

## ARTICLE

# Best interests, mental capacity legislation and the UN Convention on the Rights of Persons with Disabilities

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## SUMMARY

'Best interests' is a key principle of the Mental Capacity Act 2005 (England and Wales), Mental Capacity Bill (2014) (Northern Ireland) and Mental Health Act 2001 (Ireland), although there are currently proposals to remove 'best interests' from Irish legislation. Legislation in Scotland refers to 'benefit' resulting from interventions. Judicious use of 'best interests', in line with guidelines that prioritise the person's autonomy, will and preferences, is a powerful way to promote the values and rights that underpin the United Nations Convention on the Rights of Persons with Disabilities and to safeguard the dignity of individuals with mental disorder and/or reduced mental capacity.

## LEARNING OBJECTIVES

- Appreciate the relevance and meanings of the principle of best interests
- Understand the implications of the Convention on the Rights of Persons with Disabilities for mental capacity legislation and related practice
- Understand recent proposals to merge mental health and mental capacity legislation into a single legislative framework (e.g. in Northern Ireland)

## DECLARATION OF INTEREST

None

interests in England, Wales, Scotland, Northern Ireland and Ireland, and explores these differing conceptualisations in the context of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD).

## Mental capacity and best interests

### *How is mental capacity defined in law?*

The principle of best interests is commonly invoked in relation to mental capacity legislation, and Box 1 presents definitions of mental incapacity from legislation in England, Wales, Scotland, Northern Ireland and Ireland, based on the most recent legislative developments in each jurisdiction. It includes the Mental Capacity Bill (2014) in Northern Ireland and the Assisted Decision-Making (Capacity) Bill 2013 in Ireland, both of which are still in development but which are good indicators of the direction of change in these jurisdictions and, possibly, beyond.

Definitions of lack of capacity in these jurisdictions share substantial similarities but there are also interesting differences. The Mental Capacity Bill (2014) in Northern Ireland, for example, makes a clear effort to design a definition that is as disability-neutral as possible. For example, whereas the Adults with Incapacity (Scotland) Act 2000 states that a person may be 'incapable' by 'reason of mental disorder or of inability to communicate because of physical disability' (section 1(6)), in the Northern Irish Bill 'it does not matter (a) whether the impairment or disturbance is permanent or temporary; (b) what the cause of the impairment or disturbance is' (section 2(2)) or 'whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disorder or disability' (section 2(3)).

Overall, these definitions resemble each other in more ways than they differ. There are, however, significant differences in relation to other aspects

The idea of 'best interests' is central to the Mental Capacity Act 2005 in England and Wales, the Mental Capacity Bill (2014) in Northern Ireland and the Mental Health Act 2001 in the Republic of Ireland (hereafter referred to as Ireland), among other pieces of legislation. It can, however, be difficult to balance patients' best interests and their rights to autonomy and self-determination (Fistein 2009).

In light of ongoing fundamental revisions of legislation in Northern Ireland and Ireland, this article outlines current conceptualisations of best

**BOX 1 Legal definitions of mental incapacity in England, Wales, Scotland, Northern Ireland and the Republic of Ireland<sup>a</sup>**

Mental Capacity Act 2005 (England and Wales)	Adults with Incapacity (Scotland) Act 2000 (Scotland)	Mental Capacity Bill (2014) (Northern Ireland)	Assisted Decision-Making (Capacity) Bill 2013 (Republic of Ireland)
<p>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' (section 2(1)), regardless of 'whether the impairment or disturbance is permanent or temporary' (section 2(2)).</p> <p>A 'lack of capacity cannot be established merely by reference to (a) a person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity' (section 2(3)).</p> <p>A 'person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, writing, using sign language, or otherwise)' (section 3(1)).</p> <p>A 'person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means)' (section 3(2)).</p> <p>'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 unable to make the decision' (section 3(3)).</p> <p>'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' (section 3(4)).</p>	<p>'Incapable' means 'incapable of (a) acting; or (b) making decisions; or (c) communicating decisions; or (d) understanding decisions; or (e) retaining the memory of decisions, as mentioned in any provision of this Act, by reason of mental disorder or of inability to communicate because of physical disability' (section 1(6)).</p> <p>A 'person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid' (section 1(6)).</p>	<p>A 'person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain' (section 2(1)).</p> <p>'It does not matter (a) whether the impairment or disturbance is permanent or temporary; (b) what the cause of the impairment or disturbance is' (section 2(2)), or 'whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disorder or disability' (section 2(3)).</p> <p>A 'person is unable to make a decision for himself or herself in relation to a matter if the person (a) is not able to understand the information relevant to the decision; or (b) is not able to retain that information for the time required to make the decision; or (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; or (d) is not able to communicate his or her decision (whether by talking, using sign language or any other means)' (section 3(1)).</p> <p>The 'information relevant to the decision includes information about the reasonably foreseeable consequences of (a) deciding one way or another; or (b) failing to make the decision' (section 3(2)).</p> <p>The 'person is not to be regarded as "not able to understand the information relevant to the decision" if the person is able to understand an appropriate explanation of the information' (section 3(3)), where 'an appropriate explanation means an explanation of the information given to the person in a way appropriate to the person's circumstances' (section 3(4)).</p>	<p>A 'person lacks the capacity to make a decision if he or she is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his or her decision (whether by talking, writing, using sign language, assisted technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party' (section 3(2)).</p> <p>Capacity is to be 'construed functionally', i.e. 'a person's capacity shall be assessed on the basis of his or her ability to understand the nature and consequences of a decision to be made by him or her in the context of the available choices at the time the decision is made' (section 3(1)).</p> <p>A 'person is not to be regarded as unable to understand the information relevant to a decision if he or she is able to understand an explanation of it given to him or her in a way that is appropriate to his or her circumstances' (section 3(3)).</p> <p>The 'fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him or her from being regarded as having the capacity to make the decision' (section 3(4)).</p> <p>'Information relevant to a decision shall be construed as including information about the reasonably foreseeable consequences of (a) each of the available choices at the time the decision is made, or (b) failing to make the decision' (section 3(5)).</p>

a. The Mental Capacity Bill (2014) in Northern Ireland and the Assisted Decision-Making (Capacity) Bill 2013 in the Republic of Ireland are both in development at present; although neither has been enacted, both are good indicators of the direction of change in the two jurisdictions and, possibly, beyond.

of mental capacity legislation, including, most notably, their approaches to the principle of best interests.

### *How is the legal definition of best interests operationalised in England and Wales?*

The Mental Capacity Act 2005 (England and Wales) states that ‘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’ (section 1(5)). There is a significant background to the concept of best interests in common law (Bartlett 2007; Fennell 2010), but the Code of Practice to the Mental Capacity Act 2005 (Department for Constitutional Affairs 2007) is quite explicit about how to operationalise ‘best interests’. Specifically, a person trying to work out the best interests of someone who lacks capacity should:

- encourage the person’s participation
- identify all relevant circumstances
- find out the person’s views
- avoid discrimination
- assess whether the person might regain capacity
- if the decision concerns life-sustaining treatment, not be motivated by a desire to bring about the person’s death
- consult others
- avoid restricting the person’s rights
- take all of these factors into account in making a determination.

For example, an individual with chronic schizophrenia may lack capacity in relation to upkeep of housing, resulting in health risk. In this situation, it is necessary to encourage the person to participate in relevant decisions, to look at all relevant circumstances, which are likely to include non-medical matters (e.g. plumbing, plasterwork) and to consult others (e.g. family, neighbours). In this example, the decision to consult neighbours may raise specific issues about confidentiality, and it is a matter of concern that respect for confidentiality and promoting human rights are omitted from the list of relevant factors in the Code of Practice (Fennell 2007). Clearly, making best interests judgments can be extremely difficult (Brindle 2013; Hughes 2013).

### *How is the legal definition of ‘benefit’ operationalised in Scotland?*

The Adults with Incapacity (Scotland) Act 2000 states that ‘there shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and

that such benefit cannot reasonably be achieved without the intervention’ (section 1(2)). Scotland’s mental health legislation, the Mental Health (Care and Treatment) (Scotland) Act 2003 includes ‘the importance of providing the maximum benefit to the patient’ as a principle (section 1(3)(f)).

Like the Mental Capacity Act 2005 in England and Wales, the Adults with Incapacity (Scotland) Act 2000 provides further guidance, requiring that account is taken of ‘present and past wishes and feelings’ (section 1(4)(a)); the views of the nearest relative and primary carer, if feasible (section 1(4)(b)); the views of ‘any guardian, continuing attorney or welfare attorney of the adult who has powers relating to the proposed intervention’ (section 1(4)(c)(i)); ‘any person whom the sheriff has directed to be consulted’ (section 1(4)(c)(ii)); and ‘any other person appearing to [...] have an interest in the welfare of the adult or in the proposed intervention’ (section 1(4)(d)). Patient participation is encouraged (section 1(5)).

Therefore, while the Adults with Incapacity (Scotland) Act 2000 focuses on the decision maker being ‘satisfied that the intervention will benefit the adult’ (section 1(2)), rather than best interests *per se*, the approach still has considerable overlap with best interests in the Mental Capacity Act 2005 (England and Wales). In the example (above) of the individual with chronic schizophrenia who lacks capacity in relation to upkeep of housing, resulting in health risk, it is clear that there would be considerable overlap between interventions made on the basis of best interests (England and Wales) and those made on the basis of ‘benefit’ (Scotland).

### *How is the legal definition of best interests to be operationalised in Northern Ireland?*

In Northern Ireland, the Mental Capacity Bill (2014) states that any ‘act or decision must be done, or made, in the best interests of the person who lacks capacity’ (section 1(7)), among other principles. The best interests of the person (‘P’) must not be determined ‘merely on the basis of (a) P’s age or appearance; or (b) a condition of P’s, or an aspect of P’s behaviour, which might lead others to make unjustified assumptions about what might be in P’s best interests’ (section 6(2)). The person determining P’s best interests must ‘consider all the relevant circumstances’ (section 6(3)(a)) and ‘whether it is likely that P will at some time have capacity in relation to the matter in question’ (section 6(4)(a)). The person must ‘encourage and help P to participate as fully as possible in the determination of what would be in P’s best interests’ (section 6(5)) and take into account (section 6(6)(a)–(c) respectively):

- ‘P’s past and present wishes and feelings (and, in particular, any relevant written statement made by P when P had capacity)’
- ‘The beliefs and values that would be likely to influence P’s decision if P had capacity’
- ‘The other factors that P would be likely to consider if able to do so’.

The person must, insofar as practicable and appropriate, ‘consult the relevant people about what would be in P’s best interests’ (section 6(7) (a)), including anyone ‘who is P’s nominated person’ (section 6(8)(a)), ‘an independent advocate’ (section 6(8)(b)), ‘any other person named by P as someone to be consulted’ (section 6(8)(c)), ‘anyone engaged in caring for P or interested in P’s welfare’ (section 6(8)(d)), and any relevant attorney (section 6(8)(e)) or deputy (section 6(8)(f)).

The Northern Irish Bill also states that the ‘person making the determination’ must ‘have regard to whether the same purpose can be as effectively achieved in a way that is less restrictive of P’s rights and freedom of action’ (section 6(9)) and ‘whether failure to do the act is likely to result in harm to other persons with resulting harm to P’ (section 6(10)). In addition, ‘if the determination relates to life-sustaining treatment for P, the person making the determination must not, in considering whether the treatment is in the best interests of P, be motivated by a desire to bring about P’s death’ (section 6(11)). As a result, if a person with intellectual disability is terminally ill and lacks capacity to make decisions about medical treatment, the individual determining best interests must not only follow the steps outlined in the Bill, but also cannot be motivated by a desire to ‘bring about P’s death’; this creates a dilemma in relation to so-called ‘do not resuscitate orders’ for certain people who are terminally ill and suffering greatly; such orders appear to be forbidden by this provision.

### *How are best interests defined in Ireland?*

In Ireland, the Assisted Decision-Making (Capacity) Bill 2013 was published in 2013 and, if enacted, would replace Ireland’s outdated Ward of Court system (Kelly 2014a). As in the other jurisdictions, Ireland’s Bill includes a presumption of capacity (section 8(2)) and states that a person shall not be considered incapable ‘unless all practicable steps have been taken, without success, to help him or her’ to make the decision (section 8(3)) or ‘merely by reason of making, having made, or being likely to make, an unwise decision’ (section 8(4)). Interventions must be necessary ‘having regard to the individual circumstances’ (section 8(5)); minimise restriction of rights and ‘freedom

of action’ (section 8(6)(a)); and ‘have due regard to the need to respect the right of the relevant person to his or her dignity, bodily integrity, privacy and autonomy’ (section 8(6)(b)). Although the ‘interests’ of the person are mentioned in certain specific sections (e.g. 17(9), 23(5), 23(10), 26(1)(a) (xi), 28(1)(c), 28(2), 60(5) and 60(6)), best interests is not included as an overarching principle.

The ‘intervener’ must ‘permit, encourage and facilitate’ the participation of the relevant person (section 8(7)(a)); ‘give effect to past and present will and preferences’ (section 8(7)(b)); and ‘take into account (i) the beliefs and values of the relevant person (in particular those expressed in writing)’ and ‘(ii) any other factors which the relevant person would be likely to consider’ (section 8(7)(c)). If possible, the intervener shall ‘consider the views of (i) any person named by the relevant person as a person to be consulted’ and ‘(ii) any decision-making assistant, co-decision-maker, decision-making representative or attorney’ (section 8(7) (d)), as well as various other parties (section 8(8)).

In addition, ‘regard shall be had to (a) the likelihood of the recovery of the relevant person’s capacity in respect of the matter concerned, and (b) the urgency of making the intervention’ (section 8(9)). For example, if a person has a first episode of acute psychosis and lacks capacity in relation to certain aspects of medical care, it is likely that surgery for acute appendicitis would be an acceptable intervention (once appropriate procedures were followed), but surgery for varicose veins would not, as the latter could be deferred until capacity is restored.

Overall, while the proposed Irish capacity legislation is a significant advance on the existing situation (Kelly 2014a,b), the absence of the principle of best interests, or anything approaching it, provides a strong point of contrast with the Mental Capacity Act 2005 in England and Wales, the Mental Capacity Bill (2014) in Northern Ireland and, to a lesser extent, the Adults with Incapacity (Scotland) Act 2000. What are the reasons, if any, underpinning this contrast? Is the omission of best interests in Ireland more compliant with the CRPD, or less?

### *Operationalising best interests: the example of Ireland*

The most notable difference in capacity legislation across England, Wales, Scotland, Northern Ireland and Ireland is the absence of best interests as an overarching principle in Ireland’s new Bill. Ireland’s Bill does not even require that interventions benefit the person in the slightest, let alone be in the person’s best interests (as in

England, Wales and Northern Ireland). For doctors, principles of medical ethics and the doctrine of necessity require that all interventions are of benefit (Beauchamp 2008), but the Irish Bill represents an alarming failure to incorporate this principle into capacity legislation, so as to govern not only medical personnel but everyone involved in the care of an incapacitous person.

This situation in Ireland may reflect experience with Ireland's Mental Health Act 2001, which states that 'the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made' (section 4(1)). The issue of best interests is, however, complex in Irish law owing to the emphasis that the Constitution of Ireland (article 40(1) and (3)) places on welfare-based concerns for the vulnerable (Whelan 2009). In relation to the Mental Health Act 2001 in particular, the Irish High Court has made the 'paternal' nature of the legislation very clear:

'In my opinion having regard to the nature and purpose of the Act of 2001 as expressed in its preamble and indeed throughout its provisions, it is appropriate that it is regarded in the same way as the Mental Treatment Act of 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder.' (*M.R. v Byrne and Flynn* [2007]: p. 14.)

The Supreme Court agrees that interpretation of Ireland's 2001 Act 'must be informed by the overall scheme and paternalistic intent of the legislation' (*E.H. v St. Vincent's Hospital and Ors* [2009]: p. 12). The High Court states that this section 'infuses the entire of the legislation with an interpretative purpose' (*T. O'D. v Harry Kennedy and Others* [2007]: p. 21).

This approach to best interests may, on the one hand, represent a disproportionately disempowering approach to mental health law, at least in certain cases, but it may, on the other, reflect the Irish state's constitutional obligation to protect the vulnerable (Kennedy 2012). Moreover, even if 'best interests' has been interpreted in an overly paternalistic manner in Ireland's mental health legislation, that does not necessarily mean that it is an unsuitable principle for mental health or capacity legislation; it indicates, rather, that interpretative guidelines are needed, such as those provided in the Code of Practice to the Mental Capacity Act 2005 in England and Wales (Department for Constitutional Affairs 2007) or section 6 of the Mental Capacity Bill (2014) in Northern Ireland.

Notwithstanding these arguments, the Steering Group on the Review of the Mental Health Act

2001 (2012: p. 11) stated that 'paternalism is incompatible with such a rights-based approach and accordingly the [Mental Health Act 2001] should be refocused away from "best interests" in order to enhance patient autonomy'. This same logic appears to have been applied to the Assisted Decision-Making (Capacity) Bill 2013, although the omission of best interests as an overarching principle in the latter was also likely attributable to particular interpretations of the CRPD.

## The UN Convention on the Rights of Persons with Disabilities (CRPD)

### Principles of the CRPD

The CRPD commits ratifying countries 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity' (article 1). The 'general principles' of the CRPD are outlined in Box 2 and they do not include best interests or any identifiable approximation to it. For example, if a person with intellectual disability lacks capacity to decide about crossing a busy street, these principles provide minimal guidance for the development of guidelines that balance the principle of autonomy with a reasonable expectation of safety on the part of that person and his or her family.

Regarding its definition of 'disability', the CRPD states that 'persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with

### BOX 2 General principles of the UN Convention on the Rights of Persons with Disabilities

- Respect for inherent dignity, autonomy (including the freedom to make one's own choices) and independence
- Non-discrimination
- Full and effective inclusion and participation in society
- Respect for difference and acceptance of persons with disabilities as part of humanity and human diversity
- Equality of opportunity for all
- Accessibility
- Equality between women and men
- Respect for the right of children with disabilities to preserve their identities, and respect for the evolving capacities of children with disabilities

(Adapted from UN CRPD: article 3)

others' (article 1). Clearly, this definition does not include all people with mental disorder, because many mental disorders are not 'long-term' (Kelly 2014b). The CRPD does not, however, present its definition of 'persons with disabilities' as a comprehensive one, but states that the term 'persons with disabilities' includes people with 'long-term' impairments; others, presumably, may also fit the definition.

Overall, it appears likely that some people with mental disorder meet the UN definition at least some of the time (e.g. a person with chronic schizophrenia with progressive deficit), but others do not (e.g. a person with a single phobia). Moreover, the CRPD states 'that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others' (Preamble (e)); this broadens the definition further.

The CRPD addresses a range of rights in relation to persons with disabilities and is particularly clear that 'the existence of a disability shall in no case justify a deprivation of liberty' (article 14(1) (b)). If certain persons with mental disorder (e.g. some people with chronic schizophrenia) fit the UN definition of 'persons with disabilities', then mental health legislation in England, Wales, Scotland, Northern Ireland and Ireland is inconsistent with this provision of the CRPD (Bennett 2014; Kelly 2014b).

The CRPD raises a great number of issues in relation to mental capacity legislation, including the extents to which existing tests of mental capacity are compatible with it (Michalowski 2014) and to which existing legislation respects the will and preferences of disabled persons (Jütten 2014). From the point of view of best interests and capacity legislation, the most relevant passages of the CRPD are those relating to substitute decision-making.

### *The CRPD and substitute decision-making*

Legislation currently in place and/or recently proposed in England, Wales, Scotland, Northern Ireland and Ireland makes provision for substitute decision-making under certain circumstances, including, in England, Wales and Northern Ireland, that decisions are made in the best interests of the person and, in Scotland, that 'the intervention will benefit the adult' (Adults with Incapacity (Scotland) Act 2000, section 1(2)). These provisions may, however, all violate the CRPD, which states that 'persons with disabilities have the right to recognition everywhere as

persons before the law' (article 12(1)) and must 'enjoy legal capacity on an equal basis with others in all aspects of life' (article 12(2)): it does not explicitly endorse substitute decision-making.

In the first instance, the requirement that persons with disability 'enjoy legal capacity on an equal basis with others in *all* aspects of life' (article 12(2)) (italics added) may already be violated anyway by mental capacity legislation that limits legal capacity in certain areas, even with decision-making supports (Burch 2014). Ireland's Assisted Decision-Making (Capacity) Bill 2013, for example, excludes areas such as marriage and voting from its decision-making supports (section 106); exclusions in the Mental Capacity Act 2005 for England and Wales relate to family relationships (section 27), Mental Health Act matters (section 28) and voting rights (section 29); and exclusions in the Mental Capacity Bill (2014) for Northern Ireland relate to family relationships (section 149) and voting rights (section 150). These exclusions suggest that mental capacity legislation in these jurisdictions violates article 12 of the CRPD (Minkowitz 2007), as, possibly, does mental health legislation by permitting compulsory treatment of mental but not (most) physical illnesses (Bartlett 2012). Involuntary treatment of persons with mental disorder may also be inconsistent with article 25(d) of the CRPD, which requires 'health professionals to provide care of the same quality to persons with disabilities as to others' on 'the basis of free and informed consent'.

Article 12(3) goes on to state that ratifying countries must 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity', but does not go as far as to endorse substitute decision-making. As a result, The Netherlands, Canada and various Arab states entered reservations to the CRPD to ensure that their models of substitute decision-making were protected (Bartlett 2012).

As Szmukler *et al* (2014) point out, however, it is not at all clear that the CRPD necessarily rules out all forms of substitute decision-making. Article 12(4) states that:

'States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or

## MCQ answers

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judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests'.

This passage appears to reflect an acceptance of substitute decision-making in certain circumstances, although it was a much-contested text (Dhanda 2007). In this context, Szmukler *et al* (2014) argue that there is a significant difference between reduced decision-making capacity in relation to a specific matter for a period of time and 'disability'. They propose a 'fusion law', which would cover all persons whether they have a mental or physical illness, and allow involuntary treatment only where the person's decision-making capacity in relation to a specific treatment decision is impaired and supported decision-making has failed (Dawson 2006; Szmukler 2014).

This proposal moves away from an approach based on 'disability' to one based on decision-making capacity; it accords considerable importance to the concept of best interests, which is to be construed in accordance with the person's own views and wishes; and, to this extent at least, it appears more compliant with the CRPD than current legislation and proposals in England, Wales, Scotland and Ireland. This approach has much in common with the recent Mental Capacity Bill (2014) in Northern Ireland, but contrasts sharply with omission of best interests as a principle in the Assisted Decision-Making (Capacity) Bill in Ireland, the rationale for which is decidedly unclear (Kelly 2013).

## Conclusions

Best interests remains a key principle in the Mental Capacity Act 2005 (England and Wales), Mental Capacity Bill (2014) (Northern Ireland) and (for now) Mental Health Act 2001 (Ireland). In similar fashion, the Mental Health (Care and Treatment) (Scotland) Act 2003 includes 'the importance of providing the maximum benefit to the patient' as a principle (section 1(3)(f)) and any intervention made under the Adults with Incapacity (Scotland) Act 2000 must 'benefit the adult' (section 1(2)). In Ireland, however, there are proposals to remove best interests from the Mental Health Act 2001 and it has been omitted as a principle from the Assisted Decision-Making (Capacity) Bill 2013.

Far from being inimical to the spirit or content of the CRPD, the concept of best interests is an excellent way to promote the values and fundamental rights that underpin the CRPD. Legislation such as the Mental Capacity Act 2005 in England and Wales is plainly and primarily aimed at promoting autonomy, and best interests is clearly to be used only when the person lacks

capacity to exercise their own autonomy; this contrasts with, for example, the Children Act 1989 which requires the welfare of the child to be regarded as of paramount importance (Munro 2010).

This judicious, considered and robust use of best interests is strongly underpinned by guidelines such as those provided in the Mental Capacity Act 2005 Code of Practice in England and Wales (Department for Constitutional Affairs 2007) and the Mental Capacity Bill (2014) (section 6) in Northern Ireland, which explicitly place the person's will and preferences at the centre of determinations of best interests and can thus assist greatly with protecting and promoting CRPD rights. In this way, such practice-based guidelines can also help realise the primary purpose of the CRPD, which is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity' (article 1) – all of which are key elements of best interests.

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### Cases

*E.H. v St. Vincent's Hospital and Ors* [2009] IESC 46.

*M.R. v Byrne and Flynn* [2007] IEHC 73.

*T. O'D. v Harry Kennedy and Others* [2007] IEHC 129.

### MCQs

Select the single best option for each question stem

#### 1 The Mental Capacity Act 2005 (England and Wales) states that:

- a a lack of capacity cannot be established merely by reference to a person's age
- b a person is unable to make a decision for himself or herself if he or she ever lacked capacity for any decision
- c in legal proceedings, any question about whether or not a person possesses capacity is to be decided beyond reasonable doubt
- d a person is unable to make a decision for himself or herself if he or she has ever had a mental disorder
- e the information relevant to a decision includes only the consequences of failing to make the decision.

#### 2 The principles of the UN Convention on the Rights of Persons with Disabilities include:

- a the right to smoke
- b the best interests of the individual
- c the right to refuse to kill
- d mindfulness
- e accessibility.

#### 3 The Mental Capacity Bill (2014) in Northern Ireland:

- a states that a person lacks capacity if he or she can make a decision for himself or herself in relation to the matter at hand
- b is a fully integrated, enacted piece of legislation in Northern Ireland
- c states that the distinction between permanent and temporary impairment is fundamental in determinations of capacity
- d combines mental health legislation and mental capacity legislation into a single Bill
- e states that it is not necessary to understand information relevant to the decision in order to have capacity to make the decision.

#### 4 The Assisted Decision-Making (Capacity) Bill 2013 is currently the subject of consultation in:

- a England
- b Northern Ireland
- c Wales
- d Scotland
- e the Republic of Ireland.

#### 5 According to the Code of Practice to the Mental Capacity Act 2005, a person trying to work out the best interests of someone who lacks capacity should:

- a avoid consulting family members
- b discriminate between people on the basis of causes of disability
- c consult others
- d discourage the person's participation
- e presume that any apparent lack of capacity is permanent.