The MCA under Scrutiny: Meeting the Challenges of CRPD Compliance

WAYNE MARTIN, Principal Investigator, The Essex Autonomy Project

In the spring and summer of 2014, a group of experts convened a series of meetings at the Westminster headquarters of the UK Ministry of Justice (MoJ) in order to determine whether the Mental Capacity Act 2005 (MCA) complies with the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The meetings were organised by the research team of the Essex Autonomy Project (EAP), a research and public policy initiative funded by the Arts and Humanities Research Council (AHRC) and based at the University of Essex. The working group included civil servants from the MoJ, the Office of the Public Guardian, and the Department of Health, as well as the Official Solicitor, a senior judge of the Court of Protection, leading academic experts from psychiatry, law and ethics, and representatives of user-group organisations. In September 2014, the EAP research team reported to the MoJ on its findings (http://autonomy.essex.ac.uk/uncrpd-report). This article summarises some of the key arguments and conclusions of that report. Both the report itself and this article represent the views of their respective authors; they should not be taken to represent the views of the MoJ, the AHRC, or the other participants in these consultations.

A growing controversy

2015 marks the ten-year anniversary of Parliament's passage of the Mental Capacity Act of England and Wales (MCA). It also looks likely to bring a new high-water mark in the growing international controversy about some of its key provisions. One focus of controversy is the question of whether the MCA complies with the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The CRPD was adopted by the UN General Assembly just a year after Parliament had adopted the MCA. It was ratified by the UK in 2009 and by the EU (on behalf of all member states) in 2010. In 2011, the UK Government filed its Initial Report with the UN, as required under Art. 35 of the Convention. The Initial Report conveyed considerable optimism about the UK's compliance with the provisions of CRPD. But this optimism will soon be put to the test. In the coming months, the United Nations Committee on the Rights of Persons with Disabilities (hereafter: the Committee) will

undertake a review of British compliance with the Convention whose provisions it oversees. The UK should be prepared to face sharp criticisms from the Committee. It should also prepare to rebut some of those criticisms. The MCA is not, in its present form, fully compliant with the requirements of the CRPD. But the Committee's position on the requirements of compliance does not survive close scrutiny.

Readers of the *Elder Law Journal* will likely be familiar with the CRPD. (See in particular the article by HH Judge Denzil Lush in the maiden issue of the journal at [2011] Eld LJ 61). It is an international human rights instrument establishing legal standards for the protection of the rights of persons who may suffer from disabilities. The CRPD also establishes a 'treaty body' (the Committee) which sits in Geneva, with specific obligations under the Convention to offer general comments and recommendations regarding the CRPD and its requirements, and to undertake regular reviews of the compliance of signatory nations with its provisions. In 2014 the Committee adopted a series of General Comments and Statements which will undoubtedly inform its upcoming reviews. The first General Comment has direct bearing on central provisions of the MCA ('On Equal Recognition Before the Law'; adopted April, 2014; hereafter: GC1. The General Comment, and other relevant documents, are available on the CRPD website: www.ohchr.org/EN/HRBodies/CRPD.) Among other things, the Committee there claims that compliance with CRPD Art. 12 requires the abolition of substitute decision-making regimes (GC1, para. 28) and replacement of the best-interests paradigm (GC1, para 21).

Terminology

Straightaway a terminological clarification is in order. The term, 'substitute decision-making' has in recent years become common in international discussions of disability rights. It is not to be confused with the term 'substituted judgement' which appears in the *Explanatory Notes* to the MCA. In the terminology of the Committee, the key features of a substitute decision-making regime pertain to the mechanisms whereby one person (A) is legally authorised to make decisions on behalf of another person (B). Under a substituted decision-making regime, person A 'substitutes' her own judgement for that of B as regards a decision that needs to be made regarding B's health, welfare, finances, etc. Both the appointment of A as decision-maker and the specific decisions taken by A may be contrary to the wishes of B. Finally, the decisions taken by B are determined on the basis of an assessment of the objective best interests of A – whether or not this coincides with A's own will and preference in the matter. (For the subtleties of the Committee's formal definition of 'substitute decision-making regime,' see GC1, para 27.) It should be clear from the foregoing that the MCA is an example (indeed an exemplar!) of a substitute decision-making regime in the Committee's sense.

