Introduction

> It is a terrible thing to be assessed as lacking capacity when you do not – to have others make decisions on your behalf and set aside your own wishes based on what they think is in your best interests. You lose control over your life. You are no longer in charge of your destiny.
>
> It is a terrible thing to be said to have capacity when you do not – to be left to cause yourself and those you love great harm on the basis that you know what you are doing and you are making your own choices, when in fact your decisions are not really yours. To have others harm you and to be told no protection is offered because you have chosen this harm, even though it is against your deepest values, is horrific.[1]
>
> *Jonathan Herring and Jesse Wall*

The law draws a sharp line between those who have capacity and those who do not. People deemed to have capacity to make autonomous decisions are free to make their own decisions, for good or for ill.[2] A finding of incapacity, however, provides the justification for depriving a person of their right to determine what will happen to them, even in the most intimate of decisions.

This approach, premised on Enlightenment ideas about the bounds of legitimate state authority, depends heavily on the test for capacity, as a means of accurately distinguishing those who are capable of autonomous decision-making from those who are not. This has given rise to two concerns which have dominated the academic literature in recent years. The first – inspired in large part by the United Nations Convention on

[1] J. Herring and J. Wall, 'Autonomy, Capacity and Vulnerable Adults: Filling the Gaps in the Mental Capacity Act' (2015) 35(4) *Legal Studies* 698, 1.

[2] This is qualified only by the provisions contained in the Mental Health Act (1983) and the powers of the courts under the Inherent Jurisdiction, both of which will be considered in Chapter 1.

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the Rights of Persons with Disabilities (the CRPD) and its mandate to move towards a system of supported (as opposed to substitute) decision-making – is critical of the cliff-edge approach to capacity adopted, which fails to reflect the fact that capacity is not binary but exists on a spectrum.[3] The second – influenced by the rise of relational and feminist theories of autonomy – has been critical of the individualistic and rational 'liberal subject' which this liberal framework relies upon, arguing for the need for greater recognition in the law of the numerous social, cultural, and relational influences on our decision-making.[4] While the conclusions in this book lend support to these critiques (particularly the former), its focus is on a different consequence of the liberal underpinnings of the law, namely that in order to perform its role in delineating the autonomous decision from the non-autonomous decision, the Mental Capacity Act 2005 (MCA) subscribes to a form of value neutrality in its test for capacity, which is neither possible nor desirable.

That a person's capacity does not depend on the substance of a person's values or beliefs is considered central to the Act's legitimacy in defining when the state will defer to individual subjective choice and when it will not. Consequently, the test contained in sections 2 and 3 of the MCA proceeds on the assumption that a person subject to a capacity assessment (who I will refer to in this book as the 'agent') either possesses the capacity to make decisions or they do not, and that this can be objectively determined through a test for capacity which assesses various cognitive capacities a person may have (understanding, retention,

[3] See, for example, B. Clough, *The Spaces of Mental Capacity Law: Moving beyond Binaries* (Routledge, 2022); W. Martin *et al*., *Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If Not, What Next?* (2014) Essex Autonomy Project, 22 September 2014; G. Richardson, 'Mental disabilities and the law: From substitute to supported decision making' (2012) 65(1) *Current Legal Problems* 333–354.

[4] See, for example, C. Kong, *Mental Capacity in Relationship: Decision-Making, Dialogue and Autonomy* (Cambridge University Press, 2017); C. Mackenzie and N. Stoljar, *Relational Autonomy: Feminist Essays on Autonomy, Agency and Social Self* (Oxford University Press, 2000); C. MacKinnon, *Toward a Feminist Theory of the State* (Cambridge: Harvard University Press, 1989); M. Sandel, *Liberalism and the Limits of Justice* (2nd edn., Cambridge: Cambridge University Press, 1997); P. Wolpe, 'The Triumph of Autonomy in American Bioethics: A Sociological View' in R. de Vries and H. Subedi (eds.) *Bioethics and Society: Constructing the Ethical Enterprise* (Upper Saddle River, NJ: Prentice Hall, 1988); C. Mackenzie, 'Relational Autonomy, Normative Authority and Perfectionism' (2008) 39 *Journal of Social Philosophy* 512, 51; J. Christman, 'Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves' (2004) 117(1/2) *Philosophical Studies* 143–164.

