

Decision-making: the legal framework¹

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1 With the kind permission of Cerebra, parts of this chapter are taken from C Parker, *Disabled Children's Parent's Guide: decision making, confidentiality and sharing information*, Cerebra, 2013.

2 A detailed analysis of the MCA 2005 is beyond the scope of this book. More detailed guidance can be found in : A Ruck Keene, K Edwards, Professor A Eldergill and S Miles, *Court of Protection Handbook – a user's guide*, LAG, 3rd edn 2019 and R Jones, *Mental Capacity Act Manual*, Sweet & Maxwell, 8th edn, 2018. 329

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Key points

- Decision-making is part of everyday life; it is also crucial to the provision of care and support to disabled children.
- While parents make decisions on behalf of their young children, as those children develop and mature, it will be necessary to determine whether they are able to make decisions for themselves.
- Parents can make decisions on behalf of their children who are unable to make decisions for themselves, provided that such decisions fall within the ‘scope of parental responsibility’.
- Children and young people who are unable to make decisions for themselves should still be involved in decisions being made about them.
- The ability of children under 16 years to make decisions for themselves will depend on whether they are assessed to be ‘Gillick competent’.
- Given that the Mental Capacity Act (MCA) 2005 applies to people aged 16 and over, it is important that all those working with young people aged 16 and 17 are aware of this Act and its accompanying code of practice.
- Young people aged 16 or 17 will be assumed to be able to make decisions for themselves, unless evidence shows that they lack the capacity to do so.
- Key provisions of the MCA 2005 are summarised, including the assessment of capacity, ‘best interests’, the role of the Court of Protection and specific issues concerning those aged under 18.
- Under the MCA 2005, decisions can be made on behalf of individuals aged 16 and over who lack the capacity to make such decisions for themselves, provided that this is in the person’s best interests and does not give rise to a ‘deprivation of liberty’.
- The basis on which children and young people may be considered to be deprived of their liberty is an area of law that is complex and still developing and, accordingly, legal advice should be sought if there are concerns that the decisions being considered may lead to the child or young person being detained.

Introduction

- 7.1 Decision-making is part of everyday life – ranging from day-to-day decisions such as what to eat for breakfast and what clothes to wear,

to more significant decisions such as where to live and whether to agree to medical treatment proposed by healthcare professionals. Adults make such decisions for themselves, unless they lack the ‘capacity’⁴ to do so, in which case the process for decision-making will be governed by the Mental Capacity Act (MCA) 2005.⁵ The situation is different for under 18s. This is because, in some cases, parents and others with ‘parental responsibility’⁶ (referred to as ‘parents’ in this chapter) will be able to make decisions on behalf of their child. Furthermore, although the MCA 2005 applies to those aged 16 and 17, in some areas, there are significant differences in how the MCA 2005’s provisions apply to young people, as compared to adults. Given that there are differences in how the law affects the two age groups, this chapter refers to those aged under 16 years as ‘children’ and those aged 16 and 17 as ‘young people’.

7.2 This chapter provides an overview of the legal framework that governs how decisions are made in relation to disabled children and young people’s care and support, focusing on two main areas:

- 1) The issues that are specific to children and young people: in particular, the circumstances in which parents are able to make decisions on behalf of their child (the concept of the ‘scope of parental responsibility’) and the assessment of children and young people’s ability to make decisions for themselves (the concept of ‘Gillick competence’ and the relevance of the MCA 2005).
- 2) A summary of the provisions of the MCA 2005 and how they apply to young people (and, more rarely, children).

7.3 Other chapters provide further information on decision-making in the areas of health, education and social care.

4 MCA 2005 s2 (People who lack capacity). This is discussed below at para 7.34

5 Additionally, the High Court can exercise its powers under the inherent jurisdiction to take necessary and proportionate measures to protect adults who, although not lacking capacity under the MCA 2005, are ‘vulnerable’, for reasons (such as coercion) that prevent that adult from making an autonomous decision: *DL v A Local Authority and Others* [2012] EWCA Civ 253; (2012) 15 CCLR 267.

6 Children Act 1989 s3 defines this as: ‘the rights, duties, powers, responsibilities and authority which by law a parent has in relation to a child and his property’. Usually, but not always, the parents will have parental responsibility. Unmarried fathers will need to take steps to acquire parental responsibility. Further information is given on parental responsibility in chapter 2 at para 2.58.

An overview of the legal framework for decision-making

- 7.4 A significant difference between adults, on the one hand, and children and young people on the other, is the decision-making role of parents up until their child reaches adulthood at the age of 18.
- 7.5 Parents of young children who are not able to make decisions for themselves will make the decisions on behalf of their children. However, as children develop and mature, they will generally become more able to participate in decision-making and to start to make their own decisions, including about their care and support. Developing experience in making decisions for themselves is an important part of growing up and making the transition from childhood to adulthood.
- 7.6 Accordingly, those working with disabled children and young people, such as health and social care professionals, will start to encourage them to take an active part in planning and reviewing their own care and support. They will need to decide whether the child or young person is able to make decisions for themselves and if not, whether the decision can be made by their parents on their behalf, or in the case of young people who lack capacity under the MCA 2005, whether the decision can be made under that Act. These points are considered below.

Assessing the ability to decide

Children under 16

- 7.7 Before children reach the age of 16, the law assumes that they are not able to make decisions for themselves and their parents will make decisions for them. This means that parents will routinely be asked to make decisions on behalf of their disabled child; for example, what type of social care support is to be provided, or whether proposed medical treatment should be given to their child. However, as children develop and mature, they will generally become more able to participate in decision-making and start to make their own decisions.⁷ For disabled children, this will include decisions about their own care and support.

⁷ See UN Convention on the Rights of the Child (UNCRC) Article 12, which requires the views of children to be given 'due weight in accordance with the age and maturity of the child'.

7.8 In cases where children are considered to have the necessary maturity and understanding to make the decision in question for themselves, they are often referred to as being ‘*Gillick* competent’. This derives from the House of Lord’s decision in *Gillick v West Norfolk and Wisbech Area Health Authority*,⁸ which held that a child who has sufficient understanding and intelligence to enable him or her to understand fully what is involved in the proposed intervention will also have the competence to consent to that intervention.

7.9 As discussed in the health chapter of this book (see para 5.139), a *Gillick* competent child will be able to consent to a range of interventions, such as treatment and care and admission to hospital. That is not to say that parents are no longer involved in the decision-making process – as a general rule parents should be consulted about decisions concerning their child, but this will be subject to the child’s right to confidentiality (see below paras 7.23–7.26).⁹

7.10 Where a child is not *Gillick* competent, his or her parents may be able to make the decision on behalf of the child, but this will depend on whether that decision falls within the ‘scope of parental responsibility’ (discussed below at para 7.18).

7.11 In the past, there has been little guidance from the courts on how to assess whether a child is *Gillick* competent. For this reason, the Mental Health Act (MHA) 1983 Code of Practice issued in 2015 (‘the MHA Code 2015’) proposed four questions for practitioners to consider when assessing a child’s competence to make a particular decision (see Box 1). Although the primary concern of the MHA Code 2015 relates to mental health care, its guidance in relation to the assessment of *Gillick* competence could be applied in any case in which the child’s competence needs to be assessed.

7.12 A similar approach was adopted in *Re S (child as parent: adoption: consent) (Re S)*.¹⁰ In this case (which concerned the question whether a child aged under 16 could consent to the adoption of her baby) Mr Justice Cobb considered that for a child to be *Gillick* competent, ‘the child should be of sufficient intelligence and maturity to:

- i) understand the nature and implications of the decision and the process of implementing the decision;
- ii) understand the implications of not pursuing the decision;

8 [1986] AC 112.

9 See also Department of Health, Mental Health Act Code of Practice (MHA Code) 2015, paras 19.14–19.16.

10 [2017] EWHC 2729 (Fam).

- iii) retain the information long enough for the decision-making process to take place;
- iv) weigh up the information and arrive at a decision;
- v) communicate this decision.¹¹

7.13 Both *Re S* and the MHA Code 2015 adopt similar wording to that of MCA 2005 s3 (inability to make decisions). They also make clear that a child's competence must be assessed in relation to that child's ability to make the particular decision at the particular time. However, there is no presumption of capacity – it must be established that the child is able to make the decision. Moreover, whereas individuals can only lack capacity within the meaning of the MCA 2005 if their inability to decide is due to 'an impairment of, or a disturbance in the functioning of the mind or brain', a child might be unable to decide either for this reason, or for some other reason.¹² For example, the child may be unable to understand the relevant information, consider it and/or reach the decision in question due to a lack of the requisite maturity and intelligence. In either case, the child will lack *Gillick* competence.