The Committee and the Convention

Before proceeding further, it is important to note that it is the CRPD Committee, rather than the Convention itself, which calls for the abolition of substitute decision-making and the best-interests paradigm. The CRPD itself makes no mention of substitute decision-making at all, and its only reference to best interests comes in CRPD Art. 7, which states that the best interests of children must be a primary consideration. So in calling for the abolition of statutory arrangements like that of the MCA, the Committee has gone beyond anything that is explicitly

included in the language of the Convention. It is also important to appreciate that in ratifying the CRPD and its Optional Protocol, the UK committed itself to be *bound by the Convention*, and for its domestic practices to be *reviewed by the Committee*; it did not agree to be bound by the Committee's interpretation of the Convention. (See, for example, the International Law Association's 2011 *Final Report on the Impact of Findings of the United Nations Human Rights Treaty Bodies*.) Of course this does not mean that the Committee's interpretation of the Convention's requirements can be lightly dismissed. But it remains open to the UK to challenge or even to reject the Committee's interpretation of Article 12, while nonetheless remaining committed to the CRPD itself.

Two Arguments against substitute decision-making

So is the MCA really in violation of the CRPD by virtue of its reliance on substitute decision-making and the best interests paradigm? Here we must look to the two main lines of argument upon which the Committee and a variety of academic commentators have relied. Both arguments are rooted in Article 12 of the CRPD, which addresses the principle of Equal Recognition before the Law. Art. 12(2) requires states parties to recognise that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.' Art. 12(4) requires states parties to adopt safeguards ensuring that 'measures relating to the exercise of legal capacity respect the rights, will and preferences of the person.'

In reconstructing the two arguments against substitute decision-making, we must begin by clarifying the central term-of-art in CRPD Art. 12: the concept of *legal capacity*. It is important to be clear, firstly, that *legal capacity* is not the same as *mental capacity* – although the two constructs are often linked by particular provisions of law. At its core, the concept of *mental capacity* refers to the ability of a

person to make a decision on a particular matter at the time it needs to be made – drawing on support from others as needed. Under the MCA it is defined with reference to the statutory abilities: to understand, retain, use and weigh information relevant to a decision, and to communicate a choice (MCA s.3(1)). The concept of *legal capacity* is somewhat more elusive, and is not in fact defined in the CRPD itself. (The Committee provides a working definition at GC1, paras. 13-14.) As a first approximation, we can say that a person with full legal capacity enjoys the right to vote, to enter into contractual relations (including marriage), to instruct a solicitor, to participate in legal proceedings (including as a juror), etc. In short, a person with full legal capacity is 'a player in civil society' – recognised as having legal standing before the law, and able to exercise legal agency in both exercising and defending her rights.

According to one line of argument, the MCA's regime of substitute decision-making stands in violation of CRPD Art. 12 because of the ways in which it denies legal capacity to certain persons with disabilities. As we have already seen, CRPD Art.12(2) requires states parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. But under the MCA, some persons with disabilities can be denied full legal capacity. A disabled person might be found incapable of entering into certain financial contracts, for example, or incapable of drawing up a will, or consenting to marry, etc. According to the Committee, such arrangements violate CRPD Art. 12. 'Perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity' (GC1, para 13).

A second line of argument pertains specifically to the CRPD requirement for safeguards that ensure 'respect for the rights, will and preferences' of disabled

persons in all matters pertaining to the exercise of legal capacity. One of the fundamental principles of the MCA is the principle of best interests: 'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests' (MCA s.1(5)). The Act notoriously does not define the concept of best interests, but MCA s.4 establishes a procedure that must be followed in determining best interests in any particular circumstance. MCA s.4 does not use the CRPD terminology of 'will and preference,' but it does explicitly require the best-interests decision-maker to consider, in so far as they are reasonably ascertainable, the 'past and present wishes and feelings' of the person lacking in capacity, as well as 'the beliefs and values that would be likely to influence his decision if he had capacity' (MCA s.4(6)). But while a best-interest decision-maker must take these factors into account, they need not be decisive (*MCA Code of Practice*, para. 5.38). They must be *considered* by the best-interests decision-maker, but if they conflict with the overall best interests of the person lacking in capacity, then the best-interests decision-maker is legally obliged to override them. (For an enunciation of this principle in case law, see, for example, *Re P* [2009] EWHC 163, para. 41) Because of this intrinsic feature of the best-interests paradigm, the Committee concludes that it violates the safeguarding requirements of CRPD Art. 12: '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(b)).

