# ASSESSING LEGAL CAPACITY: PROCESS AND THE OPERATION OF THE FUNCTIONAL TEST

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## INTRODUCTION

The position of adults who lack legal capacity has been moving slowly towards the forefront of the reform agenda. The publication of the Law Reform Commission ("LRC") Report on *Vulnerable Adults and the Law*[1] has directed much needed attention to this area. Given that this issue is still governed by the outdated Lunacy Regulation (Ireland) Act 1871,[2] the LRC's recommendation that legislation be enacted to establish a modern scheme for adult guardianship is certainly to be welcomed.[3] The development of an appropriate legal framework will require engagement with complex questions of policy and principle and

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[1] L.R.C. 83-2006 (Dublin: Law Reform Commission, 2006). This Report was preceded by two consultation papers: see Consultation Paper on *Law and the Elderly* (L.R.C. C.P. 23-2003); Law Reform Commission Consultation Paper on *Vulnerable Adults and the Law: Capacity* (L.R.C. C.P. 37-2005) (Dublin: Law Reform Commission, 2005). For commentaries on the consultation papers, see Donnellan "The Law Reform Commission's Proposals on Law and Older People" and Schweppe "The Law Reform Commission's Proposals on Legal Capacity of Older People" in O'Dell (ed.) *Older People in Modern Ireland: Essays on Law and Policy* (Dublin: First Law, 2006).

[2] As supplemented by Order 67 of the Rules of the Superior Courts (S.I. No. 15 of 1986).

[3] In a comprehensive review of the area, the Law Reform Commission makes an extensive set of recommendations. These include the enactment of capacity legislation, including *e.g.* a statutory definition of capacity (para. 2.20); provision for the establishment of a Guardianship Board (para. 6.40) and of an Office of the Public Guardian (para. 7.14).

this is a challenge which urgently needs to be addressed at a legislative level.[4]

A designation of incapacity has enormous practical, legal and psychological significance for the individual involved. Following the designation, she[5] loses the freedom to make decisions for herself, at least in relation to the matter(s) to which the incapacity relates. Instead, others will decide for her on the basis of what they believe to be in her best interests. Depending on the circumstances, she may be told where to live, what medical treatment to have, what contracts she may enter, whether she may bequeath her property and whether or not she may marry or have a sexual relationship. Thus, her fundamental rights to liberty, to autonomy and to privacy will be significantly undermined by the designation of incapacity. Psychologically, too, a designation of incapacity may have an adverse impact on the individual who has to contend with both the practical limitations on her freedom and the stigmatising effect of being labelled "incapable".[6] For these reasons, the way in which capacity is assessed must be monitored carefully in order to ensure that a designation of incapacity is made only where it is necessary and appropriate.

This article examines the way in which a formal (or judicial) designation of incapacity is made.[7] The article begins with a brief historical overview of the ways in which capacity assessment has

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[4] A Private Members' Bill, entitled the Mental Capacity and Guardianship Bill, 2007, was introduced in the Seanad in February 2007 by Senators O'Toole and Henry (Bill No. 12 of 2007). The Bill fell with the dissolution of the Oireachtas; however, it may have helped to propel the issue up the legislative agenda.

[5] For convenience, the female pronoun is adopted throughout this article.

[6] Winick "The Side Effects of Incompetency Labelling and the Implications for Mental Health Law" (1995) 1 *Psychology, Public Policy and Law* 6, 8-9 argues that, in addition to the social stigma associated with a designation of incapacity, a person designated incapable may experience effects such as learned helplessness (where an individual comes to believe that she cannot change her situation and ceases to try to do so).

[7] While the article is concerned with the formal process of capacity assessment, in many situations, especially where the adult is compliant with a proposed decision, incapacity is determined informally, usually by a medical professional, without judicial oversight. In such circumstances, the discussion of the difficulties encountered by medical professionals in assessing capacity, as outlined in the text following note113 *infra*, is especially pertinent.

been dealt with by the courts. It then explores in more detail the functional test for capacity, where the assessment of capacity is specific to a particular task or function. Under the functional approach to capacity, a new assessment of capacity is required for each new decision or task. Thus, for example, the fact that a person lacks the capacity to make a will does not mean that she lacks the capacity to marry.[8] The appropriateness of the functional test for capacity is widely accepted and the test is also largely favoured by the LRC[9] in its report. However, questions may be raised regarding the current status of the functional test in Irish law in two contexts. These are where a person has been admitted to wardship or where she has been involuntarily admitted under the Mental Health Act 2001. The article argues that the application of these statutory frameworks does not remove the need for a functional approach to capacity in relation to those decisions which do not come within the ambit of the statutes.

