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Mental Capacity Act 2005

Rosie Harding

The Mental Capacity Act 2005 (MCA), which applies in England and Wales, makes legal provision for a wide range of people (family members, health and social care professionals, courts) to make decisions in the best interests of people who lack the capacity to make a decision for themselves (section 3). It applies to anyone who has impaired decision-making capacity as a result of 'an impairment of the mind or brain' (section 2). Two of the guiding principles of the MCA hold the key to considering this piece of legislation to be a women's legal landmark.

The first, and most important, is the statutory presumption that: 'a person must be assumed to have capacity unless it is established that he lacks capacity' (section 1(2)). This creation of a statutory presumption of capacity is powerful, and of great importance for vulnerable women. Prior to the MCA, there was a common law presumption of capacity, but this was not clearly extended to those with impaired capacity 'due to mental illness or retarded development'.¹ The common-law presumption was also narrower than the statutory presumption in the MCA, applying primarily in the context of medical decision-making. The consequence of this statutory presumption is that it is for the person alleging a lack of capacity to prove that the person is unable to make their own decision, rather than the person having to provide evidence that they have capacity.

The second significant aspect of the MCA is that where a 'best interests' decision is made or action taken because a person is unable to make their own decision, the least restrictive option is to be preferred (section 1(6)). This approach prioritises the autonomy rights of disabled people, ensuring that any action taken in the best interests of the person is proportionate, and that their freedoms are appropriately protected. In the case of women with intellectual disabilities, the pre-MCA approach often resulted in court-approved sterilisation procedures, and this issue will serve as the primary exemplar of the importance of this legal landmark for women.

Context

Difficulty making decisions, or being considered to have the capacity to make one's own decisions, can affect a remarkably large proportion of the population over the life course. Over 3 million people in the UK live with conditions that can cause difficulties with capacity, including learning disabilities, acquired brain injuries and dementia.² According to Mind, the mental health charity, one in four people in the UK will experience a mental health problem each year.³ Whilst not all mental health problems result in diminished mental capacity, some mental health problems (like, for example, depression and anxiety) can make it very difficult for people to make decisions about their lives. More importantly, in the context of a legal landmark for women, gender has always played a considerable role in questions of (in)capacity in law and society. Women have higher rates of

¹ *In re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112 per Lord Donaldson MR.

² Rosie Harding, 'Statutory Wills and the Limits of Best Interests Decision-Making' (2015) 78(6) *Modern Law Review* 945-970.

³ Mind (2017) Mental Health Facts and Statistics. Available at: <http://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#>

diagnosis with common mental disorders than men;⁴ women are at higher risk of developing Alzheimer's Disease than men;⁵ and women were historically more likely than men to be diagnosed with 'madness', admitted to asylums, or given psychiatric 'treatment'.⁶ The MCA's legislative enactment of a presumption of capacity, and the requirement for the least restrictive option, have acted as an important legal corrective against the marginalisation of women through findings of incapacity or 'madness'.

The legal regulation of incapacity was historically a matter for the Royal Prerogative, the history of which can be traced back as far as 1339.⁷ The royal prerogative gave the King entitlements to land belonging to 'idiots' or 'lunatics', a duty to make provision for the 'idiot', and a requirement to return the land to the right heir of the 'idiot' on his death.⁸ The specific regulatory dimensions of the Royal Prerogative changed in scope over the centuries, eventually vesting in the Lord Chancellor, and the Court, to allow a wide inherent jurisdiction to do 'whatever is necessary for the benefit of Lunatics'.⁹ The Royal Prerogative relating to property and affairs was formally abolished by the Mental Health Act 1959, and the power to administer the affairs of those who lacked capacity passed to the (old) Court of Protection. Under that legislation, whose powers were re-enacted under the Mental Health Act 1983, capacity was an 'all or nothing' determination: either a person had the capacity to deal with all of their property or they were considered to have no capacity at all. The Court of Protection jurisdiction under the 1959 Act only extended to property and affairs, usually exercised through the appointment of a 'receiver'.¹⁰ Personal decision-making about health and welfare matters were addressed through a combination of compulsory treatment powers regarding hospital admissions,¹¹ and guardianship.¹² Under the 1959 Act, guardianship was a wide ranging personal power, akin to that of a father over his under-age children. Guardianship powers were narrowed significantly under the Mental Health Act 1983, but this left a legal lacuna relating to health and welfare decision-making. Enduring Powers of Attorney were introduced in 1986 for property and financial affairs decisions,¹³ but no equivalent power was available in respect of health and welfare decisions until the MCA.