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weighting of information), without engaging with the substance or origins of the values, beliefs, or desires that underpin any given decision – that is, with the agent's evaluative judgements or their motivations for acting. While this approach is widely assumed to be more conducive to maintaining a sphere of independence in which people are free to pursue their own conception of what is good or valuable, the reality, as this book will explore, is that a value-free understanding of (and test for) capacity in fact does precisely the opposite, indeed that it provides a façade behind which judgements can be made about the origins of an agent's values, free from proper scrutiny or challenge. It will be argued that in practice, it is impossible to assess decision-making capacity without reference to the values that underpin a decision, since the parameters of what decision a person could reasonably have made, had they 'used' and 'weighed' the relevant information, must be set by that person's own values, beliefs, and commitments. Moreover, this is not merely a problem with the way in which the MCA (and specifically, the 'use or weigh' criterion) is framed. No test can assess the decision-making process without taking account of the values, priorities, and beliefs that drive that decision. Nor should it seek to do so if it is to capture the complex ways in which a person's autonomy in taking that decision may be undermined, particularly in the psychiatric context.

In fact, the failure of the Act to engage with the role that values are playing in assessments of capacity does not insulate such assessments from value judgements by assessors, but rather creates space for such judgements to be made without meaningful scrutiny or challenge. When one examines the case law[5] (supplemented with evidence from interviews conducted with doctors[6]), it is clear that assessors *are* invoking values in

[5] Given the unusually fact-sensitive nature of the case law on the MCA, it is used in this book simply to illustrate how the courts approach assessments of capacity and best interests and what factors seem to influence their judgments.

[6] A full methodology for these interviews is contained in Appendices A–E. The purpose of these interviews was to gain a better understanding of how the provisions in the MCA are being understood and applied in practice. They consist of a series of semi-structured interviews with medical consultants from a range of specialisms, in order to explore how they conducted capacity and best interests assessments. These include Liaison Psychiatry, Old Age Psychiatry, Psychiatry (emergency medicine), Psychiatry (general), Emergency Medicine, Geriatric Medicine, Intensive Care, and General Practice (see Appendix C for further details of the participants). Each interview followed the same format, which began with a series of general questions (Appendix A), asking participants what they thought they were testing for when assessing whether a person has capacity, whether they often came across hard or borderline cases and what it was that made those cases difficult, and what factors they weighed up when deciding what was in the best interests of someone who lacked capacity. They were also asked for their provisional thoughts on recent

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the determination of capacity. Often these will be the agent's own values (does the putative decision appear broadly consistent with those things that the agent states that they value and believe in?) but this is not always the case, and there are many examples in which both judges and doctors appear to be judging the coherence or rationality of a decision by reference to values other than the agent's own. Sometimes this may be driven by straightforward paternalistic concerns about the harmful outcome of the decision, but, more often, underpinning these cases can be discerned concerns about the 'authenticity' of the agent's stated values, that is, whether the values or beliefs being expressed by that person are really 'authentically held' or they are in fact attributable to some mental disorder or impairment. The implicit suggestion is often that if the agent were *not* suffering from that particular disorder or impairment, they would have decided in a different, less self-destructive way.

While this problem is not exclusive to cases involving mental disorder, it is particularly evident in that context. This is because certain disorders may distort the agent's value or belief systems without substantially undermining their ability to understand, retain, and reason abstractly about information, unlike some other types of impairment that are more likely to affect their cognitive abilities as well. Since such concerns about the authenticity of the agent's decision cannot be addressed explicitly within the current framework of the MCA, they are instead being shoehorned into the 'use or weigh' limb of the Act, with judges and doctors inferring from the fact that an agent holds certain disordered values or beliefs that they cannot properly weigh up the information

proposals put forward by the Law Commission. The participants were then presented with a number of short vignettes in which someone with questionable or uncertain capacity required treatment (Appendix B). The participants were asked to decide in relation to each of the scenarios whether they thought the person in question had capacity or not, what factors or pieces of information were important when making that assessment, and whether there was any other information they would have needed or wanted in order to make that assessment. They were subsequently asked whether, if the person was found to lack capacity, the treatment in question would be in the best interests of the patient, as well as what factors were important when making this assessment and why they were weighing the factors in that particular way. This research is qualitative and not quantitative, and given the relatively small sample size, it cannot be extrapolated to the medical body at large, as robust evidence about the way in which capacity assessments are made in general. However, it does demonstrate some common themes or factors which appear to be influencing the decisions of doctors, and some shared concerns amongst the medical profession about the difficulties inherent in making these assessments. It also highlighted that, even within the relatively small numbers of participants interviewed, there were clear differences of opinion when it came to interpreting and applying the test.

