

As we have sought to demonstrate in this article, however, it is possible to argue that, without even needing to invoke the CRPD, our courts have organically created (or identified) the very presumption that compliance requires. Indeed, in their paper, the EAP draw considerable inspiration from the approach of HHJ Marshall in *S and S* (as do we, although we would be cautious about adopting the bases she identified for departing from the presumption for the reasons set out above).

Importantly, further, we suggest that, for those for whom the sun-lit uplands of CRPD compliance are still a conceptual step too far, we suggest that a presumption of the nature identified here reflects a construction, perhaps the only construction, of the MCA that sits comfortably with Article 8 ECHR. The right to respect for private and family life has been broadly construed, encompassing every individual’s autonomy, as well as “the physical and psychological integrity of a person” (*Y.F. v Turkey* (2004) 39 EHRR 34 at paragraph [33]). This right, possessed by all in equal measure, is not limited to those with capacity: *Re E* [2012] EWHC 1639 (COP), [2012] COPLR 441 at 124. We suggest that it is clear that going against the autonomous expression of the will, even that of someone lacking capacity, infringes Article 8. Applying standard Strasbourg principles, convincing justification must be given before such an infringement can be accepted. As noted above, it may in due course be that Strasbourg will pronounce upon this question in *RB*’s case.

We should emphasise, finally, that we do not doubt that valid reasons may well be given to override the presumption we identify (whether that presumption is erected in reliance upon the ECHR or the CRPD). There will remain cases where compliance with known wishes and feelings will create such obviously adverse effects on the individual that the courts are right to hesitate before following through. As identified above, *DD* is perhaps the quintessential ‘hard’ case. Further, there will inevitably be cases where, whatever the quality of the support provided, an individual declines to amend a self-destructive decision. In such cases there is no middle ground: either a person’s wishes will be given effect, or they will not. We make no apology for putting ourselves in the camp of those who agree that there will be circumstances in which they should not be – but we need to be better in identifying to the person and to society why not. ‘Respect’ can mean no less.

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