Box 1: Assessing 'Gillick competence'

19.36 When considering whether a child has the competence to decide about the proposed intervention, practitioners may find it helpful to consider the following questions.

- Does the child understand the information that is relevant to the decision that needs to be made?
- Can the child hold the information in their mind long enough so that they can use it to make the decision?
- Is the child able to weigh up that information and use it to arrive at a decision?
- Is the child able to communicate their decision (by talking, using sign language or any other means)?

19.37 A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for another reason, such as because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack *Gillick* competence.

Department of Health, Mental Health Act 1983: Code of Practice 2015

11 *Re S (child as parent: adoption: consent)* at [18]

12 *Re S* at [16] – [17]. See also the MHA Code 19.34–19.35.

Young people aged 16 or 17

- 7.14 Given that the MCA 2005 applies to people aged 16 and over, once young people reach the age of 16, health and social care professionals and other practitioners providing care and support to them will work on the basis that they are able to make decisions for themselves, unless this is shown not to be the case.¹³ If there are concerns that the young person lacks capacity to make certain decisions, an assessment of their capacity should be undertaken in accordance with the MCA 2005 and the code of practice that accompanies this Act (Mental Capacity Act 2005: Code of Practice ('the MCA Code')). More detailed information on the MCA 2005, including how parents should be included in the decision-making process under this Act, is provided below (see para 7.27).
- 7.15 This does not mean that parents will never be asked to make decisions on behalf of their child aged 16 or 17. The MCA Code states that 'a person with parental responsibility for a young person is generally able to consent to the young person receiving care or medical treatment' where they lack capacity under the MCA 2005.¹⁴
- 7.16 Furthermore, in some cases a young person may be unable to make a decision but will not lack capacity as defined by the MCA 2005 and, therefore, that Act will not apply.¹⁵ This is because in order to lack capacity the person must be unable to decide 'because of an impairment of, or a disturbance in the functioning of the mind or brain'. The young person's inability to decide may be for a different reason, for example he or she has never been asked to make such a decision before and he or she is worrying about the implications of deciding one way or the other.¹⁶ In such cases, the young person's parent(s) may be able to make the decision on his or her behalf, but this will depend on whether the decision falls within the 'scope of parental responsibility' (formerly referred to as the 'zone of parental control' – this is discussed below (para 7.20)).

Involving children and young people in decision-making

- 7.17 Even if the child lacks the competence, or the young person lacks the capacity, to make the particular decision, they should be involved in decisions being made about them. For example, the MHA Code

13 MCA 2005 s1(2).

14 MCA Code, para 12.16.

15 MCA Code, para 12.13.

16 MHA Code 2015, para 19.31.

2015 states that ‘children and young people should always be kept as fully informed as possible’ and that they should receive clear and detailed information concerning their care and treatment, in an age appropriate format and that their views, wishes and feelings should always be sought and their views taken seriously.¹⁷ The Department of Health’s guide, *Seeking consent: working with children*, states that even if children are not able to give valid consent for themselves, they should be involved ‘as much as possible in decisions about their own health’:

Even very young children will have opinions about their healthcare, and you should use methods appropriate to their age and understanding to enable these views to be taken into account. A child who is unable to understand any aspects of the healthcare decision may still be able to express preferences about who goes with them to the clinic or what toys or comforters they would like to have with them while they are there. Similarly, where treatment choices involve multiple decisions, children may be able to give their own consent to some aspects of their care, even where they are not able to make a decision on the treatment as a whole.¹⁸

The scope of parental responsibility

- 7.18 The ‘scope of parental responsibility’ is a term used by the Department of Health to highlight the fact that while parents will be able to make a range of decisions on behalf of their child, the courts have made clear that there are limits to parents’ decision-making powers.¹⁹ The difficulty, however, is that to date there has been little guidance on where those limits are drawn. It will, therefore, be necessary to establish whether the decision in question is one that a parent can authorise.
- 7.19 Given that the precise circumstances in which parental consent can be relied upon are unclear, the scope of parental responsibility seeks to assist practitioners in assessing whether parental consent can be relied upon to authorise the decision in question – for example, admission to hospital and/or medical treatment.²⁰ Cases in which parental consent is considered to provide sufficient authority for that

17 MHA Code 2015, para 19.5.

18 Department of Health, *Seeking consent: working with children*, 2001, p9.

19 See, for example, *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112; *Hewer v Bryant* [1970] 1 QB 357 at 369; and, *Nielsen v Denmark* (10929/84) 28 November 1988 at [72]. See also discussion in *Re D (a child)* [2017] EWCA Civ 1695.

20 P Fennell, *Mental Health Law and Practice*, 2nd edn, Jordans, para 11.42.

decision to be made are described as falling within the ‘scope of parental responsibility’.²¹ Where a decision may fall outside the ‘scope of parental responsibility’, an application to the High Court under its ‘inherent jurisdiction’ (or in the case of a young person who lacks capacity under the MCA 2005 to make the relevant decision, the Court of Protection)²² is likely to be required, for which specialist legal advice will need to be sought. Examples of such cases include where a child or young person is, or may be, deprived of their liberty (see further para 7.22 below) or cases involving serious medical treatment, including end of life treatment (see chapter 5 at para 5.144 above).²³

7.20

The scope of parental responsibility was previously referred to as ‘the zone of parental control’. This term was criticised by legal commentators and practitioners alike as being vague and unhelpful.²⁴ A significant problem with the term ‘the zone of parental control’ is that it suggests that there is ‘a demarcated zone with observable boundaries’²⁵ which clearly there is not. In response to such criticism, the term has been renamed as the ‘scope of parental responsibility’ and additional guidance provided as part of the revisions to the MHA Code 2015.²⁶ Although the guidance in the MHA Code 2015 focuses on mental health care, the principle that there are limits to the type of decisions that parents can make in relation to their child applies to general health care decisions as well.²⁷ Furthermore, as discussed below, the scope of parental responsibility is relevant to decisions that might give rise to a child or young person’s deprivation of liberty.

21 MHA Code 2015, paras 19.40–19.41.

22 For a discussion on the MCA 2005, see paras 7.27–7.62, in particular paras 7.49–7.52.

23 However, if the deprivation of liberty concerns the admission to hospital for assessment and/or treatment for mental disorder, the MHA 1983 might apply.

24 See, for example, J Watts and R Mackenzie, ‘The Zone of Parental Control: a reasonable idea or an unusable concept?’ (1996) 18(1) *Tizard Learning Disability Review*, pp38–44; R Sandland, ‘Children, Mental Disorder, and the Law’ in *Principles of Mental Health Law and Policy* (eds L Gostin, P Bartlett, P Fennell, J McHale and R MacKay), OUP, 2010. This concern was noted in Department of Health, *Stronger Code: Better Care, consultation on the proposed changes to the Code of Practice: Mental Health Act 1983*, July 2014, at para 7.2.

25 B Dolan and S Simlock, ‘When is a DOL not a DOL? When parents of a 15 year old agree to it – *Re D (a child: deprivation of liberty)* [2015] EWHC 922 (Fam)’, Serjeants’ Inn Chambers, September 2015.

26 MHA Code 2015, chapter 19.

27 Department of Health, *Reference guide to consent for examination or treatment*, 2nd edn, 2009, p35.

7.21 The key points from the MHA Code 2015's guidance on the scope of parental responsibility are summarised as follows:

- Parental consent should not be relied upon when the child is competent or the young person has capacity²⁸ to make the particular decision.²⁹
- In relation to children who lack the relevant competence and young people who lack relevant capacity, the question whether parents can consent to a particular decision 'will need to be assessed in the light of the particular circumstances of the case', taking a range of factors into consideration. These fall under two broad questions:
 - The first is whether this is a decision that a parent 'should reasonably be expected to make' – covering points such as the type and invasiveness of the proposed intervention, the age maturity and understanding of the child or young person, the extent to which the decision accords with the wishes of the child or young person and whether the child or young person is resisting the decision.
 - The second question considers whether 'there are any factors that might undermine the validity of parental consent'. This covers points such as whether the parent(s) lacks capacity to make the decision or is unable to focus on what course of action is in the best interests of their child and whether there is a disagreement between the parents (one parent agreeing with the proposed decision but the other objecting to it).³⁰

Parental consent: deprivation of liberty and the scope of parental responsibility

7.22 The law relating to the deprivation of liberty of children and young people is complex. Key points relevant to determining whether children and young people are deprived of their liberty are set out in Box 3 at the end of this chapter. One particular area of confusion about the scope of parental responsibility is how it impacts upon the determination of whether a child or young person has been deprived

28 MHA 1983 s131(4) provides that parental consent cannot override the views of a young person who has capacity to decide about admission to hospital for treatment for mental disorder; see MHA Code 2015, para 19.39, in relation to treatment.