Denial of legal capacity under the MCA

If these two arguments were correct, then the MCA would certainly fail to comply with the CRPD. Moreover, the MCA's non-compliance would be structural rather than remediable, insofar as its fundamental legal and conceptual architecture

depends on substitute decision-making under the best-interests paradigm. But neither of the two arguments survive critical scrutiny when applied to the MCA. As regards the first argument, it is certainly true that the MCA permits the denial of legal capacity to certain persons with disabilities. This point is not in dispute. But CRPD Art. 12 does not underwrite an absolute prohibition on the denial of legal capacity. (See GC1, para. 32.) It requires states parties to recognise that persons with disabilities enjoy legal capacity *on an equal basis with others*. The MCA satisfies this requirement. The full defence of this claim requires more space that is available here, but two crucial points will bring its main outlines into view.

First, it is critical to appreciate that the MCA defines a standard of mental capacity that *applies to everyone* – regardless of disability status. The MCA does not deny legal capacity to individuals *on the basis of disability*; where legal capacity is denied it is *on the basis of a lack of decision-making ability*. These two concepts are by no means equivalent. Most persons with disabilities have mental capacity in at least some areas of life; indeed many have mental capacity in *all* areas of life. Moreover, some persons without disabilities suffer loss of mental capacity for some decisions. Denial of legal capacity on the basis of a person's disability status would indeed be a violation of the CRPD. But denial of legal capacity on the basis of a lack of decision-making capacity is often justifiable. Why? *Because the exercise of full legal capacity requires the making of decisions*. An individual who cannot make decisions for herself, even when all possible support is provided, simply cannot be recognised as possessing full legal capacity. Denial of legal capacity on the basis of the absence of decision-making capacity is therefore not inconsistent with the requirements of CRPD Art. 12, provided that the relevant provision of law applies to all on an equal basis.

Here is where the second crucial point comes into play. As we have just seen, the MCA's definition of mental incapacity is *facially neutral*: it applies to everyone, regardless of disability status. But there remains a legitimate cause for concern that the denial of legal capacity under the MCA constitutes *indirect discrimination*, which is banned under CRPD Art. 5. After all, a person with a disability (particularly a cognitive disability) is far more likely to be denied legal capacity under its provisions than is a member of the general population. But as the UN Human Rights Committee has recognised, 'not every differentiation of treatment will constitute discrimination' (*General Comment No. 18: Non-discrimination*, para 13). Differential treatment can be justified, 'if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant' (*ibid.*). Detailed consideration of the MCA's functional test for mental incapacity shows that it passes this threefold test. The difference between the presence and absence of decision-making capacity is an objective difference and it is a reasonable basis to adopt in pursuing the legitimate aims of the MCA: empowering people to make decisions for themselves wherever possible, and protecting those who may be unable to do so.

Respect for will and preferences

In assessing the second argument against substitute decision-making, everything comes to turn on the meaning of the principle of *respect* for will and preferences. On the Committee's strong reading of this principle, CRPD Art. 12(4) requires that actions undertaken on behalf of a person with a disability *always be determined by* the will and preference of that person. If this were correct, then the MCA's use of the best-interests standard would indeed violate the CRPD, since best-

interests decisions can and sometimes do contravene the known will and preferences of a disabled person.

But the Committee's interpretation of the principle of respect is implausibly strong. There are at least two ways in which this can be demonstrated. First, we must recognise that circumstances sometimes arise in which the will of a person diverges from their preference. A woman may *will* to deliver her baby by Caesarean section, under advice from her doctors. But due to a severe needle phobia she may have an intense *preference* against having her blood drawn in preparation for the procedure (*Re MB* [1997] EWCA Civ 3093). In such a circumstance the care team faces a choice: they can either act in accord with her will or they can act in accord with her preference; they cannot be bound by both. If 'respect' meant 'always be bound by,' then the requirement of CRPD Art. 12(4) would yield contradictory and incoherent guidance in such cases.

Second, it is crucial to interpret Art. 12(4) in the context of the whole of the CRPD, as required under the *Vienna Convention on the Law of Treaties*. Other articles of the CRPD impose a range of obligations on states parties: to ensure the effective enjoyment of the right to life by persons with disabilities (Art. 10); to protect persons with disabilities from all forms of exploitation, violence and abuse (Art. 16); to ensure access by persons with disabilities to health services (Art. 25); etc. If Art. 12(4) is interpreted as requiring absolute deference to the will and preferences of disabled persons in all circumstances, it would create irresolvable conflicts with these other provisions of the same Convention. For circumstances arise in which these objectives can only be attained by overriding the known will or preference of the individual.

But while these considerations suffice to defuse the second argument against substitute decision-making, this does not show that the MCA's best-interests provisions satisfy the safeguarding requirements of CRPD Art. 12(4). In fact they do not. The failure of compliance comes clearly into view if we focus on the key verb of MCA s.4(6). What we find there is a requirement that the best-interests decision-maker *consider* the beliefs and values, wishes and feelings of the person on behalf of whom a decision is being made. But mere consideration of these matters is not enough to satisfy the CRPD safeguarding requirements. What is needed is a strategy for strengthening these safeguards without resorting to a principle of absolute deference.

The most promising way of achieving the proper balance would be to establish a clear hierarchy among the 'checklist' items that must be considered in an assessment of best interests. In its present configuration, MCA s.4 specifies a range of matters that must be considered by the best-interest decision-maker. But it provides no principle for ranking the importance of the various factors to be considered (*Re M, ITW v Z and others* [2009] EWHC 525 (Fam), para. 32(i)). In moving the MCA towards full CRPD-compliance, it should be established *as a rebuttable presumption* that it is in the best interests of P to bring about the course of action that P prefers. A promising point of departure for framing such a principle of rebuttable presumption can be found in a ruling of HH Judge Hazel Marshall (*Re S and S (Protected Persons), C v V* [2009] WTLR 315; see in particular paras. 57-58).

The MCA's 'diagnostic threshold'

An independent failure of CRPD-compliance turns on the MCA's reliance on the so-called *diagnostic threshold*. The definition of mental incapacity in MCA s.2(1) combines two conceptually discrete elements. One part of the definition

pertains to decision-making ability – a concept which is further elaborated in functional test of MCA s. 3(1). But under the MCA's definition, a lack of decision-making ability is only tantamount to mental incapacity if the lack of decision-making ability is due to 'an impairment of or disturbance in the functioning of the mind or brain.' (For the reliance on this second element in case law, see for example *PC and the City of York* [2013] EWCA Civ 478.) This second feature of the MCA's definition has come to be known as 'the diagnostic threshold.' Its effect is to restrict the application of the MCA's best-interests provisions to those whose lack of decision-making capacity can be attributed to some kind of mental dysfunction.

At the time of the Law Commission's review of capacity law, a number of reasons were offered for incorporating the diagnostic threshold into the legal definition of mental incapacity. (See Law Commission Paper 128 (1993): *Mentally Incapacitated Adults and Decision-Making – A New Jurisdiction*.) It was suggested, for example, that the diagnostic threshold would 'avoid distress caused by overuse of protective powers' (para 3.13). This in itself is a laudable aim, but the MCA's strategy for achieving it constitutes an unacceptable form of discrimination against those who may suffer from cognitive disabilities. After all, persons with such disabilities are also liable to be distressed by the overuse of protective powers. Indeed, precisely because of their disabilities, they form a portion of the population that is particularly likely to suffer such distress.

Everyone or no-one?

The citizens of the UK and their democratic representatives effectively face a choice. Contrary to the extravagant claims of the Committee, there is nothing in the CRPD to preclude the use of a functional test for decision-making capacity as a trigger for potentially paternalistic interventions under the best-interests standards.

But such a statutory provision must apply either to everyone or to no-one. It is a violation of the CRPD to apply such a provision only to those for whom impaired decision-making skills are rooted in a mental disability, while refusing to apply the same provision to the rest of the adult population.