The Landmark

The Law Commission, under Commissioner Brenda Hoggett (now **Lady Hale**), began a review of the law relating to mental incapacity in 1989. The first consultation paper¹⁴ set out the problems with the law at that time, particularly highlighting the lack of legal frameworks relating to consent to

⁴ One in five women, compared to one in eight men: Sally McManus, Paul Bebbington, Rachel Jenkins, Tralach Brugha (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital. Available at: <http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf>

⁵ Women are approximately 1.5 times more likely to develop Alzheimer's Disease (the most common form of dementia) than men: Rosie Erol, Dawn Brooker, & Elizabeth Peel (2015) *Women and Dementia: A Global Research Review* London: Alzheimer's Disease International. Available at: <https://www.alz.co.uk/women-and-dementia> last accessed 30 Jan 2017.

⁶ Jane M Ussher. *The Madness of Women: Myth and experience* (2011) Routledge.

⁷ T.C.S Keely, 'One Hundred Years of Lunacy Administration' (1943) 8(2) *Cambridge Law Journal* 195-200.

⁸ Margaret McGlynn, 'Idiots, Lunatics and the royal prerogative in early Tudor England' (2005) 26(1) *The Journal of Legal History* 1-24.

⁹ Keely, n 7 above, at p. 195.

¹⁰ Mental Health Act 1959, ss. 100-121.

¹¹ Mental Health Act 1959, ss. 25-29.

¹² Mental Health Act 1959, ss. 33-34.

¹³ Enduring Powers of Attorney Act 1985.

¹⁴ Law Commission *Mentally Incapacitated Adults and Decision-Making: An Overview* (Law Comm Consultation No 119, 1991)

serious medical treatment.¹⁵ Around that period there had been a series of cases relating to sterilisation of mentally disabled young women,¹⁶ the most influential of which has been the decision in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1. As well as authorising the sterilisation of an intellectually disabled woman, *Re F* has been credited with the foundation (or re-discovery)¹⁷ of what has become known as the ‘inherent jurisdiction’ of the High Court to make decisions on behalf of vulnerable and incapacitated adults. In that case, the House of Lords held that serious medical treatment could be given without consent to adults who lacked the capacity to give consent, where such treatment was justified by the doctrine of necessity. The Law Commission’s consultation paper highlighted three problems with this approach to medical decision-making concerning adults with impaired capacity: the limitations of the doctrine of necessity; the suitability of a ‘best interests’, rather than substituted judgment approach; and the use of the clinical negligence standard¹⁸ as the standard to be applied in determining best interests.¹⁹ Importantly, similar questions about the scope and appropriateness of best interests remain salient to this day.²⁰

Following a series of consultations on different aspects of the law,²¹ the final report on Mental Capacity, including a draft Mental Incapacity Bill, was published in 1995.²² A further decade passed, however, before the recommendations from the Law Commission were enacted through the Mental Capacity Act 2005. In that time, use of the inherent jurisdiction had grown to fill the void left by the removal of most forms of guardianship. A group of 28 organisations and groups representing the interests of people with a range of intellectual and psychosocial disabilities came together to form the Making Decisions Alliance, and to lobby for the legislation. The Mental Capacity Act 2005 came fully into force on 1 October 2007. The process of enacting the MCA therefore, took nearly two decades. At time of writing, the MCA approaches its tenth anniversary, and the legal landscape for people with impaired capacity has changed a great deal as a result of this statute.

What happened next

The MCA changed the shape of capacity law in England and Wales, catalysing a shift in understandings of ‘capacity’ in law from global, or person-specific, towards being granular and decision-specific. The central principles of the Act regarding decision-making by people with impaired capacity are: the presumption of capacity; the requirement to provide support and assistance in making decisions; and the requirement to respect unwise, but capacitous, decisions. These three principles all foreground decision-making by people with intellectual and psychosocial disabilities, supporting their rights to enjoy legal capacity on an equal basis with others.²³ Where a person with an ‘impairment of the mind or brain’ is shown (on the balance of probabilities) to lack the capacity to make a decision for themselves, any decision made must be in their ‘best interests’ (section 1(5)).

The inclusion of ‘best interests’ as an alternative when a person lacks decision-making capacity, however, creates a point of tension between English law in this area and international human rights

¹⁵ CROSSREF *St George’s Healthcare Landmark*

¹⁶ See Law Commission, 1991, [1.9]

¹⁷ Ruth Hughes, ‘The Inherent Jurisdiction over Vulnerable Adults’ 2013 *Private Client Business* 132.

¹⁸ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

¹⁹ See Law Commission, 1991, pp 29-34.

²⁰ Harding, 2015, n 2 above.

²¹ Law Commission *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction* (Law Comm Consultation No. 128, 1993); Law Commission *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research* (Law Comm Consultation No. 129, 1993); Law Commission *Mentally Incapacitated Adults and Decision-Making: Public Law Protection* (Law Comm Consultation No. 130, 1993)

²² Law Commission *Mental Incapacity* (Law Comm No 231, 1995)

²³ UN Convention on the Rights of Persons with Disabilities, Article 12.

law.²⁴ Under the MCA, where a person lacks the capacity to make a decision, then decisions can (and must) be made in their 'best interests'. In contrast, the Committee on the Rights of Persons with Disabilities have called for the abolition of objective best interests decision-making in favour of a much more subjective approach focusing on the 'best interpretation of the will and preferences' of the individual.²⁵

The changes sparked by the MCA took some time to filter through to judicial decisions. Early cases decided under the MCA continued to use phrases like 'P lacks capacity',²⁶ which have little meaning in the context of a law that presumes capacity and requires decision-specific capacity determination.²⁷ Initially, jurisprudence from the Court of Protection considered 'best interests' as an objective test, rather than a reflection of the person's wishes and feelings. The reasons for this include the guidance given in the explanatory notes to the MCA,²⁸ alongside the continued use of the best interests balance sheet approach developed prior to the MCA in *Re A (Male Sterilisation)* [2000] 1 FLR 549. A turning point in consideration of the best interests approach under the MCA came when the first case under the MCA, *Aintree University Hospitals NHS Foundation Trust v James* (2013) UKSC 67, was heard before the Supreme Court. In that case, Lady Hale took the opportunity to clarify that, 'the purpose of the best interests test is to consider matters from the patient's point of view' (at [45]). This shift in the understanding of best interests has since been instrumental in two important cases deciding on matters relating to the withdrawal of artificial hydration and nutrition.²⁹ Lady Hale was, of course, both the architect of the MCA whilst at the Law Commission, and the arbiter on its meaning whilst a Justice of the Supreme Court. It is likely that Lady Hale's feminist principles have shaped the form and interpretation of the MCA.

Significance

Returning to the example of sterilisation of intellectually disabled women, which initially acted as a catalyst for law reform back in the late 1980s, helps to draw out the significance of the MCA as a women's legal landmark. Comparing cases from that period with similar cases under the regulatory regime introduced by the MCA, we can excavate a shift in understandings of capacity and towards the least restrictive option for women. In the late 1980s a series of cases had authorised the sterilisation of disabled women, under the inherent jurisdiction, as necessary medical procedures. In *Re F*, for example, sterilisation was considered by the court to be in F's best interests because she was in a sexual relationship, there was a 'serious objection to each of the ordinary methods of contraception,' and becoming pregnant would 'from a psychiatric point of view, be disastrous' (at 53-54). Importantly, and perhaps surprisingly, no consideration was given to F's capacity to consent to sex, despite the (infantilising) way the court described her mental capacity: 'she has the verbal capacity of a child of two and the general mental capacity of a child of four to five' (at 53).³⁰ Nor was any substantive consideration given to F's views about either the sterilisation operation or her sexual

²⁴ See further, Harding 2015, n 2 above.

²⁵ Committee on the Rights of People with Disabilities (2014) General Comment No. 1 on Article 12: Equal recognition before the law CRPD/C/GC/1.

²⁶ Under the MCA, the person at the centre of proceedings is referred to as 'P'.

²⁷ Rosie Harding, 'Legal Constructions of Dementia: Discourses of autonomy at the margins of capacity.' (2012) 34(4) *Journal of Social Welfare and Family Law* 425-442.

²⁸ MCA Explanatory Notes at [28].

²⁹ *M v Mrs N* [2015] EWCOP 76; *Briggs v Briggs* [2016] EWCOP 53.

³⁰ The first civil case to consider capacity to consent to sex was *X City Council v MB, NB and MAB* [2006] EWHC 168 (Fam); [2006] 2 FLR 968. See Ralph Sandland, 'Sex and Capacity: The management of monsters?' (2013) 76(6) *Modern Law Review* 981-1009.

relationship. Rather, it was stated by the court that ‘she is unable to express her views in words but can indicate what she likes or dislikes ... there is, however, no prospect of any development in her mental capacity’ (ibid).

By way of contrast, in *A Local Authority v K* [2013] EWHC 242 (COP), decided under the MCA, the court declined to make an order that sterilisation was in the best interests of K, a young woman with Down’s Syndrome. This was because she was not sexually active, and less restrictive forms of contraception were considered to be a more appropriate first line response if the situation arose where it was required. There have continued to be cases under the MCA where sterilisation has been thought to be in the best interests of the person at the centre of MCA proceedings. In *Re DD (No.4) (Sterilisation)* [2015] EWCOP 4 (Fam), for example, sterilisation through the occlusion of the fallopian tubes was considered to be in the best interests of an intellectually disabled woman who had previously had six pregnancies, and the medical evidence suggested that a further pregnancy would seriously endanger her life. Importantly, in *Re DD (No.4)*, it was noted that ‘considerable efforts ... have been made to enable her to make the relevant decisions’ (at [7]). The difference the MCA has made in this area is that rather than sterilisation being considered as a first step in preventing pregnancy, for the convenience of those who care for women with intellectual disabilities, it is now appropriately considered a ‘last resort’, when other methods of contraception and sex education have failed.

The MCA has made a great deal of difference to the lives of women with intellectual and psychosocial disabilities. The statutory presumption of capacity means that those who seek to override the wishes of disabled people must first prove that they lack capacity to make their own decisions. The focus in the MCA on the least restrictive option has ensured that fewer disabled women are subjected to sterilisation procedures. The MCA has also reflected, and perhaps catalysed, a shift in the discursive construction of capacity and intellectual disability. Yet the MCA model of using a functional test of capacity, alongside status provisions, and backed up by best interests substituted decision making has come under increasing levels of criticism in recent years.³¹ The tension between objective best interests and prioritising the will and preferences of the individual, as suggested by the Committee on the Rights of Persons with Disabilities,³² is now posing significant challenges. Finding a way to achieve the right balance between supporting disabled people’s autonomy whilst continuing to provide an appropriate level of protection for vulnerable people is the next big challenge in mental capacity law. The MCA has put England and Wales in a strong position to rise to that challenge, but we may well need to build another landmark to get us there.

Further Reading

Rosie Harding ‘Statutory Wills and the Limits of Best Interests Decision-Making’ (2015) 78(6) *Modern Law Review* 945-970.

Genevra Richardson, ‘Mental Disabilities and the Law: From substituted to supported decision-making?’ (2012) 65 *Current Legal Problems* 333-354.

Alison Stansfield, A J Holland, & I C H Clare, ‘The sterilisation of people with intellectual disabilities in England and Wales during the period 1988 to 1999’ (2007) 51(8) *Journal of Intellectual Disability* 569-579.

³¹ Flynn, E. & Arstein-Kerslake, A. ‘Legislating personhood: realising the right to support in exercising legal capacity’ (2014) 10 *International Journal of Law in Context* 81; Harding, Statutory Wills, n 8 above.

³² CRPD/C/GC/1, n 35 above.