

Mental Capacity Act 2005: The Statutory Principles and Best Interests Test¹

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Introduction

The Mental Capacity Act 2005, due for implementation in 2007, will create a new statutory framework intended to improve and clarify the decision-making process for people aged 16 and over who are unable to make decisions for themselves. Section 1 of the Act sets out five statutory principles intended to underline the provisions of the Act and guide its implementation and operation. The first part of this paper will look at the origins of each of the statutory principles. The second part will consider one of the principles – acting in the best interests of a person lacking capacity – in greater detail by looking at the requirements set out in the Act for determining a person's best interests.

Reform of the law relating to mental capacity has been a protracted process, starting in 1989 with a five-year inquiry by the Law Commission which published its report in 1995.³ The Government undertook further consultation on the Law Commission's proposals⁴, leading to a policy statement⁵ and eventual publication in 2003 of a Draft Mental Incapacity Bill.⁶ The draft Bill was subject to pre-legislative scrutiny by a Joint Committee of the House of Lords and House of Commons (the Joint Committee) which made a number of recommendations for improvements.⁷ This paper charts the way in which these processes have influenced the new legislation.

1 This paper is based on materials prepared for publication in G Ashton, P Letts, L Oates & M Terrell, *Mental Capacity: The New Law*, (Bristol: Jordans, forthcoming) and was first presented at Sweet & Maxwell's Mental Capacity Act conference on 30th September 2005

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3 Law Commission, *Mental Incapacity* (Law Com No 231) (London: HMSO, 1995)

4 Lord Chancellor's Department, *Who decides? Making decisions on behalf of mentally incapacitated adults*, (London: HMSO, 1997) (Cm 3803)

5 Lord Chancellor's Department, *Making decisions: the Government's proposals for making decisions on behalf of mentally incapacitated adults*, (London: TSO, 1999) (Cm 4465)

6 *Draft Mental Incapacity Bill*, (London: TSO, 2003) (Cm 5859-I)

7 *Report of the Joint Committee on the Draft Mental Incapacity Bill, Vol 1* (HL Paper 198-I, HC 1083-I) (London: TSO, 2003)

The statutory principles

Much of the evidence submitted to the Joint Committee stressed the need for a clear statement of principles to be set out on the face of any new legislation.⁸ Comparisons were made with section 1 of the Adults with Incapacity (Scotland) Act 2000 (AWI Act) which sets out five general principles to govern all “interventions” in the affairs of an adult taken under or in pursuance of the AWI Act.⁹

While some of the specific provisions of the AWI Act and the Mental Capacity Act are similar, there are significant differences in the underlying intentions and operation of both pieces of legislation as well as in the respective jurisdictions¹⁰. Despite those difference, the Joint Committee was persuaded that the statement of principles in the AWI Act provided not only necessary protection for people with impaired capacity and a framework for ensuring that appropriate action is taken in individual cases, but also that the specified principles were extremely helpful in pointing the way to solutions in difficult or uncertain situations.¹¹ In conclusion, the Joint Committee commented:

“... we were struck by the absence of a specific statement of principles on the face of the Bill as an initial point of reference, as had been done in the Scottish Act. Although the principles of the draft Bill may be discernible to lawyers from the opening clauses of the draft Bill, they may not be so obvious to the majority of non-legal persons who will have to deal with the Bill in practice”¹²

The Joint Committee’s strong recommendations¹³ that a statement of principles be incorporated on the face of the Act were accepted by the Government. As a result, section 1 of the Mental Capacity Act now sets out five guiding principles designed to emphasise the underlying ethos of the Act, which is not only to protect people who lack capacity, but also to maximise their ability to participate in decision-making. Section 1 provides as follows:

- “(1) The following principles apply for the purposes of this Act.
- (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
- (3) 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.
- (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- (5) 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.
- (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.”