While approving of the functional approach to capacity assessment, the article acknowledges the pressures which this approach places on capacity assessors and on the capacity assessment process. As Black J. once noted, a court "possesses no X-ray contrivance that can lay bare the workings of the human mind."[10] The article explores procedural matters that arise in carrying out a capacity assessment. It argues that attention needs to be paid to the detail of the process employed and it sets out a proposed framework to be employed in this context. It is hoped that, in addition to illuminating the current approach, the arguments made in this part of the article will also be useful in developing and applying any new legislative scheme.

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[8] As confirmed in *Re Park's Estate, Park v. Park* [1953] 2 All E.R. 1411.

[9] Although, as discussed in text following note 37 *infra*, the LRC tempers its approval of the functional approach in some regards.

[10] *Provincial Bank v. McKeever* [1941] I.R. 471, at 485 (these remarks were made in the context of an allegation of undue influence in relation to a banking transaction).

## I. A BRIEF HISTORY OF CAPACITY ASSESSMENT IN THE COURTS

The task of assessing an individual's capacity to make decisions has been undertaken by courts for many hundreds of years. The prerogative, or *parens patriae*, jurisdiction may be traced at least as far back as the thirteenth century.[11] Under this jurisdiction, the Crown, and subsequently the Lord Chancellor and the Courts of Chancery, had the authority to act on behalf of those subjects who were incapable of acting for themselves. From the early stages of this jurisdiction, it was necessary to determine if and when the jurisdiction arose.

Aspects of the *parens patriae* jurisdiction were given a statutory basis in the nineteenth century[12] and a Court of Protection was established with the authority to protect the affairs of adults lacking legal capacity.[13] In Ireland, jurisdiction over the affairs of adults lacking legal capacity is still contained in a nineteenth century statute.[14] The Lunacy Regulation (Ireland) Act 1871 provides that the wardship jurisdiction arises in relation to a person found to be "of unsound mind, and incapable of managing himself or his affairs."[15]

A survey of the case law shows that, prior to the latter part of the twentieth century, capacity assessment arose primarily in the contexts of admission to wardship and of testamentary and

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[11] The first formal statement of the prerogative jurisdiction may be found in the 13th century statute *de Prærogativa Regis* 17 Edward II, c.9 and c.10. However, the jurisdiction predates this. According to Shelford, *Practical Treatise on the Law Concerning Lunatics, Idiots, and Persons of Unsound Mind* (Philadephia: JS Littell, 1833), p.6 the jurisdiction originates from the time of Edward I (1275-1306).

[12] However, the *parens patriae* jurisdiction continues to operate alongside the statutory wardship jurisdiction and is vested in the High Court by virtue of section 9 (1) of the Courts (Supplemental Provisions) Act 1961. In *In re a Ward of Court* [1996] 2 I.R. 79, at 103-107, the Supreme Court held that the *parens patriae* jurisdiction had survived Irish independence.

[13] S.47 of the Regulation of Commissions in Lunacy Act 1853.

[14] In England and Wales, the jurisdiction of the Court of Protection is now contained in the Mental Capacity Act 2005, which commences in 2007.

[15] S.3. For a summary of the wardship jurisdiction in Ireland, see Law Reform Commission Consultation Paper on *Law and the Elderly* (Dublin: L.R.C. C.P. 23-2003), Chapter 4. For detailed coverage, see O'Neill, *Wards of Court in Ireland* (Dublin: First Law, 2004).

contractual capacity.[16] Capacity was assessed specific to the task in hand. Thus, in *Banks v. Goodfellow*,[17] the Court rejected the view that any degree of "mental unsoundness,"[18] even if unconnected with the testamentary disposition, rendered the testator incapable. Instead, the question for the court was whether the testator had testamentary capacity at the time he made the will. Similar conclusions were reached in the context of capacity to execute a lease[19] and capacity to contract.[20]

In determining capacity, courts operated on the basis of a presumption of capacity. Shelford described the presumption and its provenance as follows:

> Reason, being the common gift to man, raises the general presumption that every man is in a state of sanity, and that *insanity* ought to be proved; and in favour of liberty and of that dominion which, by the law of nature, men are entitled to exercise over their own persons and properties, it is a presumption of the law of England, that every person, who has attained the age of discretion, is of sound mind until the contrary is proven: and this holds as well in civil as in criminal cases.[21]

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[16] See, for example, the body of case law cited in Shelford, *Practical Treatise on the Law Concerning Lunatics, Idiots, and Persons of Unsound Mind* (Philadephia: JS Littell, 1833).

[17] (1870) L.R. 5 Q.B. 549.

