

Chapter 2: Mental Capacity

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Aims of this Chapter

This chapter will enable you to achieve the following learning outcomes from the ILEX syllabus:

- 1 Understand what the practice of law with particular application to an elderly client may involve
- 2 Understand the importance of mental capacity in an elderly client and the effect of lack of mental capacity

2.1 Introduction

If you were fortunate enough to own a private jet, and you employed a pilot to fly it for you, you would probably be content to tell your pilot where you wanted to go, and let him get on with the job of flying the plane. If any problems arose during a flight – turbulence, a failed engine – you would be glad to let him decide whether to press on or turn back, he being the expert in such matters; it is unlikely that you would consider wrenching the controls from him and trying to fly the plane yourself.

We are all used to having decisions made on our behalf. Generally, though, either expressly or implicitly, we remain in overall control, in that we assent to the delegation, and if we do not like the way it is dealt with, we can take our custom elsewhere.

What happens, though, if a person's inability to make a specific decision arises not from the lack of a particular technical skill (such as flying a plane) but from a disorder of his mind? In addition, what if the disorder is such that not only can he not make that particular decision, he also does not understand that he cannot make that decision, and that he needs to delegate it to someone who can? At that point, the person is regarded as **lacking capacity** and there are legal procedures in place to allow someone else to make the decision for him.

The law dealing with persons who lack capacity has been codified and extended in the **Mental Capacity Act 2005 (MCA 2005)**.

MCA 2005 established the **Court of Protection (CoP)**, which replaced the previous Court of Protection. The CoP is a superior court of record in its own right, with very wide-ranging powers regarding the property, affairs and welfare of persons who lack, or may lack, mental capacity. Working alongside the CoP is the **Office of the Public Guardian (OPG)** which, among other functions, will maintain registers of lasting powers of attorney and CoP orders appoint deputies, supervise deputies, and direct visits from CoP visitors.

An **MCA 2005 Code of Practice** (the **Code of Practice**) has also been published, which gives practical advice on how **MCA 2005** should be implemented. In his preface to the **Code of Practice**, Lord Falconer, who was then Lord Chancellor

and Secretary of State for Constitutional Affairs, describes how **MCA 2005** will “empower people to make decisions for themselves wherever possible, and protect people who lack capacity by providing a flexible framework that places individuals at the very heart of the decision-making process. It will ensure that they participate as much as possible in any decisions made on their behalf . . .”



Code of Practice

It is interesting to compare the approach of the **Code of Practice** with the **Vagrancy Act 1714 (VA 1714)**, which was the first piece of legislation specifically to address mental capacity. **VA 1714** gives Justices of the Peace (provided that at least two agree) powers to apprehend *persons of little or no estates who, by lunacy, or otherwise, are furiously mad, and dangerous to be permitted to go abroad*. Once apprehended, they would usually be destined for the workhouse, where they would be ranked alongside “vagrants”, detained but probably not treated, and with little prospect of release.

In the early 1800s, by which time mental disorder was regarded as a treatable illness, a Mr Metcalf – who was a patient in the notorious Bedlam (or “Bethlem”) madhouse, where at one time the public could buy tickets to go and observe the patients – wrote: “I spent 22 months in that dreary abode, Old Bethlem Hospital; not more than six weeks during that time, I believe, I was incapable, through indisposition, of judging the occurrences that daily took place.”

This focus on enabling people to make their own decisions – or participate in decisions as far as possible – implies that there may be some decisions which an individual can make and some he cannot. This may seem self-evident; a person may be able to decide, say, whether to go to Wales or Scotland for his holiday, but not be able to assess the state of his finances and decide whether he can afford the holiday in the first place. Capacity is “**function-specific**”. This can make dealing with the affairs of someone of questionable mental capacity very complex; on the face of it, it would seem that each time a decision has to be made on the person’s behalf, those involved in caring for him must first determine whether he is, in fact, able to make that particular decision himself, and if (on the balance of probabilities) he is, they must let him do so. This is in marked contrast to the experience of Mr Metcalf.

