SPECIAL ARTICLE

# Best interests provisions in the UK Mental Capacity Act 2005

Olufunso B. Aribisala[1]

The Psychiatrist (2012), **36**, 459–462, doi: 10.1192/pb.bp.111.038273

[1]Lancashire Care NHS Foundation Trust, Ribbleton Hospital, Preston, UK

Correspondence to Olufunso B. Aribisala (olufunso.aribisala@lancashirecare.nhs.uk)

First received 16 Dec 2011, final revision 27 Jun 2012, accepted 8 Aug 2012

**Summary** The Mental Capacity Act 2005 is a critical statute law for psychiatrists in England and Wales. Its best interests provision is fundamental to substitute decision-making for incapacitated adults. It prescribes a process of and gives structure to substitute decision-making. The participation of the incapacitated adult must be encouraged where practicable. In addition to this, 'the best interests checklist' must be applied in every case before a practitioner can arrive at a reasonable belief that the action or decision taken on behalf of an incapacitated adult is in his best interests. Most commentators have shown goodwill towards the workings of the Act and want it to succeed.

**Declaration of interest** None.

Psychiatrists regularly manage patients with impaired mental capacity consequent upon mental disorders. Most are familiar with the concept of best interests as outlined in *Re F*,[1] a case involving non-therapeutic sterilisation of a severely mentally disabled woman in the absence of consent. The case established that doctors may give any necessary treatment to an incapacitated adult if that treatment is meant to protect the person's health and well-being. (The term 'incapacitated adult' is used in this paper generally to mean an adult who lacks capacity to make a particular decision or take a particular action at the time the decision or action needs to be taken.) This ruling gave much needed clarity to doctors concerning what could be done for incapacitated adults.[2] Ultimately, the concept evolved and by the time of *Re S*,[3] another case of elective sterilisation in the absence of consent, it had become essentially a welfare appraisal test with the welfare of the incapacitated adult being of paramount consideration and no limits set on what may be relevant.

The Mental Capacity Act 2005 provides a coherent legal framework of decision-making for incapacitated adults (P) in England and Wales.[4] (The Act generally uses the letter P to represent a person aged over 16 who at the time when a decision needs to be made, lacks capacity, or is reasonably believed to lack capacity, for that decision.) Similar legislation has been operational in Scotland since 2000 – Adults with Incapacity (Scotland) Act 2000 – and is at varying stages of readiness in Northern Ireland – Mental Capacity (Health, Welfare and Finance) Bill; it is scheduled for enactment in 2013 and will be based on human rights principles of autonomy, justice, benefit and least harm – and Ireland.[5] The proposed Northern Ireland Bill also bases substitute decision-making on best interests but intends to explicitly include the principle of reciprocation – 'the more intrusive the intervention in the life of the person lacking capacity, the greater the safeguards that will need to be met'.[6]

At the core of the Mental Capacity Act lies the best interests provision of Section 4. But what is meant in the Act by the term 'best interests'? Is this concept any different to a medical professional doing what he believes to be best for P? This paper sets out to analyse the concept of best interests as laid out in the Mental Capacity Act relating to incapacitated adults. It essentially excludes provisions relating to children, the Deprivation of Liberty Safeguards, the Mental Health Act 1983 and the European Convention on Human Rights.

## Statutory principles

Two statutory principles in the Mental Capacity Act, commonly referred to as the best interests and least restrictive principles, relate to decision-making. The latter, in my view, is better referred to as the minimum restrictive principle. Careful reading of Section 1(6) clearly shows that the emphasis is on the minimum restriction that effectively achieves the goal of best interest. Mr Justice Lewison confirms in *Re P*,[7] a case involving the making of a statutory will that: 'section 1(6) is not a statutory direction that one "must achieve" any desired objective by the least restrictive route. [It] only requires that before a decision is made "regard must be had" to that question'. Jones similarly concludes that '[a]s only "regard" must be had to this principle, an option which is not the least restrictive option can still be in the person's best interests'.[8] The *Code of Practice* to the Mental Capacity Act (herein referred to as the Code) agrees, adding that in practice both principles will usually be combined.[4] Mr Justice Hedley put it succinctly in *Re GM; FP v GM and A Health Board (2011)* when he said

'section 1(6) . . . is a principle of minimum intervention consistent with best interests'.[9]

In Scotland, the equivalent Act deliberately excludes references to 'best interests' as this was thought to be too vague and paternalistic, not allowing due weight to be given to previously expressed views of the person lacking capacity. Instead, it focuses on 'benefit' for the person.[10]

## Best interests checklist

The UK Law Commission, judges and Parliament agreed that it was inappropriate to strictly define best interests.[11–14] The Code notes this is because of the broad range of decisions, actions and personnel involved.[4] Parliament instead prescribed a compulsory checklist of common factors, set out in Section 4, of what the decision-maker (D) must consider and steps he must take when acting or deciding for P. Baroness Hale points out that the Act's best interests checklist is 'mostly concerned with process rather than what to take into account'.[2] The Code recognises that in many instances additional factors will need to be investigated, although not all will be relevant in every case.[4]

### Avoiding unjustified assumptions

The best interests checklist starts by warning against unjustified assumptions being taken merely on the basis of age, appearance, condition or behaviour. This is particularly relevant for non-specialist psychiatrists or trainees who may need to make decisions for people with intellectual disability or dementia.

### Considering all relevant circumstances

D must consider all relevant circumstances before reaching his decision; 'relevant' seems to have been used here in the sense of being reasonably practicable. Consequently, the Code accepts that it will not always be possible or practicable for D to thoroughly investigate all possibly relevant issues that may have a bearing on the matter in question, particularly where an urgent decision needs to be made. Nonetheless, it warns decision makers not to take shortcuts but that 'a proper and objective assessment must be carried out on every occasion'.[4] It therefore seems that despite the use of 'all relevant circumstances' this subsection imposes no stricter criteria than what is expected of a diligent psychiatrist.

The Act then specifies in subsections (3) to (7) particular steps that must be taken and specific factors that must be considered in all cases.

### Regaining capacity

An essential consideration is whether P is likely to regain capacity in relation to the matter in question and if so, when. The explanatory notes to the Act declare that '[t]his is in case the decision can be put off, until the person can make it himself'.[14] A good example is substance intoxication where it may be sensible to await probable recovery of capacity.

A study[15] of psychiatric in-patients who regained decision-making capacity after treatment showed that the majority supported surrogate decision-making on their behalf by doctors when they were incapacitated. Additionally, 'almost all participants said that doctors should be able to make decisions on behalf of some people who have mental health problems'.[15] This finding should help alleviate some concerns of trainees about decision-making for incapacitated persons.

### Participation of P

This provision demands that D must, so far as reasonably practicable, permit and encourage or improve P's ability to participate as fully as possible in the relevant issue at hand. The Code sets out examples of how this may be achieved.[4] Donnelly claims[16] that this approach has a positive impact on various factors including the quality of decisions made by D, the response by P, as well as P's self-esteem and well-being.

### Wishes and feelings; beliefs and values

This subsection is central to best interests determination.

In *C v V*,[17] a case concerning the appointment of a deputy to manage financial affairs under the Mental Capacity Act, the judge concluded that great weight should be attached to the incapacitated adult's view where it is not irrational, impracticable or irresponsible. Mr Justice Lewison in *Re P* agreed that the incapacitated adult's wishes must be given great weight but not necessarily determinative weight as the Act's test is that of best interest, not substituted judgement.[7] This is borne out in a recent ruling where the High Court went against the wishes of an incapacitated adult ordering that he be given dialysis for kidney failure against his will including using reasonable restraint if necessary.[18]

#### *Balancing past and present wishes and feelings*

The Nuffield Council highlight difficulties that often arise in balancing past wishes and preferences of P when capable with present wishes and preferences where these conflict, especially if the person appears to be content or enjoying their present situation.[19] The Council found strong and irreconcilable difference of opinion among ethicists and the general public. Jones argues in favour of prioritising present wishes, feelings or preferences,[8] whereas I believe that the particular context will have to be the determinative factor in apportioning appropriate weight.

#### *Beliefs and values*

Beliefs and values are among several factors that a decision maker must consider in deciding what is in the best interests of P. In *Ahsan v University Hospitals Leicester NHS Trust* [2006] the court ruled that Mrs Ahsan, a devout Muslim who was in a permanent vegetative state following surgery, should be cared for at home in accordance with her family's request in order to fulfil her past spiritual and cultural beliefs.[20] However, where religious and cultural beliefs are potentially or in reality abusive or unlawful, the court will not sanction these. In *Westminster City Council v C* [2008][21] the Court of Appeal refused to recognise an



https://doi.org/10.1192/pb.bp.111.038273 Published online by Cambridge University Press

Islamic marriage procured by the parents of C who lacked the required capacity for this decision. The Court held the marriage was potentially, if not actually, abusive and it had a duty to protect C from abuse, per Thorpe LJ at para 32.[21] It is of note that Section 27 of the Mental Capacity Act does not permit decisions to be made for P on matters relating to consenting to marriage or to having sexual relations, among others.

*Benefit of others*

The Code argues that other factors that P might consider in deciding his best interests should he possess the capacity to do so 'might include the effect of the decision on other people, obligations to dependants or the duties of a responsible citizen'.[4] It claims that '[t]he Act allows actions that benefit other people' providing they are in P's best interests.

### Consulting others

Section 4(7) identifies people whom to consult, if practicable and appropriate, for their views as to what would be in P's best interests on the matter in question and what is known of P's wishes, feelings, values and beliefs. District Judge Ashton declares that this is the first time statute law has established the rights of carers and family to be consulted in decisions affecting an incapable adult.[22] Where P has no family or friend willing or able to act on his behalf, an independent mental capacity advocate must be instructed and then consulted, in prescribed circumstances, as to what is in P's best interests. The prescribed circumstances are set out in para 10.3 of the Code: 'providing, withholding or stopping serious medical treatment, moving a person into long-term care in hospital or a care home, . . . or moving the person to a different hospital or care home' for more than the applicable period. Applicable period is defined in the Act, Section 38(9) as meaning 'in relation to accommodation in a hospital, 28 days, and in relation to accommodation in a care home, 8 weeks'. Consultees' views are not determinative[9] but must be carefully considered, especially if D goes against the views expressed.[4]

### Life-sustaining treatment

Where best interest determination relates to life-sustaining treatment, D must not be motivated by a desire to bring about death. Life-sustaining treatment is defined in the Act as 'treatment which in the view of a person providing health care for the person concerned is necessary to sustain life'. Nonetheless, in the absence of a valid and applicable advance decision or relevant lasting power of attorney for health and welfare, case law has determined that some treatment must always be referred to the court for a decision regarding capacity and best interests. Typically, these are cases involving artificial nutrition and hydration, organ transplantation and non-therapeutic sterilisation.[23] Additionally, the Code includes 'all other cases where there is doubt or dispute about whether a particular treatment will be in a person's best interests'.[4]

### Reasonable belief concerning best interests

Section 4(9) provides appropriate protection from liability to D, if having complied with the best interests checklist he reasonably believes his decision is in P's best interests (and that P lacks capacity for the decision). The Code explains that 'coming to an incorrect conclusion about a person's capacity or best interests does not necessarily mean that the decision-maker would not get protection from liability'.[4]

## Decision maker

The Code makes it evident that different individuals may need to act as decision makers for P depending on the issue at hand. Likewise, different level of skill and documentation is required depending on the decision maker. Decision-making may also be by a team of professionals who may then delegate the execution of that decision to an individual. It is the responsibility of the decision maker to arrive at a reasonable belief that what he decides is in the best interests of P. The Code favours multidisciplinary meetings with family members in attendance as the best way to make these decisions.[4] This is an efficient way of gathering the required information but the decision maker may choose to meet individually with relevant parties. Additionally, psychiatrists are sometimes called on to make pronouncements regarding capacity and best interests. In such cases, the decision maker needs to be clearly identified (this is usually the primary/treating clinician) and the role of the psychiatrist may be advisory. Nonetheless, the psychiatrist remains responsible for the quality of his assessment and advice given.

Donnelly warns of the factors that the decision maker must be particularly mindful of before overriding P's wishes.[16] These include cases where the evidence is finely balanced, where P's capacity just falls short of the requisite level and where P is likely to resist the imposition of a decision. Overall, she approves of the Act's approach to decision-making for incapacitated adults but warns that the success of this best interests approach will require decision makers to be innovative in the way they work with affected individuals.

Box 1 presents a typical clinical scenario where a psychiatrist becomes involved in best interests decision-making.

### Exclusions

The best interests principle does not apply where there is a valid and applicable advance decision and in some cases of research.[4]

## Conclusions

The philosophy for making decisions on behalf of incapacitated adults embedded in the Mental Capacity Act is firmly anchored on Section 4. It has succeeded in providing a legislative framework for substitute decision-making for incapacitated adults that can be specific enough for individuals and yet flexible enough for a population. The continued success of the Act's approach to decision-making



https://doi.org/10.1192/pb.bp.111.038273 Published online by Cambridge University Press

**Box 1** Case vignette: psychiatrist's involvement in best interests assessment

An elderly widower was referred to the community mental health team by his general practitioner (GP) because he was making repeated telephone calls to emergency services for generalised pain. This led to multiple hospital attendances and admissions where no identified physical cause could be found. It was established by a psychiatrist that the widower had dementia in Alzheimer's disease and furthermore lacked capacity regarding the medical management of his condition on account of impaired recall of relevant events, behaviour and information. Additionally, he did not believe (and so could not understand) relevant information about his problematic behaviour, denying making multiple calls to accident and emergency services or inadvertently taking an overdose of paracetamol. A best interests meeting was called regarding his welfare. All relevant carers were invited but his GP, community pharmacist, social worker and the ambulance service were unable to attend. Present were the children involved in his care, his community matron, care agency manager, occupational therapist and the psychiatrist. Using the Mental Capacity Act provisions, best interests decisions were made regarding access to the patient at home, appropriate care package considering his safety and independence, handling complaints of pain, the need for regular analgesics from his GP with restriction of over-the-counter analgesics and treatment for his Alzheimer's disease.

would require front-line professionals to understand the process, be comfortable with it and be innovative in the way they apply it. Professionals should take confidence from the study which showed that the vast majority of mentally incapacitated adults who regained capacity believe doctors should make decisions on behalf of incapable adults.

Areas for improvement remain. In particular, greater clarity is needed for front-line professionals in how to apportion due weight and balance to various factors in the best interests checklist. Currently, the best interests test is for the purposes of the Mental Capacity Act itself. It seems that in future, this test and the common law test of best interests for other purposes may gradually be conflated into one, at least in terms of the process and approach.

Overall, the best interests provision of the Act appears to have succeeded in providing a solid, uniform and workable legal framework for professionals and carers to use to benefit those adults who are not capable of making decisions or taking actions for themselves.

## About the author

**Dr Olufunso B. Aribisala** is a consultant psychiatrist for the elderly, Preston Community Mental Health Team, Lancashire Care NHS Foundation Trust, Ribbleton Hospital, Preston, UK.

## References

1 *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

2 Hale B. *Mental Health Law* (5th edn). Sweet & Maxwell, 2010.

3 *Re S (Adult Patient: Sterilisation)* [2001] Fam 15.

4 Department for Constitutional Affairs. *Mental Capacity Act 2005 Code of Practice*. TSO (The Stationery Office), 2007.

5 Flynn E. New mental health and mental capacity legislation in Northern Ireland. Human Rights in Ireland, 2010 (http://www.humanrights.ie/index.php/2010/08/30/new-mental-health-and-mental-capacity-legislation-in-northern-ireland/).

6 Northern Ireland Assembly Committee for Health, Social Services and Public Safety. Official Report (Hansard): Mental Capacity (Health, Welfare and Finance) Bill: Departmental Briefing. Northern Ireland Assembly, 2012 (http://www.niassembly.gov.uk/Documents/Official-Reports/Health/Minutes-of-Evidence-2011-2012/120509_MentalCapacity(Health, WelfareandFinance) BillDepartmentalBriefing.pdf).

7 *Re P* [2009] EWHC 163 (Ch).

8 Jones R. *Mental Capacity Act Manual (4th edn)*. Sweet & Maxwell, 2010.

9 *Re GM; FP v GM and A Health Board (2011) EWHC 2778 (COP)*.

10 Scottish Law Commission. *Report 151 – Report on Incapable Adults*. Scottish Law Commission, 1995 (http://www.scotlawcom.gov.uk/publications/reports/1990-1999/).

11 Law Commission. *Mental Incapacity: Item 9 of the Fourth Programme of Law Report: Mentally Incapacitated Adults*. HMSO, 1995 (http://www.official-documents.gov.uk/document/hc9495/hc01/0189/0189.pdf).

12 *R (Burke) v General Medical Council* [2005] EWCA Civ 1003.

13 Re Wyatt [2005] EWCA Civ 1181.

14 Great Britain. *Mental Capacity Act 2005: Chapter 9 Explanatory Notes*. TSO (The Stationery Office), 2005.

15 Owen GS, David AS, Hayward P, Richardson G, Szmukler G, Hotopf M. Retrospective views of psychiatric in-patients regaining mental capacity. *Br J Psychiatry* 2009; **195**: 403–7.

16 Donnelly M. Best interests, patient participation and the Mental Capacity Act 2005. *Med L Rev* 2009; **17**: 1–29.

17 *C v V* [2008] EWHC B16 (COP).

18 Adams S. Kidney failure patient forced to have dialysis. *The Telegraph* 2012; 29 May (http://www.telegraph.co.uk/health/healthnews/9298215/Kidney-failure-patient-forced-to-have-dialysis.html).

19 Nuffield Council on Bioethics. *Dementia: Ethical Issues*. Nuffield Council on Bioethics, 2009 (http://www.nuffieldbioethics.org/go/ourwork/dementia/publication_530.html).

20 *Ahsan v University Hospitals Leicester NHS Trust* [2006] All ER (D) 451 (Jul).

21 *Westminster City Council v C* [2008] EWCA 198.

22 Ashton G, Letts P, Oates L, Terrell M. *Mental Capacity: The New Law*. Jordan Publishing, 2006.

23 Practice Direction E – Applications Relating To Serious Medical Treatment. Available at: http://webarchive.nationalarchives.gov.uk/20110218200720/http://www.hmcourts-service.gov.uk/cms/files/09E_-_Serious_Medical_Treatment_PD.pdf



https://doi.org/10.1192/pb.bp.111.038273 Published online by Cambridge University Press