29 MHA Code 2015, para 19.39.

30 MHA Code 2015, paras 19.40–19.41.

of his or her liberty for the purposes of Article 5 of the European Convention on Human Rights (ECHR) (right to liberty and security).³¹ The role of parents is relevant because for individuals to be deprived of their liberty, not only must they be confined ‘in a particular restricted place for a not negligible length of time’, but there must be a lack of valid consent for that confinement.³² For under 18s, this raises the question whether parents can consent to the confinement on behalf of their child. As noted in Box 3 below, in the light of recent case law, the answer depends on the age of their child. For 16 and 17 year olds, it is clear that parents cannot consent to their child’s confinement.³³ In contrast, whereas parents of under 16s may be able to give such consent,³⁴ to date little guidance has been given on how to determine whether it is appropriate for them to do so.

Confidentiality and sharing information with parents

7.23 As they develop and mature, it is common for children and young people to prefer to discuss personal matters with health, social care and other professionals without their parents being present. Indeed, for some professionals working with young people nearing adulthood, the starting point might be that parents will not be involved unless the young person specifically requests this.

7.24 Like adults, children and young people have the right to confidentiality,³⁵ so that where children are *Gillick* competent, and young people have the capacity, to make decisions about the use and disclosure of information that they have given in confidence, their views should be respected in the same way as an adult’s request for confidentiality. This means that such confidential information may only be disclosed without the child or young person’s consent if this can be justified – for example, there is a legal requirement to do so, or there is reasonable cause to suspect that the child or young person is suffering, or at risk of suffering, significant harm.³⁶

31 See chapter 2 at para 2.20 in relation to the concept of deprivation of liberty generally.

32 See Box 3 below.

33 *Re D (A Child)* [2019] UKSC 42.

34 *Re D (A Child) (Deprivation of Liberty)* [2015] EWHC 922 (Fam).

35 Not least as an aspect of the human right to respect for their private lives under ECHR Article 8, see chapter 2 at para 2.14.

36 MHA Code 2015, paras 19.14–19.15. See also chapter 10 of the MHA Code 2015 and HM Government, *Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers*, July 2018.

7.25 The MHA Code 2015 advises that practitioners should encourage children and young people to involve their parents (unless this would not be in the best interests of that child or young person) and that they should ‘also be proactive in discussing with the child or young person the consequences of their parent(s) not being involved’.³⁷ Furthermore:

Where a child or young person does not wish their parent(s) to be involved, every effort should be made to understand the child or young person’s reasons and with a view to establishing whether the child or young person’s concerns can be addressed.³⁸

7.26 It is suggested that if parents and other carers are concerned that the lack of certain information will prevent them from providing adequate care, they should inform the child or young person’s care team and ask that the care plan be reviewed to take account of these concerns.

Mental Capacity Act 2005³⁹

Introduction

7.27 The MCA 2005 provides the legal framework for taking action and making decisions on behalf of individuals aged 16 or over who lack capacity to make such decisions for themselves. It is accompanied by the MCA Code of Practice, which provides detailed guidance on the implementation of the MCA 2005.⁴⁰

7.28 The MCA Code notes that while the MCA 2005 seeks to protect people who lack capacity to make decisions for themselves, it also aims ‘to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so’.⁴¹ The extent to

37 MHA Code 2015, para 19.15.

38 MHA Code 2015, para 19.16.

39 A detailed analysis of the MCA 2005 is beyond the scope of this book. More detailed guidance can be found in : A Ruck Keene, K Edwards, Professor A Eldergill and S Miles, *Court of Protection Handbook – a user’s guide*, LAG, 3rd edn 2019 and R Jones, *Mental Capacity Act Manual*, Sweet & Maxwell, 8th edn, 2018.

40 Department for Constitutional Affairs (now Ministry of Justice), *Mental Capacity Act 2005: Code of Practice*, 2007, www.gov.uk/government/publications/mental-capacity-act-code-of-practice. It should be noted that the Ministry of Justice is revising this code; see: <https://consult.justice.gov.uk/digital-communications/revising-the-mca-2005-code-of-practice/>.

41 MCA Code, p19.

which the MCA 2005 has met these objectives is debatable. Although describing the Act as ‘a visionary piece of legislation for its time’, a 2014 House of Lords Select Committee concluded that its implementation had not met expectations. It ‘has suffered from a lack of awareness and a lack of understanding’, which has ‘allowed decision-making to be dominated by professionals’, without the required input from families and carers about the wishes and feelings of the person who lacks capacity.⁴² The committee’s comment that ‘For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives’, is echoed by *Somerset CC v MK (deprivation of liberty: best interests decisions: conduct of a local authority)*.⁴³ In that case, the court considered that the various failings by the local authority in relation to the care of a young woman with learning disabilities (including her unlawful deprivation of liberty), illustrated ‘a blatant disregard of the process of the MCA and a failure to respect the rights of both P [the young woman] and her family under the ECHR’.⁴⁴ The court added:

... it is worse than that, because here the workers on the ground did not just disregard the process of the MCA they did not know what the process was and no one higher up the structure seems to have advised them correctly about it.⁴⁵

7.29 Given that the main provisions of the MCA 2005 apply to 16- and 17-year-olds, as well as adults, it is important that everyone working with this age group understands, and are able to apply, this Act. Furthermore, a new scheme for authorising individual’s deprivation of liberty under the MCA 2005 – known as the ‘Liberty Protection Safeguards’ – are likely to be introduced in 2020. As they will apply to young people as well as adults, those working with young people will need to be familiar with these provisions as well as the general provisions of the MCA 2005. Accordingly, the following key areas are summarised below:

- MCA 2005 principles;
- supporting people to make decisions for themselves;
- capacity under the MCA 2005;

42 House of Lords, Select Committee on the Mental Capacity Act 2005, Report of Session 2013–14, *Mental Capacity Act 2005: post legislative scrutiny*, HL Paper 139, pp7–8.

43 [2014] EWCOP B25.

44 [2014] EWCOP B25 at [78].

45 [2014] EWCOP B25 at [78].

- determining best interests;
- decision-making for people who lack capacity;
- deprivation of liberty and the Liberty Protection Safeguards;
- independent mental capacity advocates (IMCAs);
- the Court of Protection and the appointment of deputies;
- specific issues for children and young people.

MCA 2005 principles

- 7.30 The MCA 2005 incorporates at the outset five principles which govern all actions and decisions taken under this Act (see Box 2) and underpin the values of the MCA 2005.⁴⁶

Box 2: Principles (MCA 2005 s1)⁴⁷

- 1) *Presumption of capacity*: a person must be assumed to have capacity unless it is established that he or she lacks capacity.
- 2) *Provision of support to assist in decision-making*: a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
- 3) *Right to make unwise decisions*: a person is not to be treated as unable to make a decision merely because he or she makes an unwise decision.
- 4) *Act in person's best interests*: 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 or her best interests.
- 5) *Consider less restrictive option*: before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Supporting people to make decisions for themselves

- 7.31 The MCA 2005, in particular through Principle 2 (provision of support to assist decision-making), highlights the importance of supporting and encouraging individuals to make decisions for themselves.

⁴⁶ MCA Code, at p19.

⁴⁷ See MCA 2005 s1 and MCA Code chapter 2.

Chapter 3 of the MCA Code provides detailed guidance on how this can be done, emphasising the importance of:

- providing information relevant to the decision;
- communicating with the person in an appropriate way;
- making the person feel at ease;
- as well as considering whether others might be able to support the person in making choices or expressing a view.