2.2 What is mental capacity?

It is interesting to note that **MCA 2005** does not include a definition of mental capacity (though the **Code of Practice** does; it defines mental capacity as *the ability to make a decision about a particular matter at the time the decision needs to be made*).

s1 MCA 2005 establishes five principles concerning mental capacity, which it may be helpful to set out in full, because they have direct implications on the practical management of the affairs of individuals whose capacity is in question. The principles are as follows.

- (1) A person must be assumed to have capacity unless it is established that he lacks capacity.
- (2) A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.
- (3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- (4) An act done, or decision made, under **MCA 2005** for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- (5) Before the act is done, or the decision is 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.

The first of these principles – that a person is to be assumed to have capacity unless it is established that he does not – perhaps explains why **MCA 2005** does not give a definition of capacity; it is more concerned with how to determine whether a person **lacks capacity**.

s2(1) states that 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. **s3(1)** defines inability to make a decision as being unable:

- (a) *to understand the information relevant to the decision;*
- (b) *to retain that information;*
- (c) *to use or weigh that information as part of the process of making the decision; or*
- (d) *to communicate his decision (whether by talking, using sign language or any other means).*

Note the “or” at the end of (c). Inability to meet any one of the four criteria will cause a person to be regarded as lacking capacity within the terms of **MCA 2005**.

With regard to (b), **s3(3)** adds that *the fact that a person is able to retain the information . . . for a short period only does not prevent him from being regarded as able to make the decision*. Obviously, if a person's memory is so poor that he has no stable frame of reference in which to place a decision, and cannot retain relevant information from the start of the decision-making process to the end, he will fail criterion (b). On the other hand, and bearing in mind that memory loss is a very common symptom of Alzheimer's, poor memory need not, of itself, render a person incapable of making a decision.

2.3 Assessing capacity

Clearly, and particularly since the implementation of **MCA 2005**, any lawyer acting for an elderly client needs to be able to recognise cases where mental capacity might be an issue and to know what to do when it arises.

The **Code of Practice** makes it clear that everything possible should be done to enable the client to make decisions (and, by implication, give instructions) himself. This includes the language used when discussing, say, the provisions

he might want to include in his will. As practitioners, dealing with wills every day and using technical terminology and short-hand in discussions with colleagues, it is easy to forget how nervous clients can be when they come to the office to discuss their wills and how alienating technical terms can be. Terms like “predecease”, “chattels”, “contingent upon” and “advancement” can easily be substituted with more everyday wording, in the discussion if not in the will itself, and doing so can make it easier for clients to understand what you are saying to them and to feel more confident in their participation in the discussion.

Whether a client had mental capacity or not when a particular transaction was carried out is a question of fact, to be determined (ultimately) by the court. The role of the legal practitioner is to recognise when a client’s mental capacity needs to be investigated, to obtain the best evidence he can as to whether the client has capacity, and then to act accordingly.

The following points refer to taking instructions for a will, because now that lasting powers of attorney have been introduced, requiring their own certification, wills are the main documents for which capacity is likely to be an issue. The same principles, however, apply to any type of work.

2.4 When is capacity an issue?

Lawyers are not doctors and a client may seem perfectly rational but, in fact, be suffering from an impairment of, or a disturbance in the functioning of, the mind or brain (**s2(1) MCA 2005**) which is affecting his ability to give valid instructions. He may, for example, have formed an irrational dislike of one of his children, who he is convinced has turned against him and no longer contacts him. The client tells you his sad tale of how his son has rejected him and instructs you to make a new will cutting out the son. It all seems perfectly plausible at the time; it is only after the client dies that you find out that he was suffering from dementia – the son had, in fact, been a model of care, visiting his father very frequently, and he produces telephone records showing how often he phoned, and so on. Understandably, the son challenges the will.

Naturally, you cannot take medical advice every time you prepare a will, but the basic rule must be to err on the side of caution, and at least if any of the following circumstances apply, it is wise to consider obtaining medical evidence:

- where the client is very elderly (over 80, for example);
- where the new will you have been asked to prepare is very different from the current one (or, if it is a first will, from what would happen on intestacy), **particularly if a major beneficiary is being cut out**;
- where a relative or friend is instrumental in having the will prepared (makes the initial contact with your firm, is present when instructions are given, etc.) and he or his family takes a significant benefit (even though, under such circumstances, you should always see the client on his own at least once);
- where the client is or has recently been in hospital (even for non-mental illness);

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