8 See in particular the evidence submitted by the Making Decisions Alliance in Report of the Joint Committee on the Draft Mental Incapacity Bill, Vol II (HL Paper 198-II, HC 1083-II) (London: TSO, 2003), Ev 85

9 Adults with Incapacity (Scotland) Act 2000, s1

10 See ‘Reflections from Scotland: Difficult Decisions Ahead’ Hilary Patrick in this issue of the JMHL

11 Evidence for the Law Society of Scotland, Joint Committee Report Vol II, Ev 2

12 Joint Committee Report, Vol I, para 39

13 Joint Committee Report Vol I, Recommendations 4 & 5

The statement of principles was warmly welcomed, not only by voluntary and professional organisations involved with people who lack capacity¹⁴, but also by MPs and Peers commenting on the principles during the Parliamentary debates. In particular, during the Bill's second reading in the House of Lords, the Lord Bishop of Worcester, said

“The result is not just a Bill with important protections for vulnerable people; Clause 1 contains a statement about a vision of humanity and how humanity is to be regarded. I hope children in generations to come will study that as one of the clearest and most eloquent expressions of what we think a human being is and how a human being is to be treated. ...

... I believe that [the Bill] states what is fundamentally right. In the course of Committee we shall no doubt improve and tighten some of the wording, but we shall never take away the powerful and eloquent statement in Clause 1. That should underlie our treatment of one another in all circumstances and for all purposes.”¹⁵

Presumption of capacity

Practitioners will already be familiar with the presumption, at common law, that an adult has full legal capacity unless it is proved that he or she does not. If a question of capacity comes before a court, the burden of proof is generally on the person who is seeking to establish a lack of capacity and the matter is decided according to the usual civil standard, the balance of probabilities.

Taking account of responses to consultation and in keeping with its proposal to establish a single comprehensive jurisdiction, the Law Commission recommended that the new statutory provisions should expressly include and re-state both the common-law principle of presumption of capacity and the relevant standard of proof.¹⁶ The presumption of capacity therefore appears in section 1(2) as the first principle relating to the Act. The Draft Code of Practice (issued in September 2004 to assist Parliamentarians in their consideration of the Mental Capacity Bill) stresses that the starting point for assessing someone's capacity to make a particular decision is always the assumption that the individual does have capacity:

“Some people may need help or support to be able to make a decision or communicate a decision ... but the need for help and support does not automatically mean that they cannot make that decision.”¹⁷

Capacity must then be judged in relation to the particular decision at the time that decision needs to be made, and the presumption of capacity may only be rebutted if there is acceptable evidence that the person is incapable of making the decision in question. In relation to day-to-day decisions in connection with the person's care and treatment, a “reasonable belief” that the person lacks capacity is sufficient, so long as reasonable steps have been taken to establish this.¹⁸

14 See for example, *Making Decisions Alliance, Briefing for 2nd Reading debate in House of Commons, 11th October 2004*, pp 7–9

15 *Hansard, HL Deb, 10 January 2005 cols 53–54, 55*

16 *Law Com No 231, para 3.2. In Scotland, the presumption of capacity is established under common*

law and is not re-stated in the AWI Act 2000

17 *Mental Capacity Bill: Draft Code of Practice (DCA, 2004)* <http://www.dca.gov.uk/menincap/mcbsdraftcode.pdf>, para 3.3

18 *Mental Capacity Act (MCA) 2005, s5(1).*

Practicable steps to help decision-making

The second of the Act's key principles¹⁹ clarifies that a person should not be treated as unable to make a decision until everything possible – or practicable – has been done to help the person make his or her own decision. All practicable steps to enable decision-making must first be shown to be unsuccessful before the person can be assessed as lacking capacity.

The Law Commission had originally proposed that it would only be necessary for “reasonable attempts” to be made to understand a person who has difficulty in communicating a decision.²⁰ However, many respondents to the consultation paper made the point that the reference to “reasonable attempts” was too weak and, for people who are not simply unconscious, “strenuous steps must be taken to assist and facilitate communication before any finding of incapacity is made”.²¹ Other respondents stressed the need for help and support to maximise a person's potential to make their own decisions, not just those with communication difficulties. This requirement has now been translated into the Act's guiding principles in section 1(3).