Such support in decision-making should be part of the care planning process.⁴⁸

7.32 The manner in which a person can be helped to make decisions for himself or herself ‘will vary depending on the decision to be made, the time-scale for making the decision and the individual circumstances of the person making it’.⁴⁹ This might include choosing where and when is best to talk to the person and ensuring that the information is provided (orally and in writing) in a manner that is appropriate for that individual (taking into account the person’s age and any communication needs). The MCA Code suggests a number of points to consider when seeking to help someone make decisions for himself or herself. These include asking family members and others who know the person about the best form of communication; whether help is available from people the person trusts (but this would need to be subject to the person’s right to confidentiality)⁵⁰ and if an advocate might improve communication.⁵¹

7.33 Those supporting a person in making decisions should ensure that they provide appropriate advice and information, but not pressurise the person into making a decision or seek to influence the decision.⁵²

Capacity under the MCA 2005

Presumption of capacity

7.34 The starting point for individuals aged 16 and over is that they have the mental capacity to make the decision in question (Principle 1: presumption of capacity). However, if there are concerns that the person lacks capacity to make the particular decision, an assessment

48 MCA Code, para 3.5.

49 MCA Code, para 3.1.

50 See further para 7.23 above.

51 MCA Code, para 3.10. See also paras 15.4–15.6.

52 MCA Code, para 2.8.

of their capacity should be undertaken. The question whether the person lacks capacity will be decided on the balance of probabilities, which ‘means being able to show that it is more likely than not that the person lacks capacity to make the decision in question’.⁵³

Lacking capacity under the MCA 2005

7.35 Given that the MCA 2005 only allows acts or decisions to be made on behalf of those who lack capacity, it is essential that those seeking to rely on the MCA 2005 understand and are able to apply the test for capacity under the MCA 2005, which is set out under section 2 as follows:

... 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.

7.36 MCA 2005 s2 makes clear that when considering capacity, the focus is on whether the person is able to make the particular decision at the particular time. There are two elements to lacking capacity under the MCA 2005, both of which must be established:⁵⁴

- 1) **The ‘functional element’:** this requires that the evidence establishes that the person is unable to decide.⁵⁵ A person is unable to make a decision if he or she cannot:
 - understand the information about the decision to be made;
 - retain the information in his or her mind;
 - use or weigh that information as part of the decision-making process; or
 - communicate his or her decision (by talking, using sign language or any other means).
- 2) **The ‘diagnostic element’:** the person’s inability to decide must be ‘because of an impairment of, or a disturbance in the functioning of the mind or brain’, which can be permanent or temporary. However, if the impairment or disturbance is temporary, the person wishing to make the decision ‘should justify why the decision cannot wait until the circumstances change’.⁵⁶

53 MCA Code, para 4.10.

54 *PC v City of York* [2013] EWCA Civ 478; [2014] Fam 10.

55 Inability to make a decision is defined in MCA 2005 s3. See also the MCA Code, para 4.14.

56 MHA Code 2015, para 13.18.

- 7.37 If the inability to decide is due to something other than ‘an impairment of, or a disturbance in the functioning of the mind or brain’ the person will not lack capacity for the purposes of the MCA 2005. This is important because the MCA Code suggests that there may be cases in which a young person is unable to decide, but does not fall within the MCA 2005 because the reason for the inability to decide is not due to the ‘diagnostic element’. The circumstances in which this may arise (which are likely to be rare) are discussed above (see para 7.16).

Assessing capacity

- 7.38 The MCA Code emphasises that the starting assumption is that the person has capacity, as well as the importance of ensuring that the person’s capacity is assessed correctly if this is in doubt.⁵⁷ An assessment of a person’s capacity must be based on his or her ability to make a particular decision at a particular time.
- 7.39 The MCA Code points out that usually the assessment will be made by the person who is directly concerned with the person at the time the decision needs to be made. Thus, those providing daily care and support (whether they are paid carers or the person’s parents, or other relatives) will need to assess the person’s capacity to make decisions about that care, for example being helped to get dressed or have a bath.⁵⁸ Where health professionals propose treatment or an examination, they must assess the person’s capacity.⁵⁹ The breadth of the need to assess capacity emphasises the requirement for significant public education about the MCA 2005 which may have been lacking to date, with many family carers unaware of their obligations under the Act.
- 7.40 Although it is for the person wishing to make the decision to decide whether or not the person has capacity to consent to that decision, in some cases a professional opinion on the person’s capacity might be necessary. This might be for a range of reasons, such as the serious consequences of the decision in question, or if there are disagreements on whether the person has capacity or not. The MCA Code suggests that this might simply involve contacting the person’s GP, or it may be appropriate to contact a specialist with experience of

57 MCA Code, paras 4.34–4.37. See *Kings College Hospital NHS Foundation Trust v C* [2015] EW COP 80 at [25]–[39] for the ‘cardinal principles’ for assessing whether a person lacks capacity.

58 MCA Code, para 4.38.

59 MCA Code, para 4.40.

working with people with the same condition as the person requiring the assessment, for example, a psychiatrist, psychologist speech and language therapist, occupational therapist or social worker.⁶⁰

7.41 If there are concerns that a disabled young person lacks capacity to make certain decisions, an assessment of his or her capacity should be undertaken, taking into account the following points:

- **Presumption of capacity (Principle 1):** unless it can be shown that the person lacks capacity, he or she must be assumed to have capacity.
- **Non-discrimination:** the assessment must not be based on assumptions about the person's capacity due to his or her age or appearance; or his or her disability or other condition; or an aspect of his or her behaviour.⁶¹ Thus, the fact that a young person has a disability is not a basis for concluding that he or she lacks capacity to make the decision in question. It must be shown that the disability affects the young person's ability to make the relevant decision at the relevant time.⁶²
- **Considering the young person's ability to decide (the 'functional element'):**
 - *Principle 2 (Provision of support to assist in decision-making):* Emphasises the importance of encouraging and supporting people to make decisions for themselves. Chapter 3 of the MCA Code provides guidance on helping people to make their own decisions.
 - *Adequacy of the information:* In all cases, the provision of relevant information will be essential.⁶³ Relevant information will include the nature of the decision, the reason why the decision is needed and the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.⁶⁴ While the provision of a broad explanation, in simple language, may be enough in some cases, in others the nature of the decision (for example if it could have serious consequences) may require more detailed information or access to advice.⁶⁵
 - *Effective communication:* The information needs to be presented in a way that is appropriate to the person's needs and

60 MCA Code, paras 4.38–4.43, 4.51–4.54.

61 MCA 2005 s2(3).

62 MCA Code, para 4.48.

63 MCA 2005 s3(1).

64 MCA 2005 s3(4); and MCA Code, para 4.19.

65 MCA Code, para 4.19.

circumstances ‘using simple language, visual aids or any other means’.⁶⁶ For young people, it will be important that the information is provided in an age appropriate manner as well as being in the most effective form of communication, such as sign language, visual representations and computer support.⁶⁷

- *Assistance in retaining the relevant information*: It should not be assumed that the fact that a person cannot retain the information for very long means that he or she is unable to make the decision. What will need to be assessed is whether the person is able to hold the information in his or her mind long enough to make an effective decision – and this will depend on the particular circumstances of the case. People can be helped to retain information, by, for example, photographs, posters, videos and voice recorders.⁶⁸
- *Assistance in using or weighing information as part of the decision-making process*: Individuals must not only be able to understand the information but be able to weigh it up and use this to make a decision. People can be supported in doing so, by for example, family members and professional advisers.⁶⁹
- *Assistance in communicating a decision*: before deciding that a person cannot communicate his or her decision, ‘it is important to make all practicable and appropriate efforts to help them communicate’, which might require the involvement of professionals such as speech and language therapists or specialists in non-verbal communication.⁷⁰
- *Seeking the views of family members and close friends*: People close to the person may be able to provide valuable information, such as the types of decisions the person is able to make (although their views on what they want for the person must not influence the outcome of the assessment).⁷¹
- **Establishing reasons for inability to decide**: If the young person is unable to decide, it will be necessary to consider whether this is ‘because of an impairment of, or a disturbance in the functioning of the mind or brain’ (‘the diagnostic element’):

66 MCA 2005 s3(2); and MCA Code, para 4.17.

67 MCA 2005 s3(2); and MCA Code, paras 4.16–4.19.

68 MCA 2015 s3(3); and MCA Code, para 4.20.

69 *V v R* [2011] EWHC 822 (QB), noted in G Ashton (gen ed), *Court of Protection Practice*, Jordan Publishing, 2015, para 2.82.