[18] The testator had been confined to an institution in 1841 (some 24 years before his death) and had remained delusional after his release, believing himself to be pursued by devils, evil spirits and by one Featherstone Alexander (who had long since died). He was, however, capable of conducting his business affairs and was described as being careful with money. At trial, the jury found him to have the necessary testamentary capacity. This verdict was upheld by the Court of Appeal, Queen's Bench Division.

[19] See *Jenkins v. Morris* (1880) 14 Ch D 674 where an individual who was subject to insane delusions was held to have the legal capacity to execute a lease once he could be shown to be capable of understanding the effect of the deed.

[20] See Theobald, *The Law Relating to Lunacy* (London: Stevens and Sons, 1924), p.217.

[21] Shelford, *Practical Treatise on the Law Concerning Lunatics, Idiots, and Persons of Unsound Mind* (Philadephia: JS Littell, 1833), p.23. Original emphasis.

However, this presumption was reversed where an individual had been made a ward of court and instead, a "presumption of continuance" applied to the effect that, once an individual had been found incapable, she continued to be so.[22]

In order to displace the presumption of capacity, courts frequently relied on expert evidence provided by members of the medical profession.[23] As the medical profession became more systematic in its classification of mental disorders, the evidence process became increasingly "medicalised" and the status of medical evidence increased accordingly.[24] This reliance on medical opinion is given a statutory basis in the Lunacy Regulation (Ireland) Act 1871, where admission to wardship involves the submission of a petition accompanied by supporting affidavits from two medical practitioners.[25]

Reflecting the growing emphasis on social, in addition to economic, autonomy, the latter part of the twentieth century saw the development of new sets of circumstances in which individuals' capacity had to be assessed. Much of the recent discussion of capacity has taken place in the context of consent to medical treatment which has provided the basis for a large body of case law, especially in England and Wales.[26]

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[22] Shelford, *ibid..*¸ p.32 noted that, if an individual had been subject to a commission in lunacy, "the burthen of proof shewing sanity is thrown upon those who seek to establish a lucid interval, or the soundness of his understanding." See *Cartwright v. Cartwright* (1793) 1 Phillim 100; *White v. Driver* (1809) 1 Phillim 84. See further Casey & Craven, *Psychiatry and the Law* (Dublin: Oaktree Press, 1999), p.318.

[23] Shelford, *ibid..*, p.40 described the testimony of "medical men" as being "valuable" in the establishment of incompetence.

[24] For a consideration of the changing role of medical evidence in the wardship process (primarily from a US perspective), see Krasik "The Lights of Science and Experience: Historical Perspective on Legal Attitudes Toward the Role of Medical Expertise in Guardianship of the Elderly" (1989) 33 *The American Journal of Legal History* 201.

[25] See further discussion in text to note 85 *infra*.

[26] See, in particular, *Re C (adult: refusal of medical treatment)* [1994] 1 W.L.R. 290; *Re MB (an adult: medical treatment)* [1997] 2 F.C.R. 541.

## II. A FUNCTIONAL ASSESSMENT OF CAPACITY

It is evident from the preceding section that a functional or task-specific approach to capacity is well established at law. As described by Chadwick L.J. in *Masterman-Lister v. Brutton*,[27] "the test of capacity has to be applied in relation to the particular transaction (its nature and complexity)…"[28] In this case, the Court of Appeal held that the fact that an individual was incapable of "managing and administering his property and affairs"[29] did not displace the requirement for a specific assessment of his capacity to litigate.[30] The Court in *Masterman-Lister* noted that the functional test also has a basis in the protections afforded under the European Convention on Human Rights.[31] The decision of the European Court of Human Rights (hereinafter "the European Court") in *Winterwerp v. Netherlands*[32] meant that the question of capacity should be separately investigated in each relevant instance. In *Winterwerp*, the claimant successfully argued a breach of his right to a "fair hearing" under Article 6 of the ECHR[33] because of a provision in the relevant Dutch legislation to the effect that a person who had been compulsorily detained in a psychiatric hospital would

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[27] See *Masterman-Lister v. Brutton & Co*. [2002] E.W.C.A. Civ. 1889.

[28] *Masterman-Lister v. Brutton & Co*. [2002] E.W.C.A. Civ. 1889, para. 62. For a detailed discussion of the application of the functional test for capacity in the context of a multi-faceted transaction, see *Bailey v. Warren* [2006] E.W.C.A. Civ. 51, paras. 69-82.

[29] This was the test at that time for admission to the English equivalent of wardship (as *per* section 94(2) of the Mental Health Act 1983).