There are a number of ways in which people can be given help and support to enable them to make their own decisions, and these will vary depending on the decision to be made, the timescale for making the decision and the individual circumstances of the person wishing to make it. The practicable steps to be taken might include using specific communication strategies, providing information in an accessible form, or treating an underlying medical condition to enable the person to regain capacity. The Draft Code of Practice gives a number of pointers to prompt consideration of a range of practicable steps which may assist decision-making, although the relevance of the various factors will vary depending on each particular situation.²² As a minimum, the following steps should be considered:

- Try to minimise anxiety or stress by making the person feel at ease. Choose the best location where the client feels most comfortable and the time of day when the client is most alert.
- If the person's capacity is likely to improve, wait until it has improved (unless the decision is urgent). If the cause of the incapacity can be treated, it may be possible to delay the decision until treatment has taken place.
- If there are communication or language problems, consider using a speech therapist or interpreter, or consult family members on the best methods of communication.
- Be aware of any cultural, ethnic or religious factors which may have a bearing on the person's way of thinking, behaviour or communication
- Consider whether or not a friend or family member should be present to help reduce anxiety. But in some cases the presence of others may be intrusive.

Unwise decisions

The third principle underlying the Act, set out in section 1(4), confirms that:

“A person is not to be treated as unable to make a decision merely because he makes an unwise decision.”

19 MCA 2005, s1(3)

20 Law Commission, *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*, Consultation Paper No 128 (London: HMSO, 1993) para 3.41

21 Law Com No 231, para 3.21

22 *Mental Capacity Bill: Draft Code of Practice*, paras 3.15– 3.22

The right to make unwise decisions has been part of the common law since at least 1850.²³ The intention here is to reflect the nature of human decision-making. Different people will make different decisions because they give greater weight to some factors than to others, taking account of their own values and preferences. Some people are keen to express their own individuality or may be more willing to take risks than others. The diagnostic threshold requiring evidence of an impairment of, or disturbance in the functioning of, the person's mind or brain²⁴ will to some extent ensure that the capacity of those who are merely eccentric is not challenged unnecessarily. However, people who have mental disabilities which could affect their decision-making capacity should not be expected to make 'better' or 'wiser' decisions than anyone else.

During pre-legislative scrutiny of the draft Bill, the Joint Committee received evidence from some witnesses expressing concern that a person with apparent capacity may be able to make repeatedly unwise decisions that put him/her at risk or result in preventable suffering or disadvantage.²⁵ Particular concerns were raised by Denzil Lush, Master of the Court of Protection who drew attention to the distinction between decision-specific capacity and more general on-going incapacity. He gave examples of cases where people had made unwise decisions, each of which they appeared capable of making, but where they in fact lacked an overall awareness or understanding of the implications of those decisions.²⁶

Some caution may therefore need to be applied in operating this principle in practice. Although as a general rule, capacity should be assessed in relation to each particular decision or specific issue, there may be circumstances where a person has an on-going condition which affects his/her capacity to make a range of inter-related or sequential decisions. One decision on its own may make sense but the combination of decisions may raise doubts as to the person's capacity or at least prompt the need for a proper assessment. But equally, an unwise decision should not, by itself, be sufficient to indicate lack of capacity.

Best interests

Section 1(5) establishes in statute the common law principle that any act done, or any decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in that person's best interests. Further details on the meaning and determination of best interests are set out in section 4 of the Act.

In seeking to establish a clear legal framework for making decisions with, or on behalf of people who lack capacity, the Law Commission proposed a single criterion to govern all decision making:

"Although decisions are to be taken by a variety of people with varying degrees of formality, a single criterion to govern any substitute decision can be established. Whatever the answer to the question 'who decides?', there should only be one answer to the subsequent question 'on what basis?'.