70 MCA Code, para 4.24.

71 MCA Code, para 4.52.

- A range of conditions might be covered by ‘an impairment of, or a disturbance in the functioning of the mind or brain . . . such as psychiatric illness, learning disability, dementia, brain damage or even a toxic confusional state, as long as it has the necessary effect on the functioning of the mind or brain, causing the person to be unable to make the decision’.⁷² It also includes physical or medical conditions that cause drowsiness or loss of consciousness, concussion following a head injury and the symptoms of alcohol or drug use.⁷³
- As noted above (para 7.16), a young person may be unable to make a decision but for reasons other than ‘because of an impairment of, or a disturbance in the functioning of the mind or brain’ in which case, the young person will not lack capacity as defined by the MCA 2005 and, therefore, this Act will not apply.⁷⁴
- **Right to make unwise decisions (Principle 3):** The fact that a person makes a decision which others consider to be unwise does not mean that he or she lacks capacity. This principle applies to young people as well as adults. While young people may take risks that are unwise, this is ‘an inherent, inevitable, and perhaps necessary part of adolescence and early adulthood experience’.⁷⁵ Nonetheless, it should be noted that:
 - While an unwise decision is not in itself a reason for suggesting that a person lacks capacity, factors such as the person repeatedly making ‘unwise decisions that put them at significant risk of harm or exploitation’⁷⁶ might suggest the need for further investigation (such as an assessment of the person’s capacity to make such decisions). It is necessary to separate out the evidence which indicates risk taking that is unhealthy, dangerous or unwise decisions ‘from that which reveals or may reveal a lack of capacity’.⁷⁷ Questions to consider include whether the person has developed a medical condition that affects his or her capacity to make particular decisions, is easily influenced by undue pressure or needs information to help him or her understand the consequences of the decision.⁷⁸

72 MCA 2005, Explanatory Notes, para 22.

73 MCA Code, para 4.12.

74 MCA Code, para 12.13.

75 *WBC v Z* [2016] EWCOP 4 at [1].

76 MCA Code, para 2.11.

77 *WBC v Z* [2016] EWCOP 4 at [67].

78 MCA Code, para 2.11.

- If a person is making decisions without fully understanding the risks involved or is unable to weigh up the information about the decision, this is relevant to capacity. There is a difference between an ‘unwise’ decision and a decision that is ‘based on a lack of understanding of risks or inability to weigh up the information about a decision’.⁷⁹

Fluctuating capacity

- 7.42 In some cases, a young person’s capacity to make decisions may fluctuate (for example, due to periodic, profound depression). In such cases, social and health care professionals should plan for the times during which the young person is not able to make decisions for himself or herself. They can do so by negotiating advance agreements with the young person when he or she has the capacity to consent to such matters, for example medical treatment. Although these are not legally binding, such agreements are helpful in developing trust and understanding between the young person and the care team.⁸⁰ They will also help to ensure that the young person’s wishes and preferences are taken into account even during periods in which he or she may not be able to express them.⁸¹

Determining best interests

- 7.43 It is essential to keep in mind that the principle of ‘best interests’ in decision-making under the MCA 2005 only applies where a person lacks capacity to make a decision or decisions for themselves. People who have capacity are free to make decisions for any reason and are not required to do what is ‘best’ for them.
- 7.44 However, anything done for, and any decision made on behalf of, a person without capacity must be done or made in the ‘best interests’

79 *YLA v PM* [2013] EWCOP 4020 at [43](e).

80 For example, see Department of Health, Mental Health Act Code of Practice (the MHA Code) 2015, at para 9.15: ‘Encouraging patients to set out their wishes in advance is often a helpful therapeutic tool, encouraging collaboration and trust between patients and professionals’.

81 MCA 2005 s4(6)(a) emphasises the importance of considering relevant written statements. See also MCA Code, paras 5.41–5.45 on the importance of taking into account the person’s previously expressed views, in particular, written statements.

of that person (Principle 4: best interests).⁸² This applies to anyone making decisions or acting under the MCA 2005, whether in relation to financial, personal welfare or healthcare decisions and whoever is making the decisions (whether family members, health or social care professionals or individuals appointed to act as the person's deputy).⁸³

7.45 The MCA 2005 does not define 'best interests', rather it sets out a range of factors that must be considered when seeking to determine what is in the person's best interests. Decision-makers 'must take into account all relevant factors that it would be reasonable to consider, not just those that are important' and they must not make the decision based on what they would do.⁸⁴ The Supreme Court has emphasised the importance of the person's own views, wishes and feelings in determining what is in his or her best interests.⁸⁵

7.46 Where a young person lacks capacity, the following points will be relevant to determining what is in his or her interests:

- **Non-discrimination:** The determination of best interests must not be based on assumptions about the young person's age or appearance; or his or her disability or other condition; or an aspect of his or her behaviour.⁸⁶
- **Encouraging participation:** Wherever possible, the young person should be encouraged to be involved in the decision-making process and give his or her views on matters relevant to the decision and what outcome he or she would like.⁸⁷ Thus, steps will need to be taken to help the young person participate, for example using simple language and/or visual aids to help the young person understand the options and asking the young person about the decision at a time and location where he or she feels the most relaxed and at ease.⁸⁸
- **Considering if the decision can be delayed until the young person has capacity:** Although it may not be possible to do so because the

82 MCA 2005 s1(5). The MCA Code at para 2.12 notes that there are two exceptions to this – research (which is not covered by this handbook) and advance refusals of treatment (which do not apply to under 18s).

83 MCA Code, para 5.2. The exceptions to this concern advance decisions to refuse medical treatment and research. See MCA Code 5.4.

84 MCA Code, para 5.7.

85 *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; [2014] AC 591, see Lady Hale at [24]: 'the preferences of the person concerned are an important component in deciding where his best interests lie'.

86 MCA 2005 s4(1).

87 MCA 2005 s4(4); and MCA Code, para 5.22.

88 MCA Code, para 5.24.

decision needs to be made as a matter of urgency, if it is possible to put off the decision until the young person regains capacity, then the decision should be deferred until that time.⁸⁹ For many disabled young people there will of course be no prospect that they will gain or regain capacity to make certain decisions.

- **Considering the young person's wishes and feelings:** So far as reasonably ascertainable, to consider the following:
 - the young person's past and present wishes, in particular, any advance statement made when the young person had capacity;
 - the beliefs and values that would be likely to influence the young person if he or she had capacity;
 - the other factors the young person would be likely to consider if he or she had capacity, such as the effect of the decision on other people, providing or gaining emotional support from people close to the young person.⁹⁰
- **Consulting other people close to the young person:** The views of anyone involved in caring for, or interested in the welfare of, the young person, must be taken into account if it is practicable and appropriate to consult them.⁹¹ This should include the young person's deputy if one has been appointed, although a deputy will be entitled to take the relevant decision themselves if it comes within the scope of their powers conferred by the Court of Protection order. Although parents will no longer have parental responsibility once their child becomes 18, they should still be consulted on what is in their adult child's best interests (unless there are good reasons for not doing so, for example there are reasonable grounds to believe that the relationship between the parent and young person is abusive). This is because they will be persons who are 'engaged in caring for' the young person or who are interested in the young person's welfare.⁹² Those consulted should be asked their views on what they think is in the young

89 MCA 2005 s4(3); and MCA Code, paras 5.25–5.28.

90 MCA 2005 s4(6); and MCA Code, paras 5.37–5.46.

91 MCA 2005 s4(7).

92 MCA 2005 s4(7)(b). See *R (W) Croydon LBC* [2011] EWHC 696 (Admin); (2011) 14 CCLR 247, at [39], for the importance of involving the consultees (in this case, the parents) at the time when the relevant decisions are being made and giving sufficient time 'for adequate time for intelligent consideration and response to be given'.

person's best interests and if they can give any information on the young person's wishes and feelings, beliefs and values.⁹³

- **Special consideration for life-sustaining treatment:** When considering whether such treatment is in the young person's best interests, the decision-maker must not be motivated by a desire to bring about his or her death. Where there is any doubt as to what is in the young person's best interests, an application should be made to the Court of Protection.⁹⁴
- **Considering less restrictive principle (Principle 5):** Before an action or decision is taken on behalf of a person who lacks capacity, consideration must be given as to whether there is an alternative approach that would interfere less with the person's basic rights and freedoms,⁹⁵ although 'it may be necessary to choose an option that is not the least restrictive alternative if that option is in the person's best interests'.⁹⁶

Decision-making for people who lack capacity

Acts in connection with care or treatment

7.47 MCA 2005 s5 provides that individuals (such as health and social care professionals, parents and other carers) can undertake certain acts 'in connection with the care and treatment' of a person who lacks capacity.⁹⁷ Those undertaking such acts must reasonably believe that the person lacks capacity (and have taken reasonable steps to establish whether or not the person does lack capacity) and that it is in the person's best interests to undertake that act. They must also follow the principles set out in section 1 of the MCA 2005 (see Box 2 above).

7.48 Provided that individuals taking action for a person who lacks capacity have complied with these requirements, they will not incur liability (ie there will not be any civil or criminal penalties) for doing so without the person's consent, so long as the act taken is something that the person could have consented to if he or she had capacity. This means, for example, that a young person who lacks capacity to consent

93 MCA 2005 s4(7); and MCA Code, paras 5.49–5.54.

94 MCA 2005 s4(5); and MCA Code, paras 5.29–5.38.

95 MCA Code, para 2.14. The courts have also taken this approach. See, for example, *FP v GM and a Health Board* [2011] EWHC 2778 (Fam); [2011] 2 FLR 1375, in which Hedley J at [18], stated that this principle 'in effect, is a principle of minimum intervention consistent with best interests'.

96 MCA Code, para 2.16.

97 See chapter 6 of the MCA Code for further guidance.

to treatment can be given that treatment by health professionals, or if the young person lacks capacity to feed or dress, those caring for the young person can help the young person to do so, relying on MCA 2005 s5. However, section 5 would not provide a defence to a claim that the person undertaking the act had done so negligently.

Restrictions on acts undertaken

7.49 The acts that can be undertaken under MCA 2005 s5 are subject to the restrictions set out in MCA 2005 s6. Of key importance is that a person who lacks capacity can only be restrained if certain conditions are met. The term ‘restraint’ covers the use, or threat to use, force to make a person do something that he or she is resisting or restricting a person’s liberty of movement, whether or not the person is resisting.⁹⁸ An individual can only use restraint if this is reasonably believed to be necessary to prevent harm to the person who lacks capacity and is a proportionate response to likelihood of the person suffering harm, and the seriousness of that harm.⁹⁹ Crucially, acts under MCA 2005 s5 cannot authorise actions that amount to a deprivation of liberty (see below at para 7.52 and Box 3).

7.50 Furthermore, acts cannot be undertaken under MCA 2005 s5 if they conflict with a decision made by an individual authorised under the MCA 2005 to make decisions for the person who lacks capacity.¹⁰⁰ In the case of a young person, this might be a deputy appointed by the court to make personal welfare and/or financial decisions on behalf of the young person (see below para 7.61).

7.51 Additional restrictions apply to decision-making in relation to those aged 18 and over. For example, adults who have the mental capacity to do so, can appoint another adult to make decisions on their behalf (referred to as a ‘lasting power of attorney’ (LPA)). These can be either financial decisions or decisions concerning their personal welfare (including healthcare) if in the future they lack the capacity to do so themselves. In cases where the person has made an LPA, actions could not be undertaken if they conflict with the attorney’s decision.¹⁰¹

98 MCA 2005 s6(4).

99 See MCA Code, paras 6.40–6.46 for further information.

100 MCA 2005 s6(6) but see section 6(7) in relation to life-sustaining treatment.

101 MCA 2005 ss9-13; see also chapter 7 of the MCA Code. Other limits apply in relation to adults. For example, medical treatment cannot be given under the MCA 2005 if this conflicts with the adults’ valid and applicable advance decision to refuse treatment: see MCA 2005 ss24-26 and also chapter 9 of the MCA Code.

Deprivation of liberty and the Liberty Protection Safeguards

7.52 Those working with young people will need to consider carefully whether the care regime in community settings such as residential schools or children's homes, gives rise to a deprivation of liberty. This will also need to be considered in cases where a young person is to be admitted to hospital. In all cases where young people are deprived of their liberty, legal authority for this must be sought. Where a deprivation of liberty has arisen, legal advice may need to be sought on what action should be taken, which will depend on the circumstances of the case.¹⁰²

7.53 Under current law, where a deprivation of liberty arises in relation to a young person who lacks capacity to make decisions about his or her care, this is likely to require an application to the Court of Protection for an order authorising the young person's care (including the deprivation of liberty) under the MCA 2005.¹⁰³ However, if the deprivation of liberty concerns the admission to hospital for assessment and/or treatment for mental disorder, the MHA 1983 might apply.¹⁰⁴ This is an area in which important changes are afoot. As noted below, when the Mental Capacity (Amendment) Act (MC(A)A) 2019 comes into force (likely to be 2020) it will introduce a new administrative scheme for authorising a deprivation of liberty, known as the 'Liberty Protection Safeguards' (LPS) which will include young people aged 16 and 17.¹⁰⁵ This new scheme will operate in addition to the existing mechanisms for authorising a young person's deprivation of liberty noted above (court order, or (in the case of psychiatric admissions) detention under the MHA 1983¹⁰⁶). At the time of writing (November 2019) a Code of Practice providing guidance on the implementation of the LPS scheme is being developed and regulations setting out further detail on how the LPS is to work in practice are awaited.

102 See discussion in Box 3 below; and MCA Code, paras 12.23–12.25.

103 *Trust A v X and others* [2015] EWHC 922 (Fam) at [51].

104 See MHA Code 2015, chapter 19.

105 See MC(A)A 2019 Sch 1. This will be inserted as Schedule AA1 to the Mental Capacity Act (MCA) 2005.

106 Part 7 of Schedule 1 to the MC(A)A 2019 covers the inter-relationship between the Liberty Protection Safeguards and the MHA 1983 – setting out the circumstances in which the MHA 1983 must be applied.

7.54 Whereas the ‘deprivation of liberty safeguards’ (DoLS) under the MCA 2005 do not apply to individuals under the age of 18,¹⁰⁷ this will change with the introduction of the LPS, given that the LPS apply to 16- and 17-year-olds as well as adults.¹⁰⁸ Furthermore, whereas the scope of DoLS is limited to care homes and hospitals, the LPS scheme covers any setting. It is therefore likely to be relevant to young people who lack capacity to make decisions about their care or treatment (their ‘care arrangements’) and who are deprived of their liberty in placements such as residential schools, children’s homes and psychiatric units (both private and NHS hospitals). It may also apply to such young people who are living in the family home.

7.55 The LPS sets out the procedures a ‘responsible body’ must follow when determining whether to authorise a person’s deprivation of liberty. Depending on the circumstances of the case, the responsible body will either be an NHS body or a local authority. For young people it is likely that the responsible body will be a local authority¹⁰⁹ save where the deprivation of liberty arises in an NHS hospital, in which case the responsible body will be the hospital managers.¹¹⁰

7.56 In essence, the responsible body must be satisfied that three conditions are met.¹¹¹ The first condition is that the person lacks the capacity to consent to the care arrangements. The second condition is that the person has a mental disorder.¹¹² The third condition is that the care arrangements are both necessary to prevent harm to the person and a proportionate response to ‘the likelihood and seriousness of harm’ to the person. As part of this process, the person’s wishes and feelings about the care arrangements must be sought.¹¹³ Although parents are not referred to specifically, the list of people who must be consulted includes those engaged in caring for the person, or with an interest in that person’s welfare. Accordingly, a young person’s parents must also be consulted unless there is good reason not to do so.¹¹⁴

107 See MCA 2005 Sch A1.

108 See MC(A)A 2019 Sch 1. This will be inserted as Schedule AA1 to the Mental Capacity Act 2005.

109 See MC(A)A 2019 Sch 1 (to be inserted into MCA 2005 Sch AA1) paras 6–12.

110 See MC(A)A 2019 Sch 1 paras 6(b) and 9(3).

111 MC(A)A 2019 Sch 1 para 13. Each of these conditions must be determined on the basis of an assessment: see MC(A)A 2019 Sch 1 paras 21–22.

112 As defined under MHA 1983 s1(2), namely: ‘any disorder or disability of the mind’.

113 MC(A)A 2019 Sch 1 para 23.

114 MC(A)A 2019 Sch 1 para 23(2)(c) and (4).

7.57 Significant concerns have been raised about the LPS scheme, in particular the lack of safeguards for individuals subject to the LPS.¹¹⁵ For example, individuals do not have an automatic right to an independent mental capacity advocate (IMCA), who will have specialist knowledge and experience of the workings of the MCA 2005. For young people, it is likely that their parents will be considered to be an appropriate person to represent and support the young person. However, they are not obliged to do so and can request that an IMCA is appointed.¹¹⁶

Independent mental capacity advocates

7.58 The role of an IMCA is to represent and support the person who lacks capacity to make the relevant decisions. Support from an IMCA must be made available to people who lack capacity when decisions are being made in relation to ‘serious medical treatment’ or a long-term change in accommodation and the person has no suitable family or friends who could be consulted on their best interests.

- **‘Serious medical treatment’** is ‘treatment which involves providing, withholding or withdrawing treatment’ which is further described in regulations.¹¹⁷ The MCA Code notes that it is impossible to set out all types of procedures that may amount to serious medical treatment but suggests that they will include chemotherapy and surgery for cancer, therapeutic sterilisation and major surgery, such as open-heart surgery.¹¹⁸
- **Change in accommodation** includes a placement in hospital for longer than 28 days¹¹⁹ or in a social care setting (eg a care home) for what is likely to be longer than eight weeks.¹²⁰

7.59 As noted above, individuals whose deprivation of liberty has been authorised under the LPS scheme do not have an automatic right to an IMCA, although those representing and supporting them can request that an IMCA is appointed. Where there is no suitable person to represent and support individuals, the responsible body

115 See, for example, the Law Society Parliamentary Brief: Mental Capacity (Amendment) Bill, December 2018.

116 MC(A)A 2019 Sch 1 para 43.

117 MCA 2005 s37(6) and the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 SI No 1832, as amended.

118 MCA Code, para 10.45.

119 MCA 2005 s38.

120 MCA 2005 s39.

must appoint an IMCA unless this would not be in the person's best interests.¹²¹

- 7.60 There is a right to advocacy under the Care Act 2014 in the assessment and support planning process for adults and young people in transition to adulthood;¹²² the statutory guidance to the Care Act makes clear that the same person can be an IMCA and a Care Act advocate, as long as they are suitably qualified for each role.¹²³

The Court of Protection and the appointment of deputies¹²⁴

- 7.61 The Court of Protection (CoP) has a range of powers, which include deciding on whether a person has capacity to make a particular decision and making declarations, decisions or orders in relation to financial or welfare matters affecting those lacking the capacity to make such decisions.¹²⁵
- 7.62 The CoP can also appoint deputies to make decisions on welfare (including educational or healthcare) decisions as well as property and financial matters on behalf of a person who lacks capacity. The deputy is likely to be a family member or someone who knows the person well, but this will not always be the case – for example, the CoP may decide to appoint a professional deputy, such as a solicitor to deal with the person's property or affairs.¹²⁶ A representative of the local authority, for example the Director of Adult Services, can also be

121 MC(A)A 2019 Sch 1 para 42(3).

122 Care Act 2014 s67.

123 Department of Health, Care and Support Statutory Guidance, issued under the Care Act 2014, March 2016, updated October 2018, para 7.9.

124 See MCA 2005 ss15–21A and MCA Code, chapter 8. For a detailed analysis of the role of the Court of Protection, see A Ruck Keene, K Edwards, Professor A Eldergill and S Miles, *Court of Protection Handbook – a user's guide*, LAG, 3rd edn, 2019.

125 See MCA 2005 s16 for the power for the court to make decisions on P's behalf and appoint deputies.

126 MCA Code, para 8.33. See *Re P* [2010] EWHC 1592 (Fam) at [9]: 'the court ought to start from the position that, where family members offer themselves as deputies, then, in the absence of family dispute or other evidence that raises queries as to their willingness or capacity to carry out those functions, the court ought to approach such an application with considerable openness and sympathy'. See also *Re GM* [2015] EWCOP 67 at [33]–[35] in which the court gave examples of when a family member would not be appointed as a deputy, such as where 'the proposed deputy has physically, emotionally or financially abused' the person who lacks capacity. For a discussion on conflicts of interests, see *Re JW* [2015] EWCOP 82 at [28]–[49].

appointed as a deputy if the CoP considers this to be appropriate but the court will need to be satisfied that the authority has arrangements to avoid possible conflict of interest.¹²⁷

7.63 MCA 2005 s16(4) states that in deciding whether it is in the best interests of the person lacking capacity to appoint a deputy, in addition to the factors set out in section 4 (best interests), the CoP must have regard to the following two principles:

- 1) a decision by the CoP 'is to be preferred to the appointment of a deputy to make a decision'; and
- 2) the powers conferred on a deputy should be 'as limited in scope and duration as is practicably reasonable in the circumstances'.

7.64 The MCA Code anticipates that personal welfare deputies 'will only be required in the most difficult cases'.¹²⁸ The CoP has taken a somewhat inconsistent approach to the code's suggestion. In *A local authority v TZ (No 2)*,¹²⁹ the local authority's application to be appointed as TZ's welfare deputy was rejected on the basis that the court did not consider this to be an appropriate case for the appointment of a welfare deputy. Noting the MCA Code's advice on this point, Baker J added:

... for most day to day actions or decisions, the decision-maker should be the carer most directly involved with the person at the time (paragraph 5.8). That is simply a matter of common-sense.¹³⁰

However, in *SBC v PBA and others*,¹³¹ the court took a different view, stating that the 'unvarnished' words of MCA 2005 s16 set down the test for the appointment of a deputy, and that the MCA Code, with its reference to 'most difficult' health and welfare cases, did not compel the court to be satisfied that the circumstances were difficult or unusual before a deputy could be appointed.

7.65 The MCA Code's advice that deputies 'will only be required in the most difficult case' was challenged by the parents of young adults with learning disabilities in the case of *Re L, RE M, RE H*. Without

127 MCA Code, paras 8.41 and 8.60.

128 MCA Code, para 8.38. See discussion in A Ruck Keene, K Edwards, Professor A Eldergill and S Miles, *Court of Protection Handbook – a user's guide*, LAG, revised 3rd edn, 2019 on the appointment of personal welfare deputies at paras 3.126–3.138.

129 [2014] EWHC 973 (COP).

130 [2014] EWHC 973 (COP) at [82].

131 [2011] EWHC 2580 (Fam). See also A Ruck Keene, 'Getting it right in the balance between autonomy and protection', *Mental Capacity Law and Policy*, 2014.

deciding the matter Hayden J set out principles for practice and procedure in the appointment of personal welfare deputies.¹³²

Specific issues for children and young people

7.66 Although the main provisions of the MCA 2005 apply to individuals aged 16 and over, some provisions distinguish between adults and young people aged 16 and 17. Furthermore, in some circumstances, the MCA 2005 can cover those aged under 16. Chapter 12 of the MCA Code provides guidance on how the MCA 2005 applies to under 18s. The key points are summarised below:

- **Planning for possible future incapacity – MCA 2005 ss9–14 and 24–26:** As noted above (para 7.51), young people cannot appoint an attorney under the LPA provisions, nor can they make an advance refusal of treatment under the MCA 2005 (the age limit for both being 18 and over).¹³³
- **Young people with special needs and/or disabilities – MCA 2005 and Children and Families Act 2014:** The 2014 Act includes special provisions concerning decision-making where individuals aged 16–25 years lack capacity to make decisions in relation to matters governed by Part 3 of that Act, for example their education, health and care plan or an appeal to the tribunal in relation to such a plan.¹³⁴ These provisions are discussed in chapter 11 at para 11.83.
- **Children and property and affairs – MCA 2005 s18(3):** The CoP can make decisions in relation to a child's property and affairs if the court thinks it likely that the child will still lack capacity to make financial decisions after reaching the age of 18.¹³⁵ For example, this would allow the court to make an order concerning the investment of an award for compensation for the child and/or appoint a deputy to manage the child's property and affairs.¹³⁶
- **Transferring proceedings between a court with jurisdiction under the Children Act 1989 and the Court of Protection – MCA 2005 s21:**

132 [2019] EWCOP 22.

133 In addition, the Court of Protection's power to make a will does not apply to those aged under 18; see MCA 2005 s18(2).

