

Chapter 4

Defining Capacity

Chapter 4: Defining Capacity

Chapter 4 is in three sections:

- A. An overview of important concepts of capacity.
- B. An analysis of the four legal tests of capacity in the Protection of Personal and Property Rights Act 1988 (PPPR Act).
- C. The test for capacity under ss 2 and 3 of the Mental Capacity Act (England and Wales) 2005 (MCA).

Capacity and best interests

- 4.1 “Capacity” and “best interests” are two fundamental concepts that underlie the English legislation. As capacity (or incapacity) is the “brightline” for determining whether the law permits intervention in people’s lives, it is essential that there is a clear test.⁵³⁵ If a person is unable to make a decision as defined in law, the best interests standard provides a legal and an ethical imperative for the person’s will and preferences to remain central to the decision-making that affects them.⁵³⁶ These clearly defined concepts in the MCA give integrity to the legal framework and make the law more accessible to everyone that uses it.
- 4.2 The principles and philosophy of the PPPR Act and MCA are very similar, as is the functional approach to defining capacity, based on an assessment of a person’s decision-making ability, not the decision made. Any definition of capacity must be considered in light of the key concepts that are used to interpret how the definition is applied.⁵³⁷
- 4.3 In this chapter, the problems and complexity of the multiple tests for capacity found in the PPPR Act and the lack of a definition of competence within the HDC Code are identified. The functional test in s 3 of the MCA is considered in light of current English case law.
- 4.4 The essence of the recommendations in Chapters 4 and 5 is that revised legislation should provide a single and unified legal test for capacity, as well as a transparent standard for decision-making, referred to as the “best interests” standard.

⁵³⁵ An introduction to the legal concept of capacity is set out in Chapter 1A.

⁵³⁶ Chapter 2 of this report has argued that the best interests standard as understood in s 4 of the MCA is an essential complement to a supported decision-making framework.

⁵³⁷ The common legal principles of the PPPR Act, the HDC Code and the MCA are considered in Chapter 2B.

4A: IMPORTANT CONCEPTS OF CAPACITY

Presumption of capacity

- 4.5 One of the most important concepts that underlies both the PPPR Act and the HDC Code, as well as the MCA, is the presumption of capacity.⁵³⁸ This presumption means that the burden of proving lack of capacity to make a specific decision (or decisions) always lies with the person who considers that it may be necessary to take a decision on the person's behalf (or who will invite a court to take such a decision). The standard of proof is the balance of probabilities.⁵³⁹ Therefore, it will always be for the decision-maker to prove that it is more likely than not that a person lacks capacity.
- 4.6 A presumption of capacity does not diminish the duty of care owed to patients in the delivery of healthcare. Both the House of Lords' report on the MCA and opinions of the Health and Disability Commissioner in New Zealand affirm that the presumption of capacity does not displace the duty to assess capacity as part of the provision of appropriate care.⁵⁴⁰

The functional approach

- 4.7 There is a wide variety of laws regulating legal capacity across jurisdictions, and it has been stated that there are as many different operational definitions of mental (in)capacity as there are jurisdictions.⁵⁴¹ In keeping with many other countries, New Zealand has rejected the "status" approach (based on a person's disability or medical condition) and the "outcome" approach (based on an evaluation of the decision made), and instead uses a "functional" approach to defining capacity. A functional test focuses on the individual's ability to make a particular decision at a particular time and the processes followed by the person in arriving at the decision.⁵⁴²
- 4.8 A functional approach is more likely to be compliant with the CRPD because it avoids directly discriminating against people merely because they have a disability. The basis of differential treatment under a functional test is the presence or absence of decision-making ability. In some instances, such as a person in a persistent coma, the fact that a person lacks ability to make decisions is clear-cut. There may also be an objective measurable difference, for example, between a patient with very advanced dementia, who has short-term memory of less than one minute, as opposed to a patient in the early stages of Alzheimer's, who may struggle with memory but can still retain information for long enough to discuss treatment options with her doctor and family. The difference between these two individuals is not a matter of subjective opinion; it is an objective measurable difference.⁵⁴³

⁵³⁸ This presumption is referred to as the "presumption of competence" in the PPPR Act, s 5 and in the HDC Code, Right 7(2). In the MCA, the presumption is referred to as the, "assumption of capacity". Section 1(2) states: "A person must be assumed to have capacity unless it is established that he lacks capacity."

⁵³⁹ Mental Capacity Act 2005, s 2(4).

⁵⁴⁰ Chapter 1B and Appendix B A Review of the Health and Disability Commissioner's Opinions about Capacity.

⁵⁴¹ Bach and Kerzner, above n 33 at 18.

⁵⁴² Letts, above n 282.

⁵⁴³ Szerletics, above n 209 at 18.

Unwise decisions and avoiding the “protection imperative”

- 4.9 The principle that a person should not be assumed to lack capacity to make a decision just because other people think their decision is unwise or imprudent is meant to deflect the outcome approach to capacity, recognising that everybody has their own values, beliefs, preferences and attitudes that inform their decisions. There may be triggers, however, that call a person’s capacity into question: for example, where a person is at significant risk of harm or exploitation, or the decision is obviously irrational or out of character for that person.
- 4.10 There have been several judicial statements in the COP that have cautioned against taking an overly protective approach towards determining a person’s capacity, referred to as the “protective imperative”, and reflecting the right to make unwise decisions.⁵⁴⁴ Baker J has described this protective imperative as follows:⁵⁴⁵

There is a risk that all professionals involved with treating and helping a person – including of course a Judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out the appropriate assessment of capacity that is both detached and objective.⁵⁴⁶

- 4.11 In more borderline cases, however, the extent to which the functional approach can provide an objective basis for assessing a process of decision-making is more difficult.⁵⁴⁷ Objective standards are hard to formulate and apply. There can be a tendency to conflate the clinical concept of “insight” with the legal concept of capacity, although the term “insight” does not appear in any mental health or mental capacity legislation.⁵⁴⁸ Whether standards of capacity should be risk-related and viewed on “a sliding scale of competence” is controversial,⁵⁴⁹ as is the extent to which the rationality of a decision is relevant,⁵⁵⁰ and whether sufficient weight is given to the role of values and emotion.⁵⁵¹ All these factors influence how capacity is assessed and how the legal tests for capacity are applied in legal decisions.⁵⁵²

⁵⁴⁴ *CC v KK*, above n 362, at [65].

⁵⁴⁵ *A NHS Trust v Dr A*, above n 214, at [34].

⁵⁴⁶ Similarly see statement by Lord Donaldson MR in *T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, CA at 664 regarding rationality cited in Jones, above n 151 at 16.

⁵⁴⁷ N Banner “Can procedural and substantive elements of decision-making be reconciled in assessments of mental capacity?” (2013) 9 Int J Law Context 71.

⁵⁴⁸ N Allen “Is Capacity ‘In Sight’?” (2009) *Mental Health L* 165. Yet insight is described as the single most consistently discussed symptom of mental illness amongst Mental Health Tribunal members: K Diesfeld, “Insight on ‘insight’: the impact of extra-legislative factors on decisions to discharge detained patients” in K Diesfeld and I Freckleton (eds) *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Aldershot, Burlington Vt, 2003) at 359-382.

⁵⁴⁹ M Jonas “Competence to Consent” in RE Ashcroft, A Dawson, H Draper and others (eds) *Competence to Consent in Principles of Health Care Ethics* (2nd ed, John Wiley and Sons Ltd, Chichester, 2007) at 255.

⁵⁵⁰ In the long build up to the MCA, the English Law Commission in its 1991 report rejected a test based on rationality as it considered that the test would inevitably slide into an assessment of the “reasonableness” of a particular decision which could not be applied in an objective or non-discriminatory way. Law Commission *Mentally Incapacitated Adults and Decision-making: An Overview*, Consultation paper No 119 (HMSO, London, 1991) at 30.

⁵⁵¹ LC Charland “Mental Competence and Value: the Problem of Normativity in the Assessment of Decision-making Capacity” (2001) 8 *Psychiat Psychol L* 135.

⁵⁵² See Chapter 7 Code of Practice and the Toolkit for Assessing Capacity in Appendix D.

Capacity is decision specific

- 4.12 The functional approach reinforces the idea that capacity is decision specific and time specific. Thus, it is often wrong to say that someone “lacks capacity”; rather, it should be said that the person lacks capacity to make a particular decision at a particular time.
- 4.13 The idea that incapacity can be viewed as “global”, so that a person’s incapacity embraces every aspect of a person’s life, has been rejected in favour of a decision and task-relative approach.⁵⁵³ As explained by Buchanan and Brock, the idea behind the task-relative approach is as follows:⁵⁵⁴

The statement that a particular individual is (or is not) competent is incomplete. Competence is always competence for some task – competence to do something. The concern here is with competence to perform the task of making a decision. Hence competence is to be understood as decision-making capacity. But the notion of decision-making capacity is itself incomplete until the nature of the choice as well as the conditions under which it is to be made are specified. Thus, competence is decision-relative, not global.

Capacity and proportionality

- 4.14 A decision-specific approach to capacity is in keeping with the notion that the assessment of capacity takes into account the level of the person’s residual ability and determines capacity in proportion to the seriousness of the decision(s) they must make. As envisaged by Lord Donaldson, in *Re T (Refusal of Treatment)*:⁵⁵⁵

What matters is that doctors should consider whether at the time [the patient] had a capacity which was commensurate with the gravity of the decisions which he purported to take. The more serious the decisions, the greater the capacity required.

4B: PPPR ACT – LEGAL TESTS

- 4.15 As with the MCA, a finding of impairment of capacity under the PPPR Act is fundamental to any resulting intervention that may be made on the person’s behalf, such as a court order or the activation of an EPOA.⁵⁵⁶

The question of capacity to make the decision that is the subject of an application (under the Act) is a threshold question that must be considered in every case; because jurisdiction to make any order ... depends on it.

- 4.16 In general, a person lacks capacity if they cannot understand the nature and foresee the consequences of decisions, or are unable to communicate them. However, there are four subtly different legal tests for incapacity in the PPPR Act, depending on the kind of substitute decision-maker appointed, and on whether care and welfare, or property decisions, are involved. Nevertheless, the different legal tests in the PPPR Act follow a common functional

⁵⁵³ M Jonas, above n 549 at 255.

⁵⁵⁴ Buchanan and Brock, above n 35 at 18.

⁵⁵⁵ *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782; [1993] Fam 95 at 113.

⁵⁵⁶ *KR v MR* (2004) 2 NZLR 847 at [25]. Also reported as *X v Y (Mental Health: Sterilisation)* [2004] 23 FRNZ 475.

approach and in this respect are similar to the single legal test in the MCA, and codify the prior common law (case law).⁵⁵⁷

- 4.17 The key difference between the tests in the PPPR Act and the MCA is that there is no disability precondition in the PPPR Act. Under the MCA, the inability to make a decision (the functional test) must have a causal link to “an impairment of, or a disturbance in the functioning of, the mind or brain” (the diagnostic test).⁵⁵⁸ There is no equivalent in the PPPR Act.

Four legal tests

- 4.18 The four threshold tests in the PPPR Act and the corresponding interventions are as follows:
1. “partly” lacks capacity: for making a personal order and appointing a property manager;⁵⁵⁹
 2. “wholly” lacks capacity: for appointing a welfare guardian;⁵⁶⁰
 3. “not wholly competent”: for activating a property-related EPOA;⁵⁶¹ and
 4. “lacks the capacity”: for activating a care and welfare-related EPOA.⁵⁶²

Test no. 1: “partly” lacks capacity – personal order

- 4.19 Section 6 provides the foundation of the jurisdiction to make personal care and welfare orders. This jurisdiction is dependent on a finding that the “subject person” either:

Lacks wholly or partly the capacity to understand the nature and foresee the consequences of decisions in respect of matters relating to his or her personal care and welfare; or

Has the capacity to understand the nature and to foresee the consequences of such decisions but wholly lacks the capacity to communicate decisions in respect of such matters.

⁵⁵⁷ The English cases that developed the functional test were mainly concerned with capacity to consent to or refuse medical treatment. For example, *St George’s Healthcare NHS Trust v S* [1998] 3 All ER 673, where a competent woman’s refusal of a Caesarean section in which the baby would die was overridden and carried out but was subsequently held to be unlawful, affirming the right to bodily integrity. See also *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819, an influential case for the “use or weigh” criteria in the MCA test, where Thorpe J at 822 described the test as follows: (1) Can the patient take in and retain treatment information? (2) Does he believe it? (3) Can he weigh that information, balancing risks and needs? Thorpe J referred to the developing test in Law Commission *Mentally Handicapped Adults and Decision-making* Consultation paper No 129 (HMSO, London, 1992) at [2.20].

⁵⁵⁸ Mental Capacity Act 2005, s 2(1), discussed below.

⁵⁵⁹ Protection of Personal and Property Rights Act 1988, s 6: personal order, s 10; order for the administration of property, s 11; and order for the appointment of a property manager, (“wholly or partly”), s 25 (2)(b).

⁵⁶⁰ Protection of Personal and Property Rights Act 1988, ss 6 and 12.

⁵⁶¹ Protection of Personal and Property Rights Act 1988, s 94(1).

⁵⁶² Protection of Personal and Property Rights Act 1988, s 94(2).

- 4.20 Whether the person is partly or wholly incapable of managing their affairs is relevant to the kind of orders the court can make.⁵⁶³ A person need only partly lack capacity for the court to make a personal order, such as an order for medical treatment, provision of services or living arrangements under s 10, or a low-level order for the administration of property under s 11. Personal orders of this kind are frequently used by the Family Court as a fall-back order where the person does not meet the threshold of “wholly” lacking capacity for the appointment of a welfare guardian. This reflects the primary objective of the Act, which is to impose the least restrictive intervention tailored to the person’s specific needs.⁵⁶⁴
- 4.21 The problem lies in understanding what the legal test of “partly” lacking capacity actually means. Applying a decision-specific approach, partial lack of capacity suggests something less than incapacity for that specific decision. Alternatively, it could suggest that a person lacks capacity in respect of the decision regarding which the court is going to make an order and not other decisions. However, rather confusingly, section 6 refers to partly lacking capacity in respect of “decisions” in general and not in a specific sense.⁵⁶⁵
- 4.22 Either way, with such an apparently low legal threshold for incapacity, significant decisions can be made regarding a person’s medical treatment or living arrangements, under this test.

Test no. 2: “wholly” lacks capacity – welfare guardian

- 4.23 For the appointment of a welfare guardian, both ss 6 and 12 apply. In addition to the test set out in s 6, quoted above, for the appointment of a welfare guardian under s 12, the person must “wholly lack capacity”, the highest threshold in the Act. The Court must be satisfied that:⁵⁶⁶
- (a) the person ... *wholly* lacks the capacity to make *or* communicate decisions relating to any particular aspect(s) of the personal care and welfare of that person; *and*
 - (b) the appointment of a welfare guardian ... is the *only* satisfactory way to ensure the appropriate decisions are made.... [emphasis added].
- 4.24 Although “wholly” is a much more stringent threshold than simply “lacks” or “partly lacks” capacity, it has not been interpreted by the Court to mean that the threshold is crossed only where the person is totally incapable of making decisions *at all*, for example, where a person has advanced dementia or is in a persistent vegetative state. If a person has limited capacity to make some decisions but has no capacity to make others, it is sufficient that the person “wholly” lacks the capacity in respect of “particular aspect or aspects” of their care and welfare over which decisions will be transferred.⁵⁶⁷ The notion that capacity is decision-specific is,

⁵⁶³ The Family Court can also choose not to make an order and instead make recommendations.

⁵⁶⁴ Protection of Personal and Property Rights Act 1988, s 8(1). The Family Court only has power to make an order to provide medical treatment (PPPR Act, s 10(1f)); not to withhold or withdraw it; such applications for withdrawal or withholding treatment which would require an application to the High Court under the *parens patriae* jurisdiction which is recognised in the PPPR Act, s 114.

⁵⁶⁵ In *Re L* [2001] NZFLR 310, the threshold “partly” lacking capacity was interpreted to include a woman whose capacity fluctuated with the state of her mental health due to psychotic episodes in which she had impaired mental functioning. Such an interpretation is contrary to the decision specific nature of capacity and appears more focussed on a status approach in managing people with mental disabilities whose capacity for decision-making may fluctuate.

⁵⁶⁶ Protection of Personal and Property Rights Act 1988, s 12(2).

⁵⁶⁷ *Re G* [1994] NZFLR 445. See also G Rossiter “Capacity Issues under the PPPRA” (2005) NZLJ 204. There has been little case law on the meaning of “wholly” in the 20 years since the initial decisions after the enactment of the PPPR Act in 1988. The High Court in *KR v MR* (above, n 556) considered this

however, undermined where Court orders are made in respect of “all aspects” of a person’s care and welfare, effectively making the welfare guardian a global decision-maker for a wide range of decisions.⁵⁶⁸

- 4.25 Yet there is a place for the appointment of the welfare guardian on an ongoing basis, where, for example, a person with severe dementia has a deteriorating condition, or in the case of a severely disabled young adult with high needs. These orders may allow some flexibility and understanding of a person’s needs in a range of circumstances, where some form of ongoing decision-making is pragmatically required to support a person whose capacity is impaired in many areas.
- 4.26 It is unrealistic, however, to require a person to “wholly” lack capacity before a welfare guardian can be appointed, and it is unlikely that this test is strictly applied in practice. The test was initially interpreted as permitting the appointment of a welfare guardian only as “an extreme form of intervention”.⁵⁶⁹ Nevertheless, even though it is intended in this way to set a high threshold for instituting substitute decision-making in respect of specific decisions, in practice it is not always applied in this way.⁵⁷⁰

Test no. 3: “not wholly competent” – property EPOA

- 4.27 The 2007 amendment to the PPPR Act added two further legal tests for the purpose of activating EPOAs relating to decisions about property, and care and welfare respectively.⁵⁷¹ To confirm that the EPOA can be activated, capacity assessors are required to certify that the person is “mentally incapable”.⁵⁷² EPOAs for both property, and care and welfare decisions require this. However, two different tests apply.
- 4.28 For the purposes of activating a property EPOA, the donor is mentally incapable if:⁵⁷³
- ... not wholly competent to manage his or her own affairs in relation to his or her property.
- 4.29 This test of “not wholly competent” implies the threshold is something less than not “wholly” lacking competence. This again leaves some doubt about the level of impairment of decision-making required to activate a property EPOA.⁵⁷⁴ A further inconsistency is that, for the court

issue. See also, *R v R* (2010) Fam-054-000472, where Judge Somerville held that a welfare guardian should be appointed for person with brain injuries. The order was made not on a global assessment, but in respect of task specific decisions from simple personal care decisions to more complicated aspects of care and welfare where the person’s capacity was said to be wholly lacking.

⁵⁶⁸ Under s 16(4)(a) of the MCA, a decision by the Court is to be preferred to the appointment of a deputy to make a decision and the powers conferred on a Deputy are to be limited in scope and duration as is “reasonably practicable in the circumstances”. There is said to be some “slippage” and that deputies may in fact make more decisions. (A Douglass, presentation to the Manchester School of Law, Manchester 30 April 2015).

⁵⁶⁹ *Re G*, above n 567, at 448-449.

⁵⁷⁰ There are wider problems of how these welfare guardian orders are implemented, the limited ability of the Court to review and monitor the orders, and the lack of availability of people to be appointed as welfare guardians in the first place. See Chapter 1B: Overview of Mental Capacity Law in New Zealand. Protection of Personal and Property Rights Act 1988, ss 94(1) and 94(2).

⁵⁷¹ As at December 2015, the Statutes Amendment Bill 2015 proposed to make minor amendments to Part 9 of the PPPR Act and to amend the requirement for a prescribed certificate, instead requiring “prescribed information”, although what the nature and content of that information is not stated.

⁵⁷³ Protection of Personal and Property Rights Act 1988, s 94(1).

⁵⁷⁴ In *Treanery v Treanery* (2008) 27 FRNZ 78, the Court considered that loss of competence must be “total” and equated it to a s 12 test. While the High Court overturned much of the Family Court’s findings ([2009] NZFLR 1062) on the grounds that the judge erred in conflating the daughter’s lack of suitability

to appoint a property manager, the person need only be “partly” lacking competence – a subtly different formulation.⁵⁷⁵

Test no. 4: ‘lacks the capacity’ – care and welfare EPOA

4.30 Section 94(2) provides a fourth incapacity test for the purpose of activating a care and welfare EPOA. The donor is “mentally incapable” if the donor:

- (a) *lacks the capacity* –
 - (i) to make a decision about a matter relating to his or her personal care and welfare; *or*
 - (ii) to understand the nature of decisions about matters relating to his or her personal care and welfare; *or*
 - (iii) to foresee the consequences of decisions about matters relating to his or her personal care and welfare or any failure to make such decisions; *or*
- (b) lacks the capacity to communicate decisions about matters relating to his or her personal care and welfare. [Emphasis added]

4.31 This test is consistent with the functional approach in the MCA, and it is disjunctive (“or”), so only one of the criteria needs to be established. The person may satisfy the test if, for example, they understand the nature of the decision but do not foresee the consequences of it. There may be some circumstances where it is unclear why a person is unable to make a decision, for example, if the person has suffered a stroke and may be depressed. They may be “able” to communicate but do not do so. It is questionable, however, whether the stand-alone criterion of lacking capacity to “make a decision” under s 94(2)(i) adds anything to the overall test because the three functional criteria that follow are all grounds for being unable to make a decision: understanding the nature of decisions, foreseeing the consequences (and failing to make “such decisions”), and the inability to communicate.⁵⁷⁶ This test – of “lacks the capacity” – for the appointment of a personal care and welfare attorney is, however, a lower threshold than the “wholly” lacking capacity criterion for the appointment of a welfare guardian.

Multiple tests and no clear definition

4.32 This use of multiple legal tests throughout the legislation produces unnecessary complexity, especially for health professionals who are required to understand the different legal thresholds and undertake capacity assessments in relation to each of them. Since the early decisions of the PPPR Act, there have been few cases that have examined the meaning of the different thresholds. Moreover, there are few reported cases under the PPPR Act where capacity has been contested, and the reports of some cases suggest that these thresholds have not been correctly applied.⁵⁷⁷ Even where careful consideration has been given to a

to be her mother’s property manager with her suitability to be a welfare guardian, the High Court did not address Judge Murfitt’s statement that there must be total lack of competence before an EPOA for property is activated.

⁵⁷⁵ Protection of Personal and Property Rights Act 1988, s 25(2).

⁵⁷⁶ Protection of Personal and Property Rights Act 1988, ss 94(2)(a)(ii), (iii) and 94(2)(b). By comparison, under the MCA the definition of being unable to make a decision in s 2 is further defined in s 3 entitled, “Inability to make decisions” followed by the four elements of the functional test.

⁵⁷⁷ See Appendix A for a review of selected PPPR Act cases accessed from the Ministry of Justice database.

person's capacity,⁵⁷⁸ often little, if any, consideration is given to the relative difference between "partly" lacking capacity and the higher threshold of "wholly" lacking capacity, for the purposes of establishing jurisdiction.

- 4.33 In summary, the two original tests under the PPPR Act and subsequent additional tests for activating EPOAs, have created an unnecessarily complicated schema of legal tests, with a spectrum from an impossibly high threshold, "wholly", through to an unacceptably low threshold of "partly" lacking capacity.

No definition of capacity in the HDC Code

- 4.34 Capacity is an essential component of valid consent. A valid consent is generally taken to consist of four elements: information provision, voluntariness, the opportunity to deliberate, and capacity (or competence).⁵⁷⁹ Under the HDC Code, consent to treatment is necessary in many situations, as required by the HDC Code or by other legislation or the common law.⁵⁸⁰ Right 7 of the HDC Code enshrines the right to make an informed choice and give informed consent. This is buttressed by two important principles: the presumption of competence, and encouraging the participation of those with diminished competence.⁵⁸¹ In addition, Right 7(4) provides a mechanism for making decisions for a person who is assessed as lacking capacity where there is no substitute decision-maker available.⁵⁸²
- 4.35 Nevertheless, despite the fact that healthcare decisions involving people with impaired capacity are made every day, and the importance of capacity to informed consent, neither the Health and Disability Commissioner Act 1994, nor the HDC Code (a regulation issued under that legislation), defines the concept of capacity (referred to as "competence") or provides clear legal standards against which capacity is to be assessed.⁵⁸³

4C: MCA – LEGAL TEST

- 4.36 There is a single legal test in the MCA defining lack of capacity. The key provision for determining capacity is s 2(1) of the MCA.⁵⁸⁴

For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

⁵⁷⁸ See for example, *VJM on behalf of the Hawkes Bay District Health Board v MH* (2011) FAM-2011-041-516, where Judge Callinicos undertook a thorough analysis of the independent psychiatrist's evidence and was satisfied that MH's inability to make a reasoned decision about the arrangements for her discharge from hospital was a "tipping point", and that the Court had jurisdiction.

⁵⁷⁹ Jonas, above n 549 at 255.

⁵⁸⁰ HDC Code, Right 7(1). See discussion by PDG Skegg "Justifications for Treatment without Consent" in P Skegg and R Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) at 188 and 214.

⁵⁸¹ HDC Code, Rights 7(2) and 7(3).

⁵⁸² An overview of the HDC Code is discussed above Part 1B.

⁵⁸³ Appendix B is a review of the Health and Disability Commissioner's opinions where a person's capacity has been at issue.

⁵⁸⁴ Mental Capacity Act 2005, s 2(1).

- 4.37 There are two limbs to the capacity test in s 2. These are:⁵⁸⁵
1. Whether the person is “unable to make a decision for himself” (functional test – as defined in s 3); and
 2. Whether that inability is because of “an impairment of, or a disturbance of the functioning of, the mind or the brain” (diagnostic test – as set out in s 2).
- 4.38 Section 3 defines what it means to be unable to make a decision in terms of the functional approach. In summary, the four elements of the functional test are the inability to: understand, retain, or use or weigh the relevant information as part of the decision-making process, or communicate their decision.⁵⁸⁶
- 4.39 The MCA definition of capacity reinforces that capacity is time-specific (at the material time) and decision-specific (unable to make a decision). It applies for the purposes of the Act, which in English law includes questions of capacity in relation to medical treatment decisions.⁵⁸⁷ Common law definitions of capacity such as capacity to make a will are not affected.⁵⁸⁸ When cases on such matters outside the Act come before the courts, judges can adopt the definition of capacity contained in this section and s 3 if they think it is appropriate.⁵⁸⁹
- 4.40 A difficulty in applying a strictly decision- or act-specific approach to capacity, within the MCA, has arisen in cases involving vulnerable women with learning disabilities that have been concerned with whether the women had capacity to consent to cohabit or have sexual relations.⁵⁹⁰ In *IM v Liverpool*,⁵⁹¹ LM was found to have capacity to consent to sex, where the man involved challenged the supervision of his contact with LM that was carried out by the local authority. The Court of Appeal followed an act-specific approach, based on whether the person understood at a general level the nature of sex, to which they were apparently consenting, in contrast to a person-specific approach, requiring a more contextual analysis of the circumstances of the particular person.⁵⁹² This reasoning suggests that the test of capacity to consent to sex merely involves being able to understand the nature of the activity, rather than having the ability to use or weigh information about it. The extent to which the capacity test in the MCA deals with these hard cases, where the person’s ability for autonomous decision-making is impaired, has therefore been called in question.⁵⁹³

⁵⁸⁵ A Ruck-Keene, V Butler-Cole, N Allen and others, above n 201.

⁵⁸⁶ The functional test in s 3 of the MCA is discussed below. Both ss 2 and 3 of the MCA are set out in full in Appendix C.

⁵⁸⁷ In New Zealand, the HDC Code provides the basis of the law of consent in relation to healthcare procedures but there is no definition of “competence”, discussed below.

⁵⁸⁸ *Banks v Goodfellow* (1869-70) LR5 QB 549. The Code of Practice recognises the common law tests of capacity to make a will, gift, enter a contract, to litigate and to enter a marriage.

⁵⁸⁹ *Local Authority X v MM and KM* [2007] EWHC 2003 (FAM) at [80], Munby J.

⁵⁹⁰ The consequences of finding that a person lacks capacity to consent to sex means that nobody else can consent to sexual relations on their behalf: Mental Capacity Act 2005, s 27(1)(b).

⁵⁹¹ *IM v LM and Liverpool City Council* [2014] EWCA Civ 37. Another case, *PC and NC v City of York Council* [2013] EWCA Civ 478, McFarlane LJ, is discussed below in respect of causation.

⁵⁹² The person or situation-specific test was supported by Lady Hale in a criminal law case involving consent: “One does not consent to sex in general. One consents to this act of sex with this person at this time and in this place” *Regina v Cooper* (2009) UKHL 42 at [27].

⁵⁹³ J Herring and J Wall “Capacity to Consent to Sex” (2014) 0 Med L Rev 1.

MCA – the functional test

4.41 As with the PPPR Act, the MCA therefore mainly adopts a functional approach to defining capacity. The key difference is that there is just one legal test to follow, set out as four logical steps. A person is unable to make a decision if they cannot:⁵⁹⁴

1. understand the information relevant to the decision; or
2. retain that information in their mind; or
3. use or weigh that information as part of the decision-making process; or
4. communicate their decision (whether by talking, using sign language or any other means).

4.42 Section 3 is based on the common law test of capacity and there is no relevant distinction between them.⁵⁹⁵ In *IM v LM*, the Court of Appeal said that:⁵⁹⁶

Every single issue of capacity which falls to be determined under Part 1 of the Act must be evaluated by applying s 3(1) in full in considering each of the four elements of the decision-making process that are set out at (a) to (d) The extent to which, on the facts of any individual case, there is a need either for a sophisticated, or for a more straightforward, evaluation by either of these four elements will naturally vary from case to case and from topic to topic.

4.43 The four elements in this test are considered below.

Understand the information

4.44 It is not necessary that the person understands every element of what is being explained to them. The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make a decision.⁵⁹⁷ An explanation of all relevant information must be given to the person using appropriate means of communication given their particular circumstances.

4.45 Being able to understand the information is not the same as being able to pass an exam on it: the person should have a broad understanding of the basic information relevant to the decision. This concept is familiar to most lawyers, but may not be so familiar to doctors, who may set the bar too high.⁵⁹⁸

4.46 In *Heart of England NHS Foundation Trust v JB*,⁵⁹⁹ JB suffered from severe schizophrenia and vascular disease. She was found to have capacity to refuse surgical treatment of her gangrenous leg against “shifting medical opinion”. Peter Jackson J held:

⁵⁹⁴ Mental Capacity Act 2005, s 3(1).

⁵⁹⁵ *Local Authority X v MM and KM*, above n 589 at [74], Munby J.

⁵⁹⁶ Above n 589 at [73].

⁵⁹⁷ Mental Capacity Act 2005, s 3(4).

⁵⁹⁸ *PH and A Local Authority v Z Limited and R* [2011] EWHC 1704 (FAM).

⁵⁹⁹ Above n 363 at [26]. Peter Jackson J “happily” distinguished the earlier and famous decision of Thorpe J in *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290 at 295, the first reported case to give any clear guidance on questions of capacity in relation to medical treatment decisions, even though both cases involved people with delusional beliefs. In refusing amputation of his gangrenous leg, C preferred

[w]hat is required here is a *broad, general understanding of the kind that is expected from the population at large*. JB is not required to understand every last piece of information about her situation and her options: even her doctors would not make that claim. It must also be remembered that common strategies for dealing with unpalatable dilemmas – for example *indecision, avoidance or vacillation – are not to be confused with incapacity. We should not ask more of people whose capacity is questioned than of those whose capacity is undoubted*. [Emphasis added].

- 4.47 Having the appropriate information, including the options available, to make the decision is vital to this process and is consistent with supporting people to make their own decisions, where possible. So it is said that a person must not start with a “blank canvas”.⁶⁰⁰

Retain the relevant information

- 4.48 Retaining information for even a short time may be adequate in the context of some decisions. This will depend on what is necessary for the decision in question. The MCA specifies that “the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision”.⁶⁰¹
- 4.49 Aids to recollection, such as notes, pictures, photographs and voice recordings, and parts of the mental state examination, may be helpful to assess how long the person can retain information. Can they remember three words? If they can’t, can they still give consistent answers when questioned about their decision?⁶⁰²
- 4.50 The ability to retain information is a discrete element of the MCA test and logically follows from the requirement to understand the information. There is no equivalent element in the PPPR Act tests. It is an important consideration, particularly with older adults or people with deteriorating memories.⁶⁰³

Use or weigh the Information

- 4.51 Using and weighing information is the evaluative component of the MCA test. It requires the ability to reason about, or weigh up, information and to appreciate the consequences. This may be the most difficult element of assessing capacity as an unwise or irrational decision does not necessarily establish that a person has failed to use or weigh the information.
- 4.52 The standard of “weighing up” or “using information” can be difficult if the person is weighing up the important information against their personal convictions, beliefs or values. It recognises that “different individuals may give different weight to different factors.”⁶⁰⁴ In *Kings*

“to die with two feet than live with one”. Note also earlier discussion of capacity in, *Re T*, above n 555 and although the ultimate decision was unanimous, each of the four judges involved decided the question of the person’s capacity differently.

⁶⁰⁰ *CC v KK*, above n 362. This case is discussed in Chapter 2E: Supported Decision-making in practice and in case law.

⁶⁰¹ Mental Capacity Act 2005, s 3(3).

⁶⁰² Interview with Dr Frances Matthews, lawyer and GP (A Douglass, Dublin, June 2015).

⁶⁰³ Ruck Keene, Butler-Cole, Allen and others, above n 201 at [30].

⁶⁰⁴ *LBL v RYJ and VJ* [2010] EWHC 2665 (COP) Macur J cited with approval by Baker J in *CC V KK* at [65]: “There is, I perceive, a danger that professionals, including judges, may objectively conflate a capacity assessment with a best interests analysis and conclude that the person under review should attach greater weight to the physical security and comfort of a residential home and less importance to the emotional security and comfort that the person derives from being in their own home.”

College NHS Foundation Trust v C and V,⁶⁰⁵ the COP had to consider whether C had the capacity to consent to life-saving renal dialysis that her doctors wished to give her following an attempted suicide. If the treatment were to have been administered the likelihood was that C would require dialysis for the rest of her life, and, if not, the inevitable outcome was that she would die. C's refusal to consent was supported by her two daughters.⁶⁰⁶ In finding that C had the capacity to refuse treatment, MacDonald J held, contrary to the opinion of two experienced psychiatrists, that it had not been shown that C was unable to use and weigh the information relevant to the decision:⁶⁰⁷

I am not satisfied that C lacks belief in her prognosis or a future that includes her recovery to the extent she cannot use that information to make a decision, or that C is unable to weigh her positive prognosis and the possibility of a future recovery in the decision making process....

... it is also important in this case not to confuse a decision by C to give no weight to her prognosis having weighed it with an inability on her part to use or weigh that information.⁶⁰⁸

4.53 In concluding, MacDonald J noted that the decision was an unwise one:⁶⁰⁹

The decision C has reached to refuse treatment dialysis can be characterised as an unwise one. That C considers that the prospect of growing old, the fear of living with fewer material possessions and the fear that she has lost, and will not regain, "her sparkle" outweighs a prognosis that signals continued life will alarm and possibly horrify many, although I am satisfied that the ongoing discomfort of treatment, the fear of chronic illness and the fear of lifelong treatment and lifelong disability are factors that also weigh heavily in the balance for C.

4.54 There are also cases where the person concerned can understand information but where the effects of a mental disability prevent them from using that information in the decision-making process. For example, a person with anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore.⁶¹⁰ Some people who have serious brain damage might make impulsive decisions regardless of information they have been given or their understanding of it.⁶¹¹ Undue influence and the overpowering will of a third party are also considered to have a role in this aspect of

⁶⁰⁵ *Kings College NHS Foundation Trust v C* [2015] EWCOP 80 at [8]. C was said to live an unconventional life where she placed a "significant premium on youth and beauty and on living a life that, in C's words, 'sparkles'".

⁶⁰⁶ C made statements such as "They are doing their best to do everything they can for me and unfortunately that is not what I want" and "I know they need to save lives. But I have chosen a different route" at [87].

⁶⁰⁷ *Kings College NHS Foundation Trust v C* at [72]. At [35], MacDonald J suggested that a finding of incapacity requires the person asserting lack of capacity to demonstrate *both* an inability to use *and* weigh relevant information however this reasoning has been questioned as not an accurate interpretation of "use or weigh" and that s 3(1)(c) can be satisfied either by establishing that a person is unable to use *or* by establishing a person is unable to weigh. W Martin and F Freyenhagen of the Essex Autonomy Project "Use or Weigh? Or Use and Weigh? A Note on the Logic of MCA sec. 3(1)" (2015) 61 *Ment Capac Law News* 15.

⁶⁰⁸ *Kings College NHS Foundation Trust v C* at [86].

⁶⁰⁹ *Kings College NHS Foundation Trust v C* at [97].

⁶¹⁰ *In Re E (Medical Treatment Anorexia)* [2012] EHC 1639 (COP) Peter Jackson J at [49] "E's obsessive fear of weight gain makes her incapable of weighing the advantages and disadvantages of eating in a meaningful way". E could understand and retain the information relevant to her decision to refuse to eat, but she was unable to assign relative weight to the advantages, disadvantages and consequences associated with the decision to eat since, "the compulsion to prevent calories entering her system has become that card that trumps all others".

⁶¹¹ *Mental Capacity Act Code of Practice*, above n 285 at 48.

the capacity test, especially where a person with borderline capacity may be less able to resist pressure applied by others.⁶¹²

- 4.55 The nearest equivalent under the PPPR Act to the MCA's criterion of "use or weigh" is its requirement "to foresee the consequences" of decisions. There is, however, a nuanced difference, as the MCA test focuses on the evidence of using or weighing information as part of the decision-making process rather than on predicting the outcome or the consequences of the decision itself. The difficulty with the PPPR Act's concept of "foreseeing the consequences" concerns the extent to which anyone, with capacity or not, can be said to value or fully evaluate the consequences of a decision if that requires the risks and benefits of the decision to be internalised.⁶¹³
- 4.56 The concept of "appreciating" that nature of the decision is used in this context in the United States.⁶¹⁴ In the recently passed Mental Capacity Bill in Northern Ireland, the notion of "appreciate the relevant information" has been added to the element of "use or weigh" in the MCA test.⁶¹⁵ It arguably adds a subtle evaluative aspect to the MCA test by importing the notion that the ability to "use or weigh" requires an appreciation of the significance of the person's situation and the probable consequences of the treatment options.

Communicate the decision

- 4.57 The inability to communicate a decision is also recognised in the PPPR Act tests and is a stand-alone ground for incapacity, even if rarely employed. Examples where it would apply would include people who are unconscious or in a coma or those with a rare condition sometimes referred to as "locked-in syndrome", who are conscious yet totally unable to communicate.⁶¹⁶ Any form of communication suffices so long as the person can make themselves understood.⁶¹⁷ The MCA and its Code of Practice also require that an explanation of the relevant matters be communicated to the person in a way that is appropriate to their circumstances (using simple language, visual aids or other means).⁶¹⁸
- 4.58 Where an individual cannot communicate a decision in any possible way, the MCA considers the individual unable to make a decision for themselves.⁶¹⁹ People who have suffered a stroke, for example, are particularly disadvantaged, as their difficulty in communicating can

⁶¹² *Re T*, above n 555 at 797, Lord Donaldson MR. The role of undue influence in the test of capacity was recognised by the Law Commission, above n 311 at 38.

⁶¹³ P Appelbaum and T Grisso "Assessing Patients' capacities to consent to treatment" (1988) 319 N Eng L Med 1635. Some New Zealand decisions have referred to 'appreciate' instead of "foresee the consequences" test when applying the s 6 PPPR Act test: *KR v MR*, above n 556.

⁶¹⁴ In relation to treatment decisions, the criteria expressed by Grisso and Appelbaum are: the ability to express a choice about treatment, to understand information relevant to the treatment decision, to appreciate the significance of the treatment information.

⁶¹⁵ Mental Capacity Bill (Northern Ireland) 2015. The meaning of "unable to make a decision" in s 4(l) includes "(c) is not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision." This element refers to "use *and* weigh" not "use *or* weigh" under s3(1)(c) of the MCA.

⁶¹⁶ One of the few cases is the New Zealand case of *Area Health Board v Attorney General* [1993] 1 NZLR 235, where the person had Guillain Barre syndrome.

⁶¹⁷ There are tools for communication with people with disabilities and recognition of the transactional nature of communication to support people in making decisions for themselves: Kim Rosen "Communication the keystone to supported decision-making" presentation to the Capacity Australia conference (November 2015, Sydney) see www.capacityaustralia.org.au/.

⁶¹⁸ Mental Capacity Act 2005, s 3(2).

⁶¹⁹ Mental Capacity Act 2005, s 3(1)(d).

mask capacity that would normally be revealed in conversation.⁶²⁰ There is increased focus on this element of capacity with the shift towards supported decision-making for people with disabilities under the CRPD.⁶²¹

The “diagnostic threshold” and causation

- 4.59 The main difference between the PPPR Act and the MCA’s tests for mental incapacity is that the MCA combines a functional test for decision-making ability with the so-called “diagnostic threshold”. The requirement of an “impairment of, or a disturbance in the functioning of, the mind or brain” is very broad and it is a misnomer to call it a diagnostic threshold.⁶²² It may be permanent or temporary.⁶²³ It may include conditions associated with some forms of mental illness, dementia, significant learning disabilities, the long-term effects of brain damage, physical or medical conditions that cause confusion, drowsiness or loss of consciousness, concussion following a head injury, and the symptoms of alcohol or drug use. The essential characteristic is a disturbance in the functioning of the mind, so many mental illnesses could potentially include an inability to make decisions, although most of them do not.⁶²⁴
- 4.60 The Essex Autonomy Project Report found that the diagnostic threshold was discriminatory of people with disabilities in terms of the CRPD and recommended that it be removed.⁶²⁵ However, it was argued that the MCA’s use of the functional test under s 3(1) as a trigger for substitute decision-making justifies a practice which would otherwise be discriminatory as it disproportionately impacts on persons with disabilities. Primarily, this is because the central aims of the MCA, as with the CRPD, are to empower people to make their own decisions wherever possible, and to protect people with impaired decision-making capacity who find themselves facing circumstances of risk.
- 4.61 For a person to be found to lack capacity there must also 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 MCA (the functional test) *because of* an impairment of the mind or brain under s 2(1) (the diagnostic test). In *PC and NC v City of York Council*,⁶²⁶ the issue of causation made all the difference in finding that PC, a woman with learning disabilities, had capacity to live with her seriously risky husband upon his release from prison. The Court of Appeal overturned the decision of the COP and held that while PC lacked capacity to understand the information and weigh it to make the decision to resume living with husband, PC’s difficulties in decision-making (although “significantly related to her mild learning disability”), were not shown to be a result of her mental impairment.⁶²⁷

⁶²⁰ A Patchet, L Allan and L Erskine “Assessment of Fluctuating Decision-Making Capacity in Individuals With Communication Barriers: A Case Study” (2012) 19 *Top Stroke Rehabil* 75.

⁶²¹ See Chapter 2E: Supported decision-making in Practice and in Case Law.

⁶²² It is not necessary for the impairment or disturbance to fit into one of the diagnoses in psychiatric diagnostic manuals such as ICD-X or DSM-V. (A Douglass, Interview with Dr Gareth Owen, psychiatrist, Kings College, London, 22 April 2015).

⁶²³ Mental Capacity Act 2005, s 2(2).

⁶²⁴ Hale, above n 194.

⁶²⁵ W Martin, S Michalowski, T Jutten and others *Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If not, what next?* (Essex Autonomy Project, University of Essex, 22 September 2014) at 16 -17.

⁶²⁶ *PC v York City Council* [2013] above n 591. PC had previously been found to have capacity to marry but the question before the court was whether she had capacity to cohabit with her husband.

⁶²⁷ Skowron, above n 205.

4.62 The s 2 diagnostic threshold was introduced as a device to limit the scope of MCA powers.⁶²⁸ An argument in favour of the diagnostic threshold in the MCA's capacity test, concerning the functioning of the mind or brain, is that it serves a gate-keeping function to ensure that a person's actions, or ability to make a decision, are not being scrutinised on the basis of unwise decisions alone. Ironically, the requirement of a diagnosis is now seen as non-compliant with the CRPD as it specifically discriminates on the ground of disability. The legal complexity associated with removing the diagnostic test is the risk that the change required for CRPD compliance will in turn result in a violation of art 5 of the European Convention on Human Rights.⁶²⁹ Unlike New Zealand, the United Kingdom finds itself in a difficult position of having to satisfy two international human rights requirements that pull in opposite directions.⁶³⁰

Summary

4.63 The functional test in the MCA offers a simple and straightforward legal test for defining capacity, in contrast to the multiple tests for capacity in the PPPR Act, and in contrast to the lack of any definition of competence *at all* in the HDC Code. The functional test in the MCA codifies the common law and is similar to the existing tests in the PPPR Act. The MCA test has already been accepted implicitly in New Zealand case law,⁶³¹ and it has been adopted as part of a threshold test in a compulsory treatment Bill for addiction currently before the New Zealand Parliament.⁶³²

4.64 It is not necessary for New Zealand to adopt the diagnostic threshold in the MCA as part of a legal test, as that element is unnecessary and can be considered discriminatory towards people with disabilities under the CRPD.

4.65 In conjunction with a revised legal test, a Code of Practice with guidance for assessing capacity would be essential to avoid inconsistent and idiosyncratic interpretations of the legal test, and to ensure that the tenets of capacity – the presumption of capacity and the right to make unwise decisions – are applied.

⁶²⁸ *Winterwerp v The Netherlands*, above n 401 at 1. The reason for the diagnostic threshold was put in the definition of capacity was for compliance with art 5 of the ECHR and the requirement of "unsoundness of mind" requiring objective medical evidence.

⁶²⁹ Szerletics, above n 209 at 44.

⁶³⁰ The new Mental Capacity Bill in Northern Ireland has sought to qualify the "diagnostic" threshold to avoid discrimination on the ground of disability. See Chapter IA Setting the Context.

⁶³¹ *Chief Executive of the Department of Corrections v Canterbury District Health Board and All Means All* [2014] NZHC 1433 at [17]. In an application by the Department of Corrections as to the lawfulness of not providing medical treatment to a serving prisoner on a hunger strike, Mr All Means All, Pankhurst J accepted the expert psychiatrist's evidence based on the MCA legal test that Mr All Means All had capacity to refuse medical treatment.

⁶³² Substance Addiction (Compulsory Assessment and Treatment) Bill, 2015. The four criteria for the compulsory treatment for substance addiction in clause cl 7(a)-(d) include the "capacity to make informed decisions" under clause 9, and adopts the functional test for "inability to make a decision" in section 3(1) of the MCA.

RECOMMENDATION FOR A SINGLE TEST FOR CAPACITY

The definition of capacity in revised legislation should provide a single and unified legal test for capacity that mirrors Section 3(1) to (4) of the MCA, including:

1. Section 3 (1):

A person is unable to make a decision if they are unable -

- (a) To understand the information relevant to the decision;
- (b) To retain that information
- (c) To use of weigh that information as part of the process of making the decision, or
- (d) To communicate their decision.

2. Section 3(2) of the MCA:

A person is not to be regarded as unable to understand the information relevant to a decision if they are able to understand an explanation of it given to them in a way that is appropriate to their circumstances (using simple language, visual aids or other means).

3. Section 3 (3) of the MCA:

The fact that a person is able to retain information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

4. Section 3(4) of the MCA:

The information relevant to a decision includes information about the reasonably foreseeable consequences of –

- (a) deciding one way or another; or
- (b) failing to make the decision.