[30] *Masterman-Lister v. Brutton & Co* [2002] E.W.C.A. Civ. 1889¸ para. 29 *per* Kennedy L.J.; Chadwick L.J., para. 74. The case was rather unusual in that the claimant sought to argue his own incapacity in order to have a personal injuries settlement to which he had earlier agreed overturned on the basis of his incapacity. The claimant had suffered from a head injury some twenty years previously. In 1997, he had obtained the opinion of a consultant in neuropsychiatric rehabilitation that he was, and since the accident had been, "incapable by reason of mental disorder of managing and administering his property and affairs" (within the terms of section 94(2) of the Mental Health Act 1983).

[31] *Ibid*.., para. 17 *per* Kennedy L.J.

[32] [1979] 2 E.H.R.R. 387.

[33] Article 6 states that in "the determination of his civil rights and obligations", everyone is entitled to a fair and public hearing by an independent and impartial tribunal.

automatically lose the capacity to administer his property.[34] The European Court rejected the State's argument that the purpose of the relevant provision was to safeguard the civil rights of a person of unsound mind who "by the very reason of his proven mental condition, needs to be protected against his own inability to manage his own affairs."[35] Instead, it concluded that, regardless of the justification for the legislation, the guarantees laid down in Article 6 had to be met.[36]

The Law Reform Commission (LRC) recommends the inclusion of a statutory statement of the applicability of a functional approach in any new capacity legislation.[37] It states that capacity is to be understood in terms of the "ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is to be made."[38]

However, the LRC's endorsement of the functional approach to capacity is tempered somewhat by the Report's recommendation that a "common sense" approach should be applied in "determining when a separate functional assessment of capacity is merited".[39] The LRC "recognise[d] that in certain situations a person is unlikely to recover lost capacity."[40] In such circumstances, the LRC offered the view that, in practice, "some leeway is needed."[41] Therefore, in individual situations, where an adult "profoundly lacks or has lost decision-making capacity in a particular sphere, or generally, and is unlikely to regain it, the need to carry out a capacity assessment every time a decision requires to be made may be reduced."[42]

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[34] [1979] 2 E.H.R.R. 387, paras. 74-77.
[35] [1979] 2 E.H.R.R. 387, para. 75.
[36] [1979] 2 E.H.R.R. 387, para. 76.
[37] Law Reform Commission Consultation Paper on *Vulnerable Adults and the Law: Capacity* (L.R.C. C.P. 37-2005) para. 2.30. This is also the approach taken in the Mental Capacity Act 2005 (England and Wales).
[38] *Ibid.*, para. 2.45.
[39] *Ibid.*, para. 2.71.
[40] *Ibid.*, para. 2.69.
[41] *Ibid.*
[42] *Ibid.*

The LRC did not consider that this approach should be enshrined in legislation but that it was a matter for consideration in each individual case.[43]

The difficulty with the LRC suggestion is that it could be all too easy to allow "common sense" to dictate a wholesale overriding of the functional approach to capacity. While it might be clearly unnecessary to require a new assessment of capacity every time medical treatment is provided to a patient in a persistent vegetative state, for example, a loose understanding that capacity assessment may be dispensed with on the amorphous basis of "common sense" could expand well beyond this category. However, as noted by the Law Commission for England and Wales in its *Report on Mental Incapacity*,[44] "most people, unless in a coma, are able to make at least some decisions for themselves and may have levels of capacity that vary from week to week or even from hour to hour".[45] This should be the underlying attitude to the need for a separate assessment of capacity and if a decision were made to dispense with the requirement for a separate assessment in some circumstances, this should be clearly legislatively delineated and not left to the discretionary application of "common sense."

While the functional approach to capacity is well-established under the current law, the impact of two statutory frameworks on the law in this respect needs to be considered further. The first of these is admission to wardship under the Lunacy Regulation (Ireland) Act 1871 and the second, compulsory admission under the Mental Health Act 2001 ("MHA").

### *A. The Impact of Admission under the Lunacy Regulation (Ireland) Act 1871*

It is clear that, under the law as it currently stands, the requirement for a functional assessment of capacity is, to a degree, displaced where an individual has been made a ward of court. However, the extent of the displacement is not entirely clear and it will be argued below that it is less extensive than has

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[43] *Ibid.*, para. 2.68.
[44] Law Com. No. 231 (London: HMSO, 1995), p.33.
[45] *Ibid.*, para. 3.5.

sometimes been presumed. Before a person may be admitted to wardship, it must be established that the person is of "unsound mind, and incapable of managing himself or his affairs."[46] It is therefore to be expected that admission to wardship would displace the requirement for a separate capacity assessment in respect of a number of business or finance related functions. Thus, for example, a ward is deemed to lack the capacity to operate a bank account. In *Re Walker (a Lunatic so found)*,[47] