Do Mental Capacity Laws Unfairly Discriminate Against People with Disabilities?

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Abstract

This article shall argue that the UK Mental Capacity Act (MCA herein) is unfairly discriminatory towards mentally disabled people, although not irreparably so. Although this article inhabits the nexus between public policy and philosophy, my argument is primarily a philosophical exploration of whether the MCA adequately reflects and protects the autonomy of mentally disabled people. I shall therefore be examining the discriminatory effects of the MCA, as well as the nature of autonomy, in arguing that this legislation unfairly discriminates against people with mental disabilities. In section I I argue that: (i) the diagnostic component of the MCA is discriminatory and ought to be removed; and (ii) the functional test is indirectly discriminatory, while the unfairness of this discrimination is rooted in the application of the legislation rather than the legislation itself. I also observe that the flexibility of the MCA allows for societal prejudices to influence rulings, further disadvantaging mentally disabled people. In section II I contend that the individualistic model of autonomy the MCA is predicated upon fails to pay deference to the socially-embedded way in which each of us makes decisions, and that this inaccurate portrayal of autonomy — coupled with the unequal power dynamics that characterise capacity assessments — places an unfair burden on people with mental disabilities. I recognise that while there are people who cannot act autonomously, and best-interest decision-making may be necessary in such circumstances, the MCA does not achieve its aim of protecting the vulnerable in the least restrictive way, nor does it safeguard against the unfair discrimination of disabled people.

Introduction

Through the efforts of numerous campaigns, charities, and pressure groups, mental health has become a higher profile political issue in the UK, with each of the six largest parties (by votes) making commitments to mental health care in their 2015 manifestos. As political awareness and social understanding of mental health has developed, there is the risk that current legislation has lagged behind. In light of these developments, examination of the MCA is required to ensure that it furthers, rather than hinders, the progression of social attitudes and the safeguarding of liberty for those with mental disabilities. Within current legislation in England and Wales, legal capacity depends upon mental capacity — for one to be able to make a legally recognised decision one must have the mental capacity to do so. In the event that someone lacks capacity to make a decision with respect to e.g. their finances, living arrangements, health, or social contacts, a decision may be made in their ‘best interests’, even if the decision contravenes their wishes. Best interest decision-making, however, reveals deep philosophical fissures. Respect for autonomy — broadly, the expression of one’s will in accordance with one’s values and principles — serves as the value framework upon which discussion is built. Yet while it is generally recognised that mental capacity is required for autonomy, and that respecting autonomy does not entail allowing someone to suffer from decisions they lack the capacity to make, determining who lacks such capacity in practice is no simple task. Set the bar too high and we fail in our duty of care towards the vulnerable; set the bar too low and the liberty of autonomous people is curtailed.

At present the laws governing the (non-criminal) deprivation of liberty are covered by the Mental Health Act 1983 (MHA herein) and the Mental Capacity Act 2005. The relationship between these legal frameworks is a complex one, with each being applicable to the same individual, however they serve slightly different functions. The MHA allows for patients diagnosed with a mental disorder to be detained and treated against their will, and is primarily concerned with the prevention of risk to either the patient or others. The MCA, on the other hand, is concerned with specifying the legal conditions for mental incapacity and provides the general framework for best interest decision-making. The diagnostic requirement of the MHA raised concerns in both academic and policy-making circles that the statute discriminates against those with mental disabilities, a charge that has similarly been levelled at the MCA. However, while the prima facie discrimination of the MHA must be examined and addressed, this will not be the project of this article. My concern shall be restricted to the MCA as it constitutes the primary legislation under which mental capacity, and thus legal capacity, is evaluated. It is therefore the primary source of contention over whether existing mental capacity legislation unfairly discriminates against mentally disabled people.

Section I shall outline the key components of the MCA — namely, the functional test and the diagnostic threshold — and examine the extent to which they are discriminatory. I argue that: (i) the diagnostic component is unjustifiably discriminatory and ought to be removed from the MCA; and (ii) the functional test is unfairly discriminatory in practice, though not in principle. I also argue that the flexibility of the MCA allows for societal prejudices to influence rulings, disadvantaging mentally disabled people. Section II shall proceed to examine the individualistic conception of autonomy underpinning the MCA, and how this compares to more relational accounts. I contend that the individualistic model fails to pay deference to the socially-embedded way in which we make decisions, and that this inaccurate portrayal of autonomy — coupled with the unequal power dynamics that characterise capacity assessments — places an unfair burden on people with mental disabilities. I recognise that whilst there are people who genuinely cannot act autonomously, and best-interest decision-making may be necessary in such circumstances, the MCA currently does not achieve its aim of protecting the vulnerable in the least restrictive way (s1 (6)), nor does...
it adequately safeguard against the unfair discrimination of disabled people.

Section I

Denial of legal capacity on grounds of mental incapacity is decision-specific. For example, someone may lack capacity vis-à-vis their health whilst having capacity regarding their living arrangements. For a person to lack mental capacity under the MCA, two broad conditions must be satisfied. The functional component of the statute (s.3(1)) stipulates that 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 …
(d) to communicate his decision [by any means]'.

If it can be established (on the balance of probabilities) that any of these conditions apply, then a person may be judged to lack capacity, if they also satisfy the diagnostic requirement. The diagnostic component states that a person lacks capacity if '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' [my emphasis]. Any ruling under the MCA must also accord with the principles of the act, as follows:

(s.1 (2)) A person must be presumed to have capacity,
(s.1 (3)) all practicable steps must have been taken before incapacity is declared,
(s.1 (4)) incapacity cannot be judged solely from an unwise decision,
(s.1 (5)) decisions made on behalf of one who lacks capacity must be made in their best interests,
(s.1 (6)) and care must be taken to ensure that the given purpose is achieved in the least restrictive way.

These principles, as well as the anti-discriminatory aims of the MCA (see s.2 (3)) and the MCA Code of Practice, shall be referred to in assessing the functional and diagnostic components.

The functional component of the MCA may disproportionately affect people with mental disabilities, but this alone cannot demonstrate unfair discrimination. By analogy, a police fitness test disproportionately disadvantages physically disabled people, but this indirect discrimination may be justifiable if the test requirements constitute a reasonable means to a legitimate end. The reason we do not typically consider police fitness tests to be unfairly discriminatory is because fitness is a legitimate requirement for a front-line officer, and a fitness test is a reasonable means of assessing fitness. Similarly, if the functional test constitutes a reasonable means to a legitimate end then it will not be unfairly discriminatory. In principle, the functional test appears to satisfy this criterion. Understanding, retaining, using, and weighing relevant information, and being able to communicate a decision are all persuasive requirements for autonomy, while determining who has autonomy is a legitimate end. However, in practice capacity assessments are conducted in a way that isolates the assessed individual from their decisional support network – something that does not fairly reflect what autonomy consists of. Thus, although the requirements for capacity set out in the functional test are persuasive, the method by which they are assessed is predicated on an erroneous, overly individualistic conception of autonomy, leading to unfair discrimination. As I shall argue in section II, autonomy is not best captured through assessing an individual in isolation from their decisional support network.

As people with mental disabilities tend to be more reliant upon such support networks, the consequence of this individualistic assessment practice is that autonomous people with mental disabilities will be subjected to paternalistic intervention more often than people with comparable autonomy who do not have a mental disability. Thus the way in which the functional component is applied constitutes an unreasonable means to a legitimate end: it is not the functional test itself that is unfairly discriminatory against people with mental disabilities, but rather the way in which it is operationalised.

The diagnostic threshold does not explicitly determine incapacity by reference to disability status, but rather an 'impairment or disturbance in the mind or brain', which is interpreted broadly and can apply to (for example) drunkenness. From the outset, the diagnostic threshold will have discriminatory effects. This is because mentally disabled people will comprise a large part of the mental impairment category, and in cases where capacity is ambiguous under the functional assessment, people with mental disabilities will likely be found incapacitous far more than their non-disabled counterparts. The mental impairment clause means that only those who fail to demonstrate competency in communicating (via any means), understanding, retaining, or using and weighing relevant information – for reasons other than a mental impairment – would have their autonomy curtailed if the diagnostic threshold were jettisoned. Notwithstanding the fact that someone who failed to meet such criteria would demonstrate a questionable degree of autonomy, why should they be regarded as deserving liberty when someone with similar decision-making powers, yet with a mental impairment, is deprived of theirs? It is hard to find a principled basis for why those who fail the functional test for non-cognitive reasons are more deserving of liberty, or less deserving of protection, than their mentally impaired counterparts. Moreover, since this discrimination stands in contrast to the anti-discriminatory aims of the legislation, the onus is on the diagnostic threshold to prove that it constitutes a plausible necessary condition for incapacity. We can contextualise this discussion by drawing upon an example that occurred prior to the MCA, where a patient with borderline personality disorder refused a blood transfusion on the grounds that her blood was evil, and that any transfused blood would also become evil. The judge stipulated that this belief was evidence of an inability to use and weigh relevant information, and therefore constituted evidence of incapacity, so we can assume the ruling would have been the same under the MCA. This contrasts with the general judicial acceptance of capacity regarding the refusal of blood transfusions on religious grounds. Let us suppose that there are relevant differences in capacity between these cases that ought to be captured in the legal framework. Arguably this could be achieved by s.3(4a) and s.3(1e), and if not – buttressing an insufficient capacity assessment with a discriminatory one of questionable relevance to autonomy is ad hoc and poor jurisprudential practice. Furthermore it shall be demonstrated that despite the principle of non-discrimination and the commitment to allow unwise autonomous decisions, the presence of disability does in fact influence judgements of incapacity.

Under the MCA, both the functional test and the diagnostic threshold are construed broadly. There are advantages to this flexibility – in some circumstances it may be difficult to account for incapacity in a rigorous way. This is especially true of people suffering from conditions that distort perceptions or values, such as anorexia nervosa or severe depression. People with such conditions appear to satisfy the functional criteria, but intuitively seem to lack capacity (for ego-syntonic conditions this intuition is even harder to underpin). The flexibility of the MCA allows for socially accepted, though under-substantiated, understandings of capacity to influence judgements, challenging the supposed normative neutrality of mental capacity legislation. In other words, such flexibility allows for social prejudices to percolate into judgements of capacity. For example, people with psychological conditions are far more likely to be regarded as deserving liberty when someone with similar decision-making powers, yet with a mental impairment, is deprived of theirs? It is hard to find a principled basis for why those who fail the functional test for non-cognitive reasons are more deserving of liberty, or less deserving of protection, than their mentally impaired counterparts. Moreover, since this discrimination stands in contrast to the anti-discriminatory aims of the legislation, the onus is on the diagnostic threshold to prove that it constitutes a plausible necessary condition for incapacity. We can contextualise this discussion by drawing upon an example that occurred prior to the MCA, where a patient with borderline personality disorder refused a blood transfusion on the grounds that her blood was evil, and that any transfused blood would also become evil. The judge stipulated that this belief was evidence of an inability to use and weigh relevant information, and therefore constituted evidence of incapacity, so we can assume the ruling would have been the same under the MCA. This contrasts with the general judicial acceptance of capacity regarding the refusal of blood transfusions on religious grounds. Let us suppose that there are relevant differences in capacity between these cases that ought to be captured in the legal framework. Arguably this could be achieved by s.3(4a) and s.3(1e), and if not – buttressing an insufficient capacity assessment with a discriminatory one of questionable relevance to autonomy is ad hoc and poor jurisprudential practice. Furthermore it shall be demonstrated that despite the principle of non-discrimination and the commitment to allow unwise autonomous decisions, the presence of disability does in fact influence judgements of incapacity.

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than other groups ‘in virtue of their diagnosis’. Similarly, Emmett et al. observed that for cognitively impaired patients ‘professional assessments routinely made assessments that were outcome-driven rather than based on an assessment of mental function’ – i.e. would base their assessment of capacity on whether the decision was rational or sensible. While Williams et al. found that for some cognitively-impaired people ‘a lack of capacity was assumed’. These findings imply that, in practice, mental disability can colour judgements of incapacity – in direct contravention of s.1(2), s.1(3), s.1(4), and the anti-discriminatory aims outlined in the Code of Practice. It is understandable that in circumstances where (in)capacity is not totally clear medical professionals prefer to err on the side of paternalistic caution, with the flexible criteria providing little guidance. However, superimposing one’s preconceptions of mentally disabled people onto capacity judgements constitutes a discriminatory failure to ensure their liberty, suggesting the need for greater safeguards in capacity assessments.

Alternatively it may be the case that the diagnostic requirement helps to screen for incapacitous people, but this in no way justifies employing it as a necessary condition. Moreover, given that such screening is inherently discriminatory, the burden of proof is on the diagnostic threshold to demonstrate that such screening is so effective in identifying incapacity that this discrimination is justified (despite the anti-discriminatory aims). When we consider that mentally disabled people will be disproportionately impacted in cases of ambiguous capacity, and the functional test’s flexibility leaves scope for the prejudicial to influence the judicial, this burden may prove too heavy to bear. Of course, prejudicial attitudes could still influence capacity judgements were the diagnostic threshold jettisoned. However, removing the explicit link between mental impairment and incapacity would place greater emphasis on assessing capacity on an equal basis – if the functional test proves insufficient in this task, this would motivate greater rigour in the assessment criteria; if it proved sufficient, the association between cognitive impairment and incapacity, and the resultant stigmatisation of mental disabilities, would be further mitigated against with no ill effect.

Section II

The MCA is predicated upon a model of autonomy that vouches self-reliance and individualism. On this view, an autonomous person is someone who requires, and is subject to, little external influence or guidance in expressing their will. This is evidenced by the way in which capacity assessments are conducted – the individual is assessed with reference to their own decision-making capacities, severing them from the support networks that most of us make decisions within. Of course there is a point at which guidance becomes undue influence and undermines autonomy, and the courts have been attentive to this. However this does not entail that any modicum of influence inhibits autonomy. Rather, ‘appropriate social relations form an inherent part of what it means to be self-directed’.

Such relational accounts do not seek to reductively collapse individual capacities and needs into amorphous notions of relationality, but rather seek to recognise that employing narrow, atomistic accounts of autonomy ‘can lead to a sterile and unsophisticated assessment … of capacity’. Individualistic conceptions obfuscate the interdependent way in which capacity is formed, and in doing so unfairly disadvantages those with mental disabilities. The current way in which capacity is assessed isolates the individual from their support network, thus providing the assessor with only a partial representation of the individual’s capacity – a partial representation that disproportionately harms those people who are more dependent on such networks, such as mentally disabled people. This is not to suggest that functional assessments are wholly inappropriate for determining capacity – indeed, self-determination depends upon internal competencies as well as external support. Rather it is to suggest that reliance upon others in certain domains should not be indicative of incapacity. Neither is this a castigation of best-interest decision-making – this will be appropriate for those with severe impairments. However, it should be recognised that some people (such as the mentally disabled) require additional support to exercise the autonomy they do possess, and this admission should not impinge upon their right to liberty. Furthermore, when viewed through a relational autonomy lens it becomes clear that autonomy is better promoted through establishing support networks that enable people to fully participate in society, in turn facilitating the development of the competencies which autonomy (partially) consists in.

Identifying capacity through an overly individualistic framework (as the MCA does) can disrupt this process through unwarranted paternalism, fostering learned helplessness and arresting the development of autonomy in those whose support networks play a larger role in guiding decision-making. Therefore to better promote the autonomy of disabled people, the MCA should adopt a more relational approach to (in)capacity assessment, for example, through consideration of the support network available to the assessed individual, which would better reflect that which autonomy consists in whilst upholding liberty and protecting the vulnerable in a less restrictive, discriminatory way – consistent with s.1(6) and the Code of Practice.

Another dimension that unfairly disadvantages mentally disabled people is the unequal power relations that characterise capacity assessments. This dynamic places the onus on mentally impaired people to demonstrate their capacity, a task which is likely to be more challenging for mentally disabled people who may be more reliant upon support networks for decision-making than others. Communicative failures are attributed to the assessed rather than the assessor. Indeed, ‘case law offers several examples of people found to lack … capacity by assessors whom they did not like … only to be found to have capacity by other assessors.’ When this is taken in conjunction with the fact that disabled people are more likely to be subject to capacity assessments due to their diagnoses, the current approach places an unfair burden upon mentally disabled people and does so in a discriminatory fashion. All of this illustrates that in practice the flexibility of the legislation, the unequal power dynamics of the formal assessment process, and the stigma surrounding mental disabilities conspire to discriminate against disabled people. Moreover this discrimination has yet to be justified on autonomy-promoting grounds. It is important to note that this does not call for the wholesale abandonment of functionally determined best-interest decision-making, but rather calls for greater safeguards and more holistic assessment criteria in judging incapacity. If greater regard were given to the quality and stability of the individual’s support network, if both professional and personal sources were consulted in determining capacity, and if capacity assessments were conducted in the presence of a key member of the individual’s support network (perhaps alongside individual assessments), this would better reflect what autonomy consists in – providing assessors with a more comprehensive understanding of the individual’s capacity while helping to reduce communication failures mistakenly attributed to incapacity. This will not entirely remove the difficulty in determining who lacks capacity, and there will always be certain cases that generate concerns; however if these measures were implemented then mental capacity legislation would be better positioned to navigate this challenging ethical and legal area in a way that respects the autonomy of mentally disabled people.

Conclusion

The MCA in its existent form must do more to ensure the equal treatment of mentally disabled people. I have argued that the diagnostic threshold requires justification
for its discriminatory practice to be deemed fair – a justification that has yet to be given. Meanwhile the functional test is unfairly discriminatory towards mentally disabled people, though not irreparably so. If the functional component can incorporate a more holistic assessment of autonomy that pays deference to the interdependent way in which capacity is formed, perhaps via some of the suggestions put forward above, then it will be able to ameliorate the unfair burden currently placed on mentally disabled people. I have acknowledged the difficulty of balancing flexibility and rigour in reconciling respect for autonomy with protecting the vulnerable, and there is perhaps no silver bullet solution to this. However introducing the changes mentioned above would help align the MCA with what autonomy consists in while reducing the scope for prejudicial attitudes to influence capacity assessments. Of course these measures alone would not be sufficient to combat the prejudicial attitudes themselves, and must rather operate in conjunction with a greater emphasis on educating society about mental health. This would help to help challenge the prevailing stigma surrounding mental disabilities, and may assist in mitigating the influence that social prejudice plays in judgements of incapacity. Equality and autonomy are principal aims of the MCA, and rightly so. With political will and social awareness, these aims can be realised.

References
4 Ibid, Pg 80.