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relevant to the decision in question. This not only conflates questions about *whether* the agent can weigh information with those of *how much weight* they are giving to information (which is difficult to reconcile with the liberal framework on which the MCA is based), but it also means that such determinations are not subjected to proper scrutiny, and the normative assumptions that underpin them are left unchallenged.

Determining that a mental disorder or impairment has compromised a person's *cognitive* capacities in a way that makes them unable to make a decision is, of course, already an explicit element of the MCA, with s2(1) requiring that the agent's inability to make a decision must be caused by an impairment in the functioning of the mind or brain.[7] While at times this can be difficult to assess, it does not raise the same issues as the determination that an agent's values or belief systems derive from disorder or impairment, and so any decision resting on them is taken without capacity. The effect of the latter is to essentially prevent people from acting on the basis of *certain* values and beliefs, thus implicitly imposing substantive conditions on when a decision will be deemed autonomous or not.

This is especially so given that mental disorder is itself diagnosed by reference to an agent's behaviour or stated beliefs or values, such that the very same behaviour which gives rise to a diagnosis of a disorder may also be the basis on which the person's decision is deemed incapacitous. This creates the risk of a status-based approach to capacity being introduced through the back door, whereby when one suffers from certain psychiatric illnesses, one is automatically deemed to lack the capacity to take certain decisions.

Given these concerns, it is important to interrogate the empirical and normative claims underpinning the determination in some of these cases that a person's (impaired) values indicate that they lack capacity. The book will focus on claims relating to values affected by mental disorder, since this is the context in which such concerns most commonly arise. This includes examining the core assumption that mental disorder is capable of being distinguished – both practically and conceptually – from non-disorder, and that it undermines the person's capacity for autonomous decision-making in some meaningful way. Whether these claims are correct depends in part on how mental disorder is conceptualised and

[7] Mental Capacity Act 2005, section 2(1). For more discussion of the 'causative nexus' between the inability to make a decision and the impairment in the functioning of the mind or brain, see *PC v. York CC* [2013] EWCA 478 (Civ).

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whether there is any 'natural' or scientific fact about disorder, which can be determined without recourse to social or cultural norms. After all, if disorder is based *merely* on judgements about the normality (or abnormality) of certain behaviours or beliefs, then it might legitimately be asked why so-called disordered values or beliefs ought to be treated any differently from any others.

Through an examination of the wide-ranging literature on the nature of mental disorder, it will become clear that it is not possible to identify disorder without making reference to personal or social norms. The notion of disorder requires that a person's thought processes, beliefs, or behaviour are dysfunctional in some way, and this cannot be ascertained without judging it against some implicit standard of what is 'normal' thinking. Once this is accepted, it becomes clear that the line between disordered and 'ordered' values or beliefs is not categorical but rather blurred, being socially and culturally contingent.

However, the fact that determining the boundary between order and disorder will not always be easy (either theoretically or empirically) does not mean we should abandon altogether the notion of disorder and, with it, any attempt to distinguish disordered from non-disordered values or behaviours. While rejecting disorder as a basis for intervention may well be a 'neat' conceptual solution, it will not always be a compassionate one: too puritanical a commitment to liberal ideals of freedom and value neutrality risks ignoring the very real suffering experienced by a large number of people who would be left unprotected from the serious risk of harm they may pose to themselves. While negotiating the exact boundaries of disorder is difficult,[8] there are nonetheless observable features of 'disorder' which distinguish it from simply 'abnormal' or 'deviant' behaviour, namely that the behaviour in question is caused by some dysfunctional psychological mechanism or 'abnormality of the mind' as opposed to being a deliberate act of agency, and that it results in the person experiencing distress or impairment in the conduct of everyday activities, such as holding down a job or forming successful relationships.

If it is possible to distinguish disordered values in this way, the question then becomes whether (and how) the fact that a person's values are disordered affects or undermines their capacity for autonomous decision-making. Does the mere fact that a person acts on the basis of disordered values *always* mean they are unable to make an autonomous

[8] Although this problem also afflicts the application of the Mental Health Act 1983, the focus of this book is on the Mental Capacity Act 2005.

