



**Session 1:**  
**(a) Capacity and best interests**  
**(b) Particular decisions on discharging  
from hospital**

Alison Gerry

Doughty Street Chambers

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# Introduction:

## The two regimes: MHA and MCA

- The MCA 2005 is concerned only with capacity and best interests of the person concerned. The MCA 2005 applies to decision-making in connection with **all acts of care and treatment of an incapacitated person**, including for mental disorder, except where treatment is governed by Part IV of the MHA 1983.
- The MHA 1983 is relevant only to the treatment of mental disorder and permits the compulsory confinement and treatment of mentally disordered persons where it is justified by reference to the statutorily defined diagnostic and risk criteria, these contain no components relating to capacity or best interests.

# Introduction

## MCA: Capacity and best interests

- The MCA 2005 was designed to codify a network of protective safeguards for vulnerable persons who are **unable to make decisions for themselves due to a lack of mental capacity**, and it left the MHA 1983 regime virtually intact. It includes provision of a regime which provides for access to court to challenge any deprivation of liberty and so satisfy Article 5(4) ECHR (s.21A).
- The two concepts which underpin the MCA 2005 framework are the concepts of **mental capacity** and **best interests**.
- It is only where a person **lacks mental capacity** in respect of a **particular decisions** that the MCA 2005 applies and a **best interests decisions** must be made.

# Capacity: How to determine if P lacks capacity

- The first issue in any case is to consider is whether P lacks mental capacity.
- The relevant principles when determining mental capacity are set out in s.1 MCA 2005 and include that a person must not be assumed to lack capacity unless it is established that he lacks capacity (s.1(2)) and that a person is not be treated as unable to make a decision merely because he makes an unwise decision (s.1(4)).
- The relevant “cardinal principles” when determining capacity were helpfully summarised by MacDonal J in *Kings College Hospital NHS Foundation Trust v. C and V* [2015] EWCOP 80

# Capacity: The “Cardinal Principles”

- **First**, a person must be assumed to have capacity unless it is established that they lack capacity, there is a **presumption of capacity**.
- **Second**, determination of capacity under Part I of the Mental Capacity Act 2005 is always '**decision specific**' having regard to the clear structure provided by sections 1 to 3 of the Act.
- **Third**, a person is not to be treated as unable to make a decision unless **all practicable steps to help him** to do so have been taken without success (Mental Capacity Act 2005 s 1(3)).
- **Fourth**, a person is not to be treated as unable to make a decision merely because he or she **makes a decision that is unwise**

# Capacity: The “Cardinal Principles”

- **Fifth**, 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** (the '**diagnostic test**', s 2(1) 2005 Act). It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (MCA 2005 s 2(2)).
- **Sixth**, a person is "unable to make a decision for himself" if he is unable **(a) to understand the information relevant to 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 decision** whether by talking, using sign language or any other means (the '**functional test**', s. 3(1) MCA 2005 ). An inability to undertake any one of these four aspects of the decision making process will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain. The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (MCA 2005 s 3(4)(a)).



# Capacity: The diagnostic and functional test

- The order in which the relevant terms of the MCA 2005 are drafted places the 'diagnostic test' in s 2(1) before the 'functional test' in s 3(1). However, having regard to the wording of s 2(1), namely, "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", the order in which the tests are in fact applied must be carefully considered.
- It is important to remember that for a person to be found to lack capacity there must be a **causal connection** between being **unable** to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act and the 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s 2(1) of the Act."

# Capacity: Code of Practice

4.30 of the Code of Practice states:

“It is important to acknowledge the difference between:

- Unwise decisions, which a person has the right to make (Chapter 2 principle 3), and
- Decisions based on a lack of understanding of risks or inability to weigh up the information about a decision.

Information about decisions the person has made based on a lack of understanding the risks or inability to weigh up the information can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.”

# Capacity: When should it be assessed?

- Whenever capacity to make a particular decision is in doubt.
- Decide on best time of the day to conduct the assessment.
- Important that the person who carries out the assessment and concludes a lack of capacity is able to justify that conclusion, based on the diagnostic and functional tests.
- Must start from the presumption that the person has capacity to make the decision. (see Code of Practice para 4.34)
- Must not presume a lack of capacity just because, for example, a person has a learning disability.

# Capacity: Who should assess capacity?

See Code of Practice Para 4.38.

- Person who assesses capacity is usually the person who is directly concerned with the individual at the time the decision needs to be taken.
- For acts of care or treatment the assessor must have a 'reasonable belief' that the person lacks capacity to agree to the action or decision to be taken. Doctor/healthcare professional must assess person's capacity to consent prior to providing treatment/conducting and examination.
- For legal transactions a legal practitioner must assess the individual.
- More complex decision are likely to need more formal assessments.

# Best Interests: The Overarching principle

- If a person lacks capacity to make a particular decision then that decision must be made on their behalf by considering what decision is in their “best interests”
- The overarching principle is that any decision made on behalf of a person who lacks capacity must be made in their best interests, but this is **not necessarily the same as enquiring what the person would have decided if he or she had had capacity**. As the explanatory notes to the Mental Capacity Bill explained:

"Best interests is not a test of "substituted judgment" (what the person would have wanted), but rather it requires a determination to be made by applying an objective test as to what would be in the person's best interests".

# Best Interests: S.4 MCA 2005

- S.4 MCA 2005: Best interests
  - (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of –
    - (a) the 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 what might be in his best interests.

# Best Interests: S.4 MCA 2005

S.4 MCA 2005...

- (2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
- (3) He must consider –
  - (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
  - (b) if it appears likely that he will, when that is likely to be.
- (4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

# Best Interests: S.4 MCA 2005

S.4 MCA 2005...

(6) He must consider, so far as is reasonably ascertainable –

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

# Best Interests: P's wishes and feelings

- When deciding what weight to give a person who lacks capacity own wishes and feelings of relevance is how 'near' that person is to having capacity to make the relevant decision. In *The PCT v P, AH and A Local Authority* [2009] COPLR Con Vol 956 Hedley J held that:

“The court's approach to the expressed wishes of an incapacitated person was that the nearer the person was to capacity, the greater the weight to be given to his views; regard had to be paid to both the strength and the consistency of those views; weight had to be given to the impact on P of knowing that his wishes were not being given effect; and regard should be had to the extent to which those wishes were rational, sensible, responsible and practical”

# Best Interests: Code of Practice

Code of Practice provides further guidance in Chapter 5 deals, which deals with the application of the best interests principle.

Notes that is states:

“Working out what is in someone’s best interests may be difficult, and the Act requires people to follow certain steps to help them work out whether a particular act or decision is in a person’s best interests. In some cases there may be disagreement ... As long as the person who acts or makes the decision has followed the steps to establish whether a person has capacity and done everything they reasonably can to work out what someone’s best interests are, the law should protect them.”



# Best interests: Quick summary

- Encourage participation
- Identify all relevant circumstances
- Find out the person's views
- Avoid discrimination
- Assess whether the person may regain capacity
- Consult others
- Avoid restricting the person's rights
- Weigh up all factors in order to work out best interests



(b) Particular issues that may arise on discharge from hospital

# Introduction:

## Discharge from hospital and MCA

- Statutory duty placed on PCTs/health authorities and local social services authorities to provide after care services for those who cease to be detained under the MHA 1983 and leave hospital (s.117).
- The principles of the MCA 2005, namely capacity and best interests, will apply to decisions and care planning under this provision.
- They will also be relevant during the planning for any conditional discharge of a restricted patient under MHA 1983, s 73(2).
- Where long term accommodation is being planned, an independent mental capacity advocate (IMCA) may be appropriate if there is no other person to be consulted on behalf of an incapacitated person.

# s.17 leave and MCA

- If a mentally incapacitated patient is granted leave under s.17 where the conditions of the leave amount to a deprivation of liberty then this *should if possible* be authorised either under Schedule A1 MCA if to a care home/hospital setting, or by the Court of Protection if not to a care home/hospital setting.
- The legal position is currently uncertain as to whether a DOLS SA is **required** for an incapacitated patient on s.17 leave (see *SoS for Justice v MM: Welsh Minister v PJ* [2017] EWCA Civ 194 and *A Local Authority v PB* [2011] EWCOP 2675, para. 64 (iii)).
- An authorisation can only be granted if there is no conflict between the DOL SA and the conditions of the patient's leave.
- Transfer from hospital to a care home will be authorised under s.137.

# Guardianship

- The MHA 1983 scheme includes an adult guardianship regime under (s. 7 MHA) which patients may receive care in the community with ‘a minimum constraint to achieve as independent a life as possible within the community’.
- For a Guardianship the diagnostic and risk criteria analogous to those required for detention under the MHA 1983 must be satisfied and similar formalities are attached to the application procedure.

# Guardianship

The Main Code suggests that guardianship may be the best option for a person who lacks capacity to make relevant decisions in the following circumstances:

- Where it is important that one person or authority should be in charge of making decisions about where the person should live (for example where there have been long-running or difficult disagreements about where the person should live);
- Where it is thought that the person will probably respond well to the authority and attention of a guardian, and so be more prepared to accept treatment for the mental disorder (whether they are able to consent to it or it is being provided for them under the MCA 2005); or
- authority is needed to return the person to the place they are to live (for example a care home) if they were absent.

# Guardianship: MHA and MCA?

A patient who is subject to the guardianship regime *may* be detained under the MCA 2005 if two conditions are met:

- It does not conflict with a requirement imposed by the guardianship regime. For example, a guardian's right to impose residence at a specified place cannot be countermanded under the MCA 2005. However, if the guardian does not object to the patient being accommodated in the care home or hospital in which the proposed DOLs detention would occur, that patient would not be ineligible for the DOLs on this ground.
- It is for the purpose of being given medical treatment for mental disorder, but only if (a) he does not object to the relevant accommodation and/or treatment for mental disorder; and (b) if a validly appointed donee or deputy has not consented to the matters to which he objects.
- See also *KD v A Borough Council* [2015] UKUT 251 (AAC) and *GW v. Gloucestershire County Council* [2016] UKUT 499 (AAC).

# Move to Supported living or other “private setting”

- If P lacks capacity to decide where to reside and/or what care/treatment is required then a best interests decision will need to be made as to place of residence and/or care and treatment.
- The decision maker must comply with s.1(5) and s.1(6) of the MCA 2005:  
“1(5) an act done or decision made under this Act for or on behalf of a person must be done or made in his best interests 1(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.”

# Discharge to a private setting

- A private DOL is where a person is not living in a residential care home setting or in a hospital such that the authorisation procedure under Schedule A1 does not apply.
- If the place of residence and/or care and treatment plan amount to a **deprivation of liberty**, and discharge is not to a care home/nursing home/hospital, then any deprivation of liberty **must be authorised by the Court of Protection. An application will need to be made to the COP for an order under s.16(2)(a).**
- If there is a **serious dispute** as to where P should reside or the treatment plan **then an application to the Court of Protection should be made for a best interests decision to be made.**

# Will there be a Deprivation of Liberty?: the acid test

Cheshire West [2014] UKSC 19

- The Acid test:
  - Lack of capacity
  - Continuous supervision or control
  - Not free to leave
- Irrelevant factors include
  - P's compliance with restrictions
  - P's lack of objection to restrictions
  - The reason or purpose of the restrictions
  - The relative norm of the restrictions given P's care of physical care needs

# When can a DOL be imputed to the state?

- Article 5 ECHR will only be engaged (and so authorisation under MCA required) where the deprivation of liberty is imputed to the state.
- In *A Local Authority v A and B* [2010] EWHC 978 (fam) Mr Justice Munby referred to the decision in *Storck v Germany* (2005) 43 EHRR when stating that the state can be responsible for a DOL where the following factors are satisfied:
  - Direct involvement in the imposition or implementation of the deprivation of liberty
  - Failing to ensure there is sufficient domestic legislation to supervise and regulate the deprivation of liberty
  - Failing in its positive obligation to protect a person from a deprivation of liberty

# DOL imputed to the state

- Yes if imposing the continuous control or supervision upon the person or preventing them from leaving (need COP authority – if no time to get authority then **may** be able to rely on doctrine of necessity at common law until authorisation granted, but only where there is an immediate threat to life and limb, P is compliant and there is no objection from others).
- Yes if indirectly involved in care regime – so where local authority is providing the care and is a decision maker in the care planning process.
- No (probably) if not directly imposing continuous control or supervision. So, if the authority carried out care and needs assessment, and agreed to arrange or provide care to meet the assessed needs in P's own home, then authority is not exercising any control or supervision over the person, even if the care is directly commissioned by the authority. There is here no DOL that can be imputed to the state.

# DOL imputed to the State

## Decision in re R [2016] EWCOP 33

- Haringey applied to the Court of Protection for a determination as to whether a young man with an intellectual disability, epilepsy and autism was deprived of his liberty and if so for this to be authorised. It was argued by Haringey that R was not being deprived of his liberty as he was free to leave his placement and that even if he was it was his family who were responsible for the deprivation because they had chosen the placement.
- Senior Judge Lush held that the arrangements for R met the ‘acid test’ and that the LA had been actively involved in the care planning for the purposes of s.4 MCA 2005, the LA was the ultimate decision maker and there was therefore an obligation on the LA to make an application to the COP for authorisation of the deprivation of liberty.

# DOL: imputation to the State

- Cases of *SRK* and *RE R* provide some assistance, but they are fact specific.
- There is no definitive clear guidance on whether there can ever be state involvement in a purely private setting where care has been arranged privately and is paid for privately.
- State involvement may arise where e.g. Safeguarding alert concerning level of restrictions, where police or other authority return a person to home or supported living, a referral is made by the LA to a supported living or extra care housing scheme and LA is aware of need for restrictive measures.

# Tenancy agreements

- If the person lacks capacity to enter into/surrender a tenancy agreement then a best interests decision will need to be made as to whether they should enter into/surrender such an agreement.
- Where a person lacks capacity then the tenancy agreement can be signed on their behalf by the LA/CCG/Financial deputy
- Unless there is a dispute as to lack of capacity and/or best interests decision to enter/not to enter into a tenancy agreement then there is no need to refer this decision to the Court of Protection.

# Finances

- Where P lacks capacity to manage their finances there needs to be best interests decisions made. These can be made by:
- A court appointed Property and Affairs Deputy, or LPA under s.9 MCA 2005 (can be family member or friend, or professional, or Local Authority/CCG)
- Court of Protection, where no financial deputy in place or where the decision to be made is not included within the powers of the deputy/LPA.
- An Appointee: where P is in receipt of income from state benefits and has no capital which justifies the appointment of a deputy the Secretary of State can appoint an appointee to collect the state benefits. Applications should be made to the Benefits Agency in Form BF56.

# Marriage: Factors to consider re Capacity

The only issue will be capacity. The relevant factors to consider were summarised in *Sheffield CC v E* (2005):

“68. ... The law, as it is set out in these authorities, can be summed up in four propositions:

- i) It is not enough that someone appreciates that he or she is taking part in a marriage ceremony or understands its words.
- ii) He or she must understand the nature of the marriage contract.
- iii) This means that he or she must be mentally capable of understanding the duties and responsibilities that normally attach to marriage.
- iv) That said, the contract of marriage is in essence a simple one, which does not require a high degree of intelligence to comprehend. The contract of marriage can readily be understood by anyone of normal intelligence.

# Marriage: Capacity, financial consequences

- More recently in *London Borough of Southwark v KA* (2016) Mr Justice Parker set out the test for capacity to marry in the following way:

“76. The test for capacity to marry is also a simple one:

- a) Marriage is status specific not person specific.
- b) The wisdom of the marriage is irrelevant.
- c) P must understand the broad nature of the marriage contract.
- d) P must understand the duties and responsibilities that normally attach to marriage, including that there may be financial consequences and that spouses have a particular status and connection with regard to each other.
- e) The essence of marriage is for two people to live together and to love one another.
- f) P must not lack capacity to enter into sexual relations.”

- NB. Here then the duties are said to include “financial consequences” of marriage.

# Care and Treatment

- The MCA 2005 does not specifically authorise care or treatment but
  - Section 5 affords carers, healthcare professionals and others protection from liability for acts carried out in connection with care and treatment of incapacitated persons.
  - Section 6 sets the parameters of 'restraint' which may be used in respect of a person lacking capacity without falling outside of the range of acts which will not give rise to civil or criminal liability.

# MCA: s.28 exclusion

- Section 28 of the MCA 2005 expressly states that the MCA 2005 regime does not authorise either the giving of treatment for mental disorder or the consent to a patient being given treatment for mental disorder where the consent to treatment provisions of Part IV of the MHA 1983 apply.
- Part IV of the MHA 1983 applies only to the defined category of patients who are 'liable to be detained' .
- There is an exception relating to the administration of ECT (MHA 1983, s 58A(5)).

# MCA and MHA Consent to treatment provisions

- Advance decisions, donees and deputies.
- The MHA 1983, Part IV consent to treatment provisions will trump any conflicting advance decision, donee of an LPA or a deputy.
- However, the MCA 2005 is not wholly irrelevant to the MHA 1983 context. In relation to advance decisions, the Main Code advises that healthcare staff should still take account of an advance decision and consider whether the detained patient can be safely treated using a form of treatment which he has not refused in advance.

# MCA/MHA: Donees and Deputies

- Donees and Deputies can neither consent to treatment under the MHA 1983 nor make decisions which conflict with the requirements of a guardianship regime on behalf of a patient under the MHA 1983.
- Detained patients can create LPAs and the Court of Protection can still appoint deputies in respect of such patients. However, if donees take decisions which conflict with the requirements of a particular mental health regime, such as a condition to maintain contact with health services in respect of a patient on s 17 leave, this will be treated as if it were the decision of the patient and could lead to the potentially adverse consequence of recall to hospital.
- Attorneys and deputies are able to exercise the patient's rights under the MHA 1983 on behalf of patients provided that they have the requisite authority. They cannot, however, exercise the powers of the nearest relative unless they are in fact the patient's nearest relative.

# Treatment for mental disorder: MHA or MCA?

MHA where:

- person needs treatment for mental disorder which cannot be given under the MCA 2005 (e.g because the person has made a valid and applicable advance decision to refuse an essential part of the treatment intended to be given whether proposed to be administered under a DOLs or not).
- Where it is not possible to assess or treat the person safely or effectively for mental disorder without the treatment being compulsory. This is because treatment for mental disorder cannot occur under any MCA 2005 detention regime if the person validly objects to it.
- There is good reason to believe that the person may not get the required treatment for mental disorder without recourse to the MHA 1983 and a member of the public may suffer harm in consequence. This is precisely the sort of situation in which detention for treatment for mental disorder might be justified by reference to the risk to the public.
- The person lacks capacity to decide on some elements of the treatment for mental disorder but has the capacity to refuse a vital element of it and does do so. If a person is known to have capacity in relation to a particular matter, treatment for that cannot be given under the MCA 2005.



# Serious healthcare treatment

- The Code of Practice (para 8.18) suggests the following decisions should be brought before the Court of Protection:
  - Decisions about the proposed withdrawing of artificial nutrition or hydration (ANH) from patients in PVS
  - Cases involving organ or bone marrow donation
  - Cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity and
  - All other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests.

# Displacing Nearest Relative

- The power to displace a Nearest Relative rests with the County Court and not the Court of Protection (MHA s.29 and s.30)
- Reasons to 'displace' NR are:
  - that the nearest relative of the patient is incapable of acting as such by reason of mental disorder or other illness (s.29(3)(b))
  - that the nearest relative of the patient unreasonably objects to the making of an application for admission for treatment or a guardianship application in respect of the patient (s.29(3)(c))
  - that the nearest relative of the patient has exercised without due regard to the welfare of the patient or the interests of the public his power to discharge the patient under this Part of this Act, or is likely to do so (s.29(3)(d))
  - that the nearest relative of the patient is otherwise not a suitable person to act as such (s.29(3)(e)).