134 Children and Families Act 2014 s80; and the SEND Regs 2014 SI No 1530 regs 63–64.

135 MCA 2005 ss2(6) and 18(3).

136 See MCA Code, paras 12.3–12.4.

Regulations set out a range of considerations to be taken as to which court (ie the CoP or the Family Court) should hear a particular case.¹³⁷ The MCA Code notes that a case involving a young person who lacks mental capacity to make a specific decision could be heard in the family courts or in the Court of Protection. It adds:

If the case might require an ongoing order (because the young person is likely to still lack capacity when they are 18), it may be more appropriate for the Court of Protection to hear the case. For one-off cases not involving property or finances, the Family Division may be more appropriate.¹³⁸

In *Re A-F (Children) (No 2)*, which concerned young people who were subject to care orders under section 31 of the Children Act 1989 and whose care arrangements gave rise to a deprivation of their liberty, Sir James Munby (sitting as a Judge of the High Court) held that their cases should not be transferred to the Court of Protection.¹³⁹ This was because the benefits weighed ‘heavily in favour’ of maintaining the care orders whereas there were ‘no reasons for thinking that . . . the children’s welfare will be better safeguarded within the Court of Protection’.¹⁴⁰

- **Criminal offence (Ill-treatment or neglect – MCA 2005 s44):** There appears to be no age limit to this provision which makes it a criminal offence for an individual who is caring for a person who lacks capacity (to make decisions concerning their care¹⁴¹) to ill-treat or wilfully neglect that person. The provision could, therefore, apply to a child provided that he or she lacked capacity under MCA 2005 s2, albeit other criminal offences are likely to be applicable whether or not the child lacks capacity, such as offences of child cruelty or neglect.¹⁴²

137 Mental Capacity Act 2005 (Transfer of Proceedings) Order 2007 SI No 1899 art 3(3)(c).

138 MCA Code, paras 12.24; see also para 12.7.

139 [2018] EWHC 2129 (Fam).

140 *Re A-F (children) (No 2)* [2018] EWHC 2129 (Fam) at [12 (vi)]. The points to be considered by the court when deciding if an application for a care order should be transferred to the Court of Protection to be dealt with under the MCA 2005 instead were set out in *B (a local authority) v RM and others* [2010] EWHC 3802 (Fam). These were endorsed by Sir James Munby, President of the Family Division in *Re A-F (children) (No 2)*; see [9]–[11].

141 *R v Dunn* [2010] EWCA Crim 2935, see also *R v Hopkins* [2011] EWCA Crim 1513 at [43].

142 MCA Code, para 12.5.

Box 3: Deprivation of Liberty: Children and Young People

In *P v Cheshire West and Chester Council; P and Q v Surrey County Council (Cheshire West)*,¹⁴³ the Supreme Court clarified that the following three components must be in place for there to be a deprivation of liberty under Article 5 ECHR:

- (a) the objective component of confinement in a particular restricted place for a not negligible length of time; (b) the subjective component of lack of valid consent; and (c) the attribution of responsibility to the state.¹⁴⁴

Accordingly, the points to consider are whether the person's situation means that they are confined and if they are, whether valid consent has been given for that confinement. If there is no consent the person is deprived of their liberty, whereas if valid consent has been given for the confinement, no deprivation of liberty arises. If there is a deprivation of liberty, the next question is whether the state is responsible for that deprivation of liberty. It should be noted that while the responsibility of the state may be engaged where a public body has been directly involved (for example, where a local authority accommodates a child or young person under section 20 of the Children Act 1989), it might also arise without such direct involvement. This is because 'Article 5 imposes a positive obligation on the state to protect a person from interferences with liberty carried out by private persons, at least if it knew or ought to have known of this'.¹⁴⁵

In *Re D (A Child)*,¹⁴⁶ the Supreme Court confirmed that consideration of the three components noted in *Cheshire West* is just as relevant to determining whether children and young people are deprived of their liberty as it is to adults. However, the courts have modified the test to be applied when considering whether under 18s are confined. Another question explored by the courts is whether, and if so, in what circumstances, under 18s' parents can consent to a confinement on their child's behalf so that no deprivation of liberty arises. These points are considered below.

143 [2014] UKSC 19; (2014) 17 CCLR 5. These were first set out by the European Court of Human Rights in *Storck v Germany* (2006) 43 EHHR 6.

144 [2014] UKSC 19; (2014) 17 CCLR 5 at [37].

145 *Re D (A Child)* [2019] UKSC 42 at [43]. See also *Secretary of State for Justice v Staffordshire County Council and Others* EWCA [2016] Civ 1317 at [78].

146 [2019] UKSC 42.

Is the child or young person confined?

When considering whether an under 18 year old is confined for the purpose of the ‘objective component’ (namely, being confined in a particular restricted place for a not negligible length of time), the courts have highlighted the need for a different approach to the ‘acid test’ proposed in *Cheshire West* (which considers whether the person is ‘under continuous supervision and control’ and ‘not free to leave’).¹⁴⁷ In *Re D (A Child)*, Lady Hale determined that ‘the crux of the matter’ is whether ‘the restrictions fall within normal parental control for a child of this age or do they not?’¹⁴⁸ so that ‘a mentally disabled child who is subject to a level of control beyond that which is normal for a child of his age has been confined within the meaning of Article 5’.¹⁴⁹

Can parents consent to the confinement on behalf of their child?

Like adults, children who are *Gillick* competent and young people with capacity can consent to their confinement so that no deprivation of liberty arises.¹⁵⁰ A more controversial question that has arisen in cases where under 18s lack the capacity or competence to make such decisions for themselves, is whether parents can consent to the confinement on their child’s behalf.

In relation to young people aged 16 and 17, the Supreme Court clarified in *Re D (A Child)*, that parents may not consent to the young person’s confinement.¹⁵¹ This means that where 16 and 17 year olds are confined and do not consent to their confinement (whether because they have capacity and do agree to their confinement, or they lack the capacity to make such decisions) they will be deprived of their liberty.

The courts have also held that if a child or young person is subject to a care order, neither the parents nor the local authority

147 [2014] UKSC 19; (2014) 17 CCLR 5at [48] and [49].

148 [2019] UKSC 42 at [39]; noting comments made by Lord Kerr in *Cheshire West* ([77] – [78]). See also the discussion in *Re A-F (Children)*, [2018] EWHC 138 (Fam), in particular [33] and [43] and *Re RD (Deprivation or Restriction of Liberty)* [2018] EWFC 47.

149 [2019] UKSC 42 at [42].

150 *Local authority v D* [2016] EWHC 3473 (Fam). Compare with discussion on consent and secure accommodation orders under section 25 of the Children Act 1989 in *T (A Child)* [2018] EWCA Civ 2136.

151 [2019] UKSC 42. This decision upheld the appeal against the Court of Appeal’s decision in *Re D (A Child)* [2017] EWCA Civ 1695.

can consent to the confinement on the child or young person's behalf.¹⁵²

The area which remains unclear – and is therefore of significant concern – is the circumstances in which parents of under 16s may be able to consent to their child's confinement. As the Supreme Court's decision in *Re D (A Child)* concerned only 16 and 17 year olds, the case of *Re D (A Child: Deprivation of Liberty)* (also known as *Trust A v X and Others*)¹⁵³ still applies to under 16s. This case held that the parents of D, a 15-year-old boy with autism, could consent to their son's placement in a locked ward of a psychiatric hospital for 15 months. D was assessed to lack *Gillick* competence to decide about these matters and the judge considered that his parents' decision was within 'the proper exercise of parental responsibility'.¹⁵⁴ Keehan J, emphasised that his decision was based on the particular facts and declined to give wider guidance on the approach to be taken in such cases, noting that such cases 'are invariably fact specific and require a close examination of the 'concrete' situation on the ground'.¹⁵⁵

Given the emphasis the courts have given to whether parents' consent to their child's confinement falls within the 'scope of parental responsibility', it is suggested that when determining whether parents can consent to their child's confinement, practitioners may find it helpful to consider the MHA Code's guidance on the scope of parental responsibility (discussed at paras 7.18–7.21 above). The guidance highlights the importance of weighing up a range of factors relevant to whether parents can consent to their child's confinement and extend beyond the question whether the parents are acting in their child's best interests. Such factors include the nature of the intervention, the wishes of the child or young person and whether restraint is required.¹⁵⁶

152 *Re AB (A Child) (Deprivation of Liberty: Consent)* [2015] EWHC 3125 (Fam) at [29] (considered in *Re D (A Child)* [2017] EWCA Civ 1695 at [31]). In *Re D (A Child)* [2019] UKSC 42 at [18], Lady Hale noted that while all the parties were in agreement with this view, the basis for reaching this conclusion had not been explained.

153 [2015] EWHC 922 (Fam); [2015] Fam Law 636. For commentary on this case see A Ruck Keene, 'Baby Bournewood?', *Mental Capacity and Policy*, April 2015 and C Parker (2016) *Trust A v X and others: The Ghost of Nielsen returns?* *Medical Law Review*, 24(2) 268.

154 *Re D (A Child: Deprivation of Liberty)* [2015] EWHC 922 (Fam) at [57].

155 [2015] EWHC 922 (Fam) at [68].

156 MHA Code 19.41.