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decision, or are there some instances in which such a decision can still be autonomous? Drawing on the philosophical literature on the concept of autonomy, it will be argued that autonomous decision-making requires more than merely an expression of choice if it is to be valuable. It requires the decision to be in some way authentic to the agent, that is, to reflect the values, beliefs, and priorities that the agent holds to be valuable to them. Where this is not the case, their decision cannot be truly autonomous. So, if the capacity threshold is intended to distinguish those who are capable of autonomous decision-making from those who are not, and (as most modern liberal understandings accept) an essential ingredient of an autonomous decision is its authenticity, then it would seem right in principle to find an agent to lack capacity if their decision lacks that authenticity.

The question, then, is how mental disorder affects authenticity. This is difficult to answer given the many different interpretations of authenticity in the philosophical literature, which point to different factors as being important to establishing whether a desire is authentic or not: the causal origins of a desire, the agent's attitude towards that desire, or the coherence of that desire with the agent's character system. These different accounts of authenticity and their implications for mental disorder will be explored in detail in Chapter 3. Suffice to say for now, however, that while there will often be overlap between these accounts (an agent may not endorse a desire precisely because they understand it to be disordered in origins and otherwise incoherent with their character system), the mere fact that a value or desire might be disordered in origin is not alone sufficient to render it inauthentic, if the agent would otherwise endorse or sanction that desire as part of their cohering character system or identity. Consequently, while an agent acting on the basis of disordered beliefs or values will often be acting inauthentically (since they would not endorse that belief or value system otherwise), this will not always be the case, and situations could arise (in theory at least) in which there is reason to believe that the agent would endorse or sanction their belief, even knowing it derived from illness. Mr B in *Wye Valley* might be a potential example of this from the case law: his religious beliefs were deeply meaningful to him, even though they stemmed from hallucination.[9] In such cases, it would be difficult to justify finding that person to lack capacity, since it is not clear that their

[9] *Wye Valley NHS Trust v. B* [2015] EWCOP 60, [43].

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capacity for autonomous decision-making has been undermined by their disorder or impairment.

In cases such as this, capacity assessors must navigate a difficult course between respect for autonomy and protecting vulnerable people from non-autonomous and deeply harmful choices. While I argue in this book that there will be occasions in which it is right to find the agent to lack capacity where the decision they wish to make is being based on disordered values or beliefs, once the shaky conceptual ground on which such judgements are made is acknowledged (depending as they do both on judgements at a societal level about what amounts to socially or culturally 'normal' behaviour, and at an individual level about whether the agent's behaviour is sufficient to fall into the categories of disorder), it becomes essential that these judgements should be brought out into the open, where they can be subject to appropriate scrutiny. This book therefore explores ways in which the law could seek to address concerns about authenticity, how it might identify when a person's disordered values or beliefs ought to be considered as part of their authentic value-system, and when they should be regarded as undermining a person's capacity for autonomy. Ultimately, I conclude that while philosophically it may be difficult to justify intervening where the agent would endorse certain values or beliefs, the difficulty in translating this into a workable legal test leans in favour of adopting a more pragmatic proxy, which focuses on the origins of the values or beliefs that the agent applies to the information in their decision-making. (The agent's attitude toward that desire should then be reflected in the weight accorded to it in the best interests assessment.) A new limb of the MCA is therefore proposed, which focuses on whether the person is unable to make a decision because the values or beliefs by which they are evaluating the relevant information have been caused by or altered as a consequence of the person suffering from a disorder, illness, or impairment. This would negate the need to shoehorn such cases within the 'use or weigh' criterion.

This is not held out as a perfect solution: there simply is no perfectly 'tidy' solution to such a messy conceptual and practical problem. One concern with such an approach may be that in practice, given the way that mental disorder is diagnosed (via observation of the agent's behaviour or belief systems), the provision might effectively impose substantive conditions on capacity: holding certain value systems (for example, that avoiding calories is more important than anything else, including life) will, in reality, always give rise to a diagnosis of disorder, and so decisions

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based on them will always be deemed incapacitously taken. However, despite the threat this poses to liberal ideals of value neutrality, it will be argued that in practice, the greater scrutiny allowed for by this limb will result in less unwarranted intrusion into the private sphere than currently occurs. For this reason, this solution will also be preferred to two alternatives that have been suggested in the literature: an 'appreciation' limb of the capacity test (as seen in other jurisdictions, including Northern Ireland) and an 'ability to value' limb, sometimes advocated as a less direct challenge to liberalism.

However, acknowledging the complexity and fragility of capacity assessments on the margins, especially where concerns relate to the 'authenticity' of decisions, has implications beyond how we test for capacity. It ought also to affect how we approach best interests decision-making.

Highlighting the inevitable grey area that exists on the cusp of capacity calls into question the 'cliff-edge' approach we currently adopt whereby the agent either has capacity – in which case they may decide as they wish, without any fetters and no matter how harmful the decision may be – or they lack it, in which case a decision will be taken for them, which 'takes account' of their wishes but does not necessarily follow them. It suggests the need to 'soften' this cliff edge, to dilute the current all-or-nothing approach to capacity, by according greater weight to the agent's wishes, values, and beliefs in the assessment of their best interests, in a way that better aligns with the vision of the CRPD.

It also casts a light on the way in which the impairment of cognitive capacities, and the disruption of values, may not always go hand in hand. A person's values and beliefs may have been affected by disorder without any impairment of the person's cognitive processes, just as a person's cognitive capacities may be impaired while their values remain intact. This is important for determining a person's best interests, since it implies that a person may retain authentic values even if they have lost their ability to act on them – values which *ought* to be respected in any decisions taken for them. Similarly, as noted earlier, a person might endorse values or beliefs even knowing that they originate in mental disorder, and so may be acting autonomously, even if under the proposed changes to the test for capacity, they would be found to lack capacity. This also ought to be reflected in the weight accorded to them in the best interests assessment.

Chapters 5 and 6 will therefore consider what changes need to be introduced to the way in which best interests assessments are taken in

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order to reflect these points. It will begin by examining how best interests decisions are currently being taken, concluding that despite a number of empowering court decisions, the lack of direction on how to apply the MCA has still resulted in different weight being attributed to the agent's wishes, based on a variety of (sometimes implicit) factors. Meanwhile, this trend towards greater empowerment has not yet trickled down to decisions being taken on the ground by doctors and care workers, which still remain characterised largely by paternalism and risk aversion. A new approach to best interests is therefore necessary if assessors are to feel able to prioritise the wishes of the individual, even where that will put the agent at risk of harm.

Accordingly, it will be suggested that there ought to be a presumption that the agent's wishes and feelings will be determinative of what is in their best interests, which may only be rebutted where giving effect to them will expose the person to a risk of significant harm. This reflects the clear psychological and emotional harm done to a person when their wishes are frustrated and when treatment or care interventions (which often involve incursions into their liberty or bodily integrity) are imposed on them against their will. However, as the foregoing discussion has highlighted, even where the harms *are* significant, there will still be occasions where the agent's wishes and feelings should nonetheless take precedence; where to do otherwise would involve frustrating their deeply and authentically held beliefs, values, or commitments. Assessors should therefore be provided with a list of factors that they *must* take into account when determining how much weight to give to the agent's wishes in this context, which will ensure greater consistency of approach, through providing a framework for assessors to work through the relevant issues. This should be supplemented to an amendment to the defence to battery contained in section 5 of MCA so that it applies only where the intervention was necessary to prevent the agent from suffering serious harm.

The concept of decision-making capacity lies at the confluence of law, philosophy, and psychiatry. Yet as the foregoing discussion has highlighted, a fundamental tension exists between the liberal ideal underpinning legal and philosophical notions of capacity – that all people ought to be free to pursue their own conception of a good life, according to those values that are important to them – and the intuition that lies at the heart of psychiatry, that there are certain values or beliefs, deriving from mental illnesses, which do not demand respect and from which the agent ought to be protected. When determining how the law ought to

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conceptualise and test for capacity, therefore, a balance must be struck between philosophical or jurisprudential purity on the one hand, and the state's important duty to protect its most vulnerable citizens on the other. This book has attempted to strike this balance, yet in doing so, it recognises the challenge posed by cases on the cusp of capacity, which are, by definition, complex and messy. Given this, the importance of ensuring sensitive yet empowering best interests decisions is paramount, and it is hoped that through the changes proposed to section 4 of the MCA here, the law will strike a better balance between empowering people to make decisions which reflect and promote their values and beliefs, and protecting them from making harmful decisions which they cannot understand and would not ultimately wish for themselves.

This issue is of increasing importance in the wake of the CRPD. Fundamental to the CRPD is the notion that in order to treat people with disabilities with dignity and respect, we must empower them in decisions which affect them, supporting them to take their own decisions wherever possible, in accordance with what matters to them. This is embodied in the directive in Article 12(4) CRPD that signatories (including the UK) must undertake to 'ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person',[10] irrespective of their disability or legal capacity. Yet despite the absolutist language of the CRPD, no one would plausibly contend that we ought to respect *any* expressed preference, irrespective of its content, cause, or consequences. To use an extreme example, few would seriously argue that if a sufferer of Schizophrenic Affective Disorder held a delusional belief that he could fly, and sought to jump off a multi-storey building, we ought to respect this decision and allow him to fall to his death. As a result, the question of how we determine *which* expressions of will or preferences to give effect to is crucially important: we must understand how and when a person's mental disorder is undermining their ability to make authentic, and so autonomous, decisions, if we are to know how best to support them in decisions about their treatment and care. Without this, we risk throwing those who suffer from mental illness 'into the fires of libertarian ideology'.[11]

[10] UN General Assembly, *Convention on the Rights of Persons with Disabilities: Resolution Adopted by the General Assembly*, 24 January 2007, A/RES/61/106, Article 12.

[11] A. Plumb, 'UN Convention on the Rights of Persons with Disabilities: Out of the Frying Pan and into the Fire? Mental Health Service Users and Survivors Aligning with the Disability Movement' in H. Spandler, J. Anderson, and B. Sapey (eds), *Madness, Distress*

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Navigating the tension between respect for (and deference to) idiosyncratic values and protection from disorder or impairment must, therefore, be a precondition for adopting any CRPD-compliant model. However, it is also crucial to understanding how any 'fused' mental capacity and mental health legislation ought to be framed; an issue that has gained salience since the passing of Northern Ireland's (fused) Mental Capacity Act in 2016. Clearly, if calls to adopt fused legislation prove successful, the treatment and detention of those suffering from mental illness will become contingent on the person's mental capacity. Ensuring that the test for capacity is able to adequately accommodate the impact of disorder on decision-making capacity would thus be essential.

It should be noted that while the argument put forward in this book lends support for embracing a less-severe all-or-nothing approach to capacity, it does not argue in favour of adopting a supported decision-making scheme in this jurisdiction at this time. In addition to the concern expressed earlier that properly accounting for mental disorder is a precondition for any ethically acceptable supported decision-making scheme, there are also pragmatic reasons for this. As Gavin Davidson *et al.* have argued, implementing a scheme of supported decision-making 'takes time and resources, and may require a shift in attitudes of some care providers and in some service users themselves'.[12] It is doubtful that there is the time, resources, or appetite for this at present, particularly in a political climate grappling with the fallout from Brexit, the Covid-19 pandemic, and the Ukraine war. Even before any of these events, the Law Commission was clear when considering avenues for reform of the Mental Capacity Act in 2015 that the abandonment of substituted decision-making would be 'highly politically and ethically contentious at this stage' and fell outside of the remit of their review.[13] Given that the prospect of such a scheme being implemented imminently is, as Genevra

and the Politics of Disablement (Bristol: Bristol University Press 2015). Quoted in A. Ruck Keene, N. Kane, S. Kim, and G. Owen, 'Mental Capacity – Why Look for a Paradigm Shift?' (2023) *Medical Law Review* (January), p. 9 (advanced availability online). Available at: https://academic.oup.com/medlaw/advance-article/doi/10.1093/medlaw/fwac052/6987005.

[12] G. Davidson et al., 'Supported Decision Making: A Review of the International Literature' (2015) 38 *International Journal of Law and Psychiatry* 61, 73.

[13] Law Commission Consultation Paper No. 222, 'Mental Capacity and Deprivation of Liberty' (2015). Available at: www.lawcom.gov.uk/wp-content/uploads/2015/07/cp222_mental_capacity.pdf, 12.44.

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Richardson describes, 'vanishingly slim',[14] this book instead seeks to posit a more immediate and workable solution, which takes account of and seeks to remedy some of the difficulties generated by a threshold approach to capacity, without abandoning the concept altogether.

Nor does the book seek to argue explicitly for reforming (or abandoning) the Mental Health Act (MHA), although its findings undoubtedly lend support for those who seek to do so. As this book is concerned with the impact of disorder on autonomous decision-making, its critique is less directly relevant to a framework which is based on risk avoidance rather than respect for autonomy. However, given that its findings clearly imply that at least some people suffering from mental disorders *can* decide autonomously, this may buttress criticisms of the MHA for permitting the detention and treatment of those with disorders against their capacitous wishes. It thus lends broad support for those favouring a move to fused mental health and capacity legislation, albeit only with changes to the test for capacity proposed previously.

Before going on to consider the law's current approach to these issues, it is helpful to briefly elaborate on some of the concepts which this book will draw upon. Although not defined in the Act, the term 'values' is being used here to denote principles or ideals that guide and motivate our attitudes and actions. Through helping us to determine what matters to us (what is valuable or important), they enable us to evaluate actions, persons, or situations and, from that, to guide our decisions and actions. They may be personal values, in the sense of things the individual views as personally important to them (such as the importance of family, of religion, of independence, of loyalty, etc.), or moral values, in the sense of principles which help them to assess what is morally right or wrong (such as principles of equality, fairness, honesty, etc.). Beliefs, meanwhile, are convictions that something is true about the world. These will often shape and inform those values: a person attaches great importance to spirituality because of their belief in God's salvation, for example. By contrast, desires (or wishes) are hopes that some particular thing (or set of things) will happen. This may be a reflection of their values or beliefs (a person wishes to live at home *because* they deeply value independence above all else, for example), but this will not always be the case, and people often wish for things in the short term which are incompatible with their long-term values (for instance, a person may deeply value their

[14] Richardson, 'Mental Disabilities and the Law'.

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religious convictions while also wishing to skip Mass one sunny Sunday so as to go to the beach instead).

Agnieszka Jaworska distinguishes valuing from mere desiring by identifying three features which are essential to, or strongly indicative of, valuing. First, 'a person could contemplate being free from a desire with a sense of relief, but one would always view the possibility of not valuing something that one currently values as an impoverishment, loss or mistake.'[15] Consequently, 'we think it would be a mistake to lose our current values – we hold our values to be correct, or at least correct for us',[16] whereas we do not always think the same of a desire, which we may (as in the case of certain unconventional sexual desires) desperately wish to lose. Secondly, 'a person's values are usually entangled with her sense of self-worth in a way which is not true of desires: a person values herself in terms of how well she lives up to her values.'[17] Finally, values 'express the person's concern with something fully independent of his or herself. By contrast, in merely desiring something, part of the person's aim is usually the pleasure or the agreeable state of mind that will result from achieving or contemplating the object of desire.'[18] This is not necessarily the case for all values, since sometimes people come to value some of their pleasures (Jaworska gives the example of a food connoisseur). Nonetheless, where something matters to a person irrespective of how it would affect their own experience, 'this is very likely not a mere desire, but a value'.[19]

The importance of this distinction for the agent's capacity and best interests will depend, in part, on the nature of the impairment from which they suffer. While the MCA applies to all those whose capacity is in doubt, the nature, extent, and longevity of that incapacity varies. For some such as those with learning disabilities or someone who has sustained a brain injury – their impairment may be relatively stable. For others – such as those in acute pain or suffering from a mental illness – incapacity might fluctuate. Meanwhile, for those with a degenerative cognitive illness such as dementia, incapacity is progressive, with the individual gradually losing capacity as their cognitive functions

[15] A. Jaworska, 'Respecting the Margins of Agency: Alzheimer's Patients and the Capacity to Value' (1999) 28(2) *Philosophy & Public Affairs* 105–138, 114.
[16] Ibid, 115.
[17] Ibid.
[18] Ibid, 116.
[19] Ibid.

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decline. Depending on the type of impairment, the relationship between the agent's values and desires, and the role and significance of these in the assessment of their capacity and their best interests, will vary. The agent may have values that predate their loss of capacity, for example, or they may not. Their loss of capacity may coincide with a distortion of their values; or their values may remain constant, but their ability to formulate desires which reflect those values may have become impaired. While the question of how the law should respond to these different scenarios will be explored in Chapters 1–6, it is worth noting at the outset a fundamental limitation of the MCA: that in attempting to apply a single test for capacity to such a diverse range of clinical presentations and impairments, it is perhaps inevitable that it will apply less aptly to some circumstances or impairments than to others. It is the contention of this book that reforms to the test for capacity are necessary if it is to properly accommodate the impact of mental disorders on decision-making autonomy.

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