We explained in our overview paper that two criteria for making substitute decisions for another adult have been developed in the literature in this field: 'best interests' on the one hand and 'substituted judgment' on the other. In Consultation Paper No 128 we argued that the two were not in fact mutually exclusive and we provisionally favoured a 'best interests' criterion which would contain a strong element of 'substituted judgment'. It had been widely accepted

23 *Bird v Luckie* (1850) 8 Hare 301

24 MCA 2005, s2(1)

25 *Joint Committee report Vol I, paras 72, 78*

26 *Joint Committee report Vol II, Ev 184, Q495-Q496*

by respondents to the overview paper that, where a person has never had capacity, there is no viable alternative to the ‘best interests’ criterion. We were pleased to find that our arguments in favour of a ‘best interests’ criterion found favour with almost all our respondents.”²⁷

It is notable that the Scottish Law Commission took a different approach in formulating proposals which led to the AWI Act:

“We consider that “best interests” by itself is too vague and would require to be supplemented by further factors which have to be taken into account. We also consider that “best interests” does not give due weight to the views of the adult, particularly to wishes and feeling which he or she had expressed while capable of doing so. The concept of best interests was developed in the context of child law where a child’s level of understanding may not be high and will usually have been lower in the past. Incapable adults such as those who are mentally ill, head injured or suffering from dementia at the time when a decision has to be made in connection with them, will have possessed full mental powers before their present incapacity. We think it is wrong to equate such adults with children and for that reason would avoid extending child law concepts to them. Accordingly, the general principles [of the AWI Act] are framed without express reference to best interests”.²⁸

The Joint Committee on the draft Bill compared the two approaches and came down in favour of including the concept of best interests within the Act’s key principles:

“We heard evidence that the concept of best interests has been usefully developed by the courts and that its inclusion in statute would assist in promoting awareness and good practice, thereby ensuring some consistency in approach.”²⁹

Least restrictive alternative

The Law Commission originally proposed that the “least restrictive alternative” principle should be included in the new legislation as one of the factors to be taken into account in determining the best interests of a person who lacks capacity.³⁰ The Commission considered that the principle had been developed over many years by experts in the field so as to become widely recognised and accepted.³¹ The Draft Mental Incapacity Bill therefore included this principle in the proposed statutory checklist for best interests.³² However, in response to the Joint Committee’s recommendation,³³ the Government agreed to incorporate the least restrictive option as the fifth key principle to guide the use of the Act generally, rather than just one factor in the best interests checklist.³⁴

Before any action is taken, or any decision is made under the Act in relation to a person lacking capacity, the person taking the action or making the decision must consider whether it is possible to act or decide in a way that interferes less with the person’s rights and freedom of action. Where there is more than one course of action or a choice of decisions to be made, all possible options

27 *Law Com No 231, paras 3.24 – 3.25*

28 *Scottish Law Commission, Report on Incapable Adults, (Scot Law Com No 151) (Scottish Executive, 1995) para 2.50.*

29 *Joint Committee report, Vol I, para 82*

30 *Law Com No 231, paras 3.28, 3.37*

31 *For a discussion of the origins and development of the principle of least restrictive alternative, see Denzil Lush, ‘The Mental Capacity Act and the new Court of Protection’ in Journal of Mental Health Law 12, 37–38*

32 *Draft Mental Incapacity Bill, clause 4(2)(e)*

33 *Joint Committee report, Vol I, para 44*

or alternatives should be explored (including whether there is a need for any action or decision at all) in order to consider which option would be the least restrictive. However, other options need only be considered so long as the desired purpose of the action or decision can still be achieved.

Determining best interests

The principle of acting in the best interests of a person who lacks capacity has become well established in the common law and the concept has been developed by the courts in cases relating to incapacitated adults, mainly those concerned with the provision of medical treatment.³⁵ Section 1(5) of the Act enshrines this principle in statute as the overriding principle that must guide all actions done for, or all decisions made on behalf of, someone lacking capacity. Section 4 goes on to describe, for the purposes of the Act, what steps should be taken in determining what is in a person's best interests.

Given the wide range of decisions and acts covered by the Mental Capacity Act and the varied circumstances of the people affected by its provisions, the concept of best interests is not defined in the Act. In considering the need for a definition, the Law Commission acknowledged that:

“no statutory guidance could offer an exhaustive account of what is in a person's best interests, the intention being that the individual person and his or her individual circumstances should always determine the result.”³⁶

Instead, the Law Commission recommended that statute should set out a checklist of common factors which should always be taken into account. It also suggested some important considerations as to how a statutory checklist should be framed:

“First, a checklist must not unduly burden any decision-maker or encourage unnecessary intervention; secondly it must not be applied too rigidly and should leave room for all considerations relevant to the particular case; thirdly, it should be confined to major points, so that it can adapt to changing views and attitudes.”³⁷

The Joint Committee agreed with this approach:

“We agree that no list of ‘best interest’ factors can ever be comprehensive or applicable in all situations. We therefore endorse the approach recommended by the Law Commission that a checklist of common factors to be considered in all cases should be set out in statute. However, it should be made clearer in the Bill that in addition to these common factors, all other matters relevant to the incapacitated individual and the decision in question must also be considered.”³⁸

Both as a result of recommendations made by the Joint Committee and amendments made during the Parliamentary process, the best interests checklist contained in section 4 has been extended and made more prescriptive in relation to certain types of decisions, in particular those involving end-of-life decisions.

34 MCA 2005, s1(6)

Fam 15

35 See for example *Re A (Male Sterilisation)* [2000] 1 FLR 549; *Re S (Sterilisation: Patient's Best Interests)* [2000] 2 FLR 389; *Re F (Adult Patient: Sterilisation)* [2001]

36 *Law Com No 231, para 3.26*

37 *Law Com No 231, para 3.28*

The best interests checklist

Under the Act, a person's capacity to make the decision or take the action in question must first be assessed and section 4 only comes into play once it has been established that the person lacks capacity and needs someone else to decide or act on his/her behalf. It then sets out a checklist of factors which must be considered in deciding what is in a person's best interests, aimed at identifying those issues most relevant to the individual who lacks capacity (as opposed to the decision-maker or any other persons). Not all the factors in the checklist will be relevant to all types of decisions or actions, but they must still be considered if only to be disregarded as irrelevant to that particular situation.

Principle of equal consideration

During the Bill's Report stage in the House of Lords, an amendment was passed to make it clear that lack of capacity cannot be established merely by reference to a person's age or appearance, or any condition or aspect of his/her behaviour which might lead others to make unjustified assumptions about the person's capacity.³⁹ This amendment was originally proposed by the Making Decisions Alliance (a coalition of around 40 charities that campaigned for the Mental Capacity Act) as a "principle of non-discrimination and equal consideration" which the Alliance sought to have included in the Act's statement of principles, in order to ensure that people with impaired capacity are treated no less favourably than people with capacity:

"Our concerns stem from evidence, anecdotal and otherwise, that prejudices and attitudes about the quality of life of a person with serious learning disabilities, mental health problem or a head injury or other condition that leads to loss of capacity can get in the way of supporting that person and how they are, what they want and what they need."⁴⁰

While the Government was sympathetic to these concerns, the drafting of a broad 'equal consideration' principle proved unworkable. Instead the Government put forward two amendments, one relating to the definition of capacity and the second concerning best interests determinations in order to:

"... reinforce the belief, shared across the House, that no-one should be assumed to lack capacity, excluded from decision-making, discriminated against or given substandard care and treatment simply, for example, as a result of disability."⁴¹

Therefore, section 4(1) begins with a clear statement that a determination of someone's best interests must not be based merely on the person's age or appearance, or any condition or aspect of his/her behaviour which might lead others to make unjustified assumptions about the person's best interests. The reference to "condition" covers a range of factors, including both mental or physical disabilities as well as temporary conditions. "Appearance" is also deliberately broad, covering visible medical problems, disabilities, skin colour, religious dress and so on.

This is intended to ensure that people with impaired capacity are treated no less favourably than people with capacity. Thus, decisions about best interests must not be based on any preconceived ideas or negative assumptions, for example about the value or quality of life experienced by older people or people with mental or physical disabilities who now lack capacity to make decisions for themselves.

38 *Joint Committee Report, Vol I, para 85*

39 *MCA 2005, s2(3)*

40 *Making Decisions Alliance, House of Lords Briefing, Second Reading 10 January 2005, p3*

All relevant circumstances

A determination of a person's best interests involves identifying those issues most relevant to individual who lacks capacity in the context of the decision in question. The statutory checklist sets out the minimum necessary considerations but all other matters relevant in the particular situation must also be taken into account. Section 4(2) therefore requires the person making the determination to consider "all the relevant circumstances" as well as following the steps set out in the checklist.

It is recognised that the person making the determination may not be in a position to make exhaustive enquiries to investigate every issue which may have some relevance to the incapacitated person or the decision in question. Therefore relevant circumstances are defined as those:

- “(a) of which the person making the determination is aware, and
- (b) which it would be reasonable to regard as relevant.”⁴²

Regaining capacity

Following further consultation on the checklist suggested by the Law Commission for the determination of best interests, the Government proposed an additional factor – whether the person is likely to regain capacity.⁴³ One of the Act's key principles is that before a person is found to be incapable of making a decision, all practicable steps must be taken to help the person make that decision.⁴⁴ In keeping with this approach, when looking at best interests, it is important to consider whether the individual concerned is likely to have capacity to make that particular decision in the future and if so, when that is likely to be.⁴⁵ It may be possible to put off the decision until the person can make it him/herself. This delay may allow further time for additional steps to be taken to restore the person's capacity or to provide support and assistance which would enable the person to make the decision.

The Draft Code of Practice suggests some factors which may indicate that a person may regain capacity⁴⁶:

- The cause of the incapacity can be treated, either by medication or some other form of treatment or therapy
- The incapacity may decrease in time (for example where caused by the effects of medication or alcohol, or following a sudden shock)
- People may learn new skills or be subject to new experiences which increase their capacity to make certain decisions, for example a young adult with learning disabilities who leaves his parental home to live in supported accommodation and gains new skills as a result
- The person may have a condition which causes capacity to fluctuate (such as some forms of mental illness) so it may be possible to arrange for the decision to be made during a lucid interval
- A person previously unable to communicate may learn a new form of communication

41 *Hansard, HL Deb, 15 March 2005, col 1318*

42 *MCA 2005, s4(11)*

43 *Lord Chancellor's Department, Making Decisions, para 1.12*

44 *MCA 2005, s1(3).*

45 *MCA 2005, s4(3)*

46 *Mental Capacity Bill: Draft Code of Practice, para 4.16*

Permitting and encouraging participation

Section 4(4) requires that, even where a person does not have capacity to make an effective decision, he or she should be both permitted and encouraged to participate, or to improve his or her ability to participate as fully as possible in the decision-making process or in relation to any act done for him or her. It will always be important to consult the person on the particular act or decision to be made and to try to seek their views, not only to encourage the development of decision-making skills, but also as an important contribution in determining best interests. The practicable steps to enable decision-making will also be relevant here.⁴⁷

Life-sustaining treatment

A specific factor in the best interests checklist relates to decisions concerning the provision of life-sustaining treatment, which is defined as treatment which a person providing health care regards as necessary to sustain life, usually the life of a person lacking capacity to consent to that treatment.⁴⁸ Section 4(5) clarifies that in determining whether the treatment is in the best interests of someone who lacks capacity, the person making the determination must not be motivated by a desire to bring about the individual's death.

A great deal of the debate in both Houses of Parliament concerned life and death decisions affecting people who lack capacity. In order to provide clarity and reassurance on these very difficult issues, the Government agreed to a number of amendments introducing specific statements in the legislation. In particular, section 62 confirms that the Act does not have the effect of authorising or permitting euthanasia or assisted suicide. Secondly, in relation to decisions about whether the provision or continuance of life-sustaining treatment would be in a person's best interests, section 4(5) clarifies that the decision-maker must not be motivated by a desire to bring about the person's death.

This particular factor was introduced as an amendment in the House of Lords after an undertaking was given in correspondence between the Lord Chancellor and the Roman Catholic Archbishop of Cardiff, Peter Smith, that the Act would make this point absolutely clear. Commenting on a situation where no advance decision has been made about whether treatment should be continued or refused, the Lord Chancellor said:

“The decision about whether to continue to give life-sustaining treatment will then fall to be taken by the doctor, acting with an attorney who has relevant powers. ... In some cases a decision ... will still be taken by the court. The Bill preserves the jurisdiction exercised in the Tony Bland case and restates the principles applied in that case. These are very difficult decisions, even for a court. In making them the decision-maker must act in the best interests of the patient. Above all, he must make an objective assessment. The decision cannot simply be the personal value judgement of the decision-maker – the decision-maker cannot say “If I were in the patient's position, I would want to die” – nor can it be motivated by the desire to bring about the death of the patient.”⁴⁹

Any decision about life-sustaining treatment for a person lacking capacity will take as its starting point the assumption that it is in the person's best interests for life to continue. However, there will be some cases, for example in the final stages of terminal illness or for some patients in a

⁴⁷ See above and *Draft Code of Practice*, paras 3.15–3.22

⁴⁹ *Hansard*, HL Deb, 10 January 2005, cols 14–15

⁴⁸ MCA 2005, s4(10)

permanent vegetative state where there is no prospect of recovery, where it may be in the best interests of the patient to withdraw treatment or to give palliative care that might incidentally shorten life. All the factors in the best interests checklist must be considered, but the person determining best interests must not be motivated in any way by the desire to bring about the person's death.

The person's wishes and feelings, beliefs and values

A particularly important element of the best interests checklist is the consideration, so far as these can be ascertained, of:

- “(a) the person's past and present wishes and feelings (and in particular, any relevant written statements 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.”⁵⁰

This places the focus firmly on the person lacking capacity, taking into account the issues most important to him or her and what s/he would have wanted to achieve. It also reflects the need to make every effort to find out whether the person has expressed any relevant views in the past, whether verbally, in writing or through behaviour or habits, as well as trying to seek his or her current views.

The Draft Code of Practice acknowledges that, while this factor establishes the importance of individual views, those views will not automatically determine the outcome.⁵¹ Indeed, in some cases, there may be a conflict between the person's past and present wishes, so that these must be weighed against each other and considered alongside other factors in the checklist.

The reference to written statements in section 4(6)(a) was included as a Government amendment in the House of Lords in response to lobbying by the Making Decisions Alliance and other stakeholder organisations. Those organisations had requested that advance statements, particularly those expressing wishes about medical treatment, should be given some form of statutory recognition and should specifically be taken into account in determining a person's best interests.

The draft Mental Incapacity Bill published in 2003 made no mention of the person's “beliefs and values” but this was added to the Bill in response to a recommendation of the Joint Committee:

“The Medical Ethics Alliance suggested to us that the factor involving the need to consider the incapacitated person's “past and present wishes and feelings” should also contain reference to that person's *values*. Others suggested that specific reference should be made to social, psychological, cultural, spiritual and religious issues. It is anticipated that the need to consider a wide range of issues, in particular religious and cultural concerns, will be spelt out in the Code of Practice. We seek reassurance that the form of words used in the Bill will require a person's values to be given due weight.”⁵²

The reference to factors the person “would be likely to consider” if able to do so reflects current caselaw in relation to the powers exercised by the Court of Protection to make a statutory will, where:

⁵⁰ MCA 2005, s4(6)

⁵² Joint Committee Vol I, para 90

⁵¹ Draft Code of Practice, paras 4.19–4.22

“subject to all due allowances, ... the court must seek to make the will which the actual patient, acting reasonably, would have made if notionally restored to full mental capacity, memory and foresight.”⁵³

Section 4(6)(c) extends this notion as a factor to consider for all decisions or actions, whether or not the person concerned ever had capacity in relation to the matter in question. The Draft Code of Practice suggests that this might also include “altruistic motives and concern for others as well as duties and obligations towards dependants or future beneficiaries.”⁵⁴

The views of other people

For the first time, the Mental Capacity Act establishes the right for carers, family members and other relevant people to be consulted on decisions affecting the person. People with a right to be consulted include anyone named by the person lacking capacity as someone to be consulted, carers and anyone interested in the person’s welfare, donees and deputies.⁵⁵ Any person who is determining the best interests of someone lacking capacity is required to take into account the views of these key people, but only if it is “practicable and appropriate” to consult them. The Draft Code of Practice suggests:

“This is not intended to give absolute discretion to the decision-maker about whom to consult, rather decision-makers will need to show they have thought carefully about whom to consult and be prepared to explain why a consultation which they declined to carry out was either impracticable or inappropriate.”⁵⁶

The consultation is limited to two matters – first, what those people consider to be in the person’s best interests on the matter in question, and secondly whether they can provide any information on the wishes, feelings, values or beliefs of the person lacking capacity. If prior to losing capacity, the person concerned has nominated someone whom he or she would like to be consulted, the named person is more likely to have that information. People who are close to the person lacking capacity, such as relatives, partners and other carers may also be able to assist with communication or interpret signs which give an indication of the person’s present wishes and feelings.

The requirement for consultation must be balanced against the right to confidentiality of the person lacking capacity. That right should be protected so that consultation only takes place where relevant and with people whom it is appropriate to consult. For example, it is unlikely to be appropriate to consult anyone whom the person had previously indicated should not be involved. However, there may be occasions where it is in the person’s best interests for specific information to be disclosed, or where the public interest in disclosure may override the person’s private interest in maintaining confidentiality.⁵⁷ If professionals are involved in the determination of best interests, they will also need to comply with their own duties of confidentiality in accordance with their professional codes of conduct.

Duty to apply the best interests principle

The principle set out in section 1(5) confirms that any act done, or any decision made, on behalf of a person lacking capacity must be done in his/her best interests. Section 4(8) confirms that the

53 *Re D(J)* [1982] 2 All ER 37 at 43

54 *Mental Capacity Bill: Draft Code of Practice*, para 4.22

55 MCA 2005, s4(7)

56 *Mental Capacity Bill: Draft Code of Practice*, para 4.23

57 *S v Plymouth City Council and C*, [2002] EWCA (Civ 388) at para 49.

best interests principle, and the duties to be carried out in determining best interests, also apply in certain circumstances where the person concerned may not in fact lack capacity in relation to the act or decision in question. The specified situations are:

- Where a donee is acting under a Lasting Power of Attorney in relation to financial matters while the donor still has capacity
- Where someone exercising powers under the Act “reasonably believes” that the person lacks capacity

Reasonable belief

The second situation reflects the position that in most day-to-day decisions or actions involved in caring for someone, it will not be appropriate or necessary to carry out a formal assessment of the person’s capacity. Rather, it is sufficient for them to “reasonably believe” that the person lacks capacity to make the decision or consent to the action in question.

This is based on the Law Commission’s explanation that:

“It would be out of step with our aims of policy, and with the views of the vast majority of the respondents to our overview paper, to have any general system of certifying people as “incapacitated” and then identifying a substitute decision-maker for them, regardless of whether there is any real need for one. In the absence of certifications or authorisations, persons acting informally can only be expected to have reasonable grounds to believe that (1) the other person lacks capacity in relation to the matter in hand and (2) they are acting in the best interests of that person.”⁵⁸

Therefore, section 4(9) confirms that, in cases where the court is not involved, carers (both professionals and family members) and others who are acting informally can only be expected to have *reasonable grounds for believing* that what they are doing or deciding is in the best interests of the person concerned, but they must still, so far as possible, apply the best interests checklist and therefore be able to point to objective reasons to justify why they hold that belief.

Section 4(9) also applies to donees and deputies appointed to make welfare or financial decisions as well as to those carrying out acts in connection with the care and treatment of a person lacking capacity. In deciding what is “reasonable” in any particular case, higher expectations are likely to be placed on those appointed to act under formal powers and those acting in a professional capacity than on family members and friends who are caring for a person lacking capacity without any formal authority.

Conclusion

It has long been recognised that complex legislation of this sort will require an accompanying Code of Practice for the guidance of practitioners using the Act and those affected by its provisions, and also to assist with interpretation and implementation of the Act.⁵⁹ In particular, the need to have regard to the Code is highly likely to be relevant to a question of whether someone has acted or behaved in a way which is contrary to the best interests of a person lacking capacity, or otherwise failed to apply the statutory principles. It will therefore be particularly important for practitioners to respond to the public consultation on the draft Code, due in spring 2006, and to make sure they are familiar with the final version when the Act comes into effect in April 2007.

⁵⁸ Law Com No 231, para 4.5

⁵⁹ Law Com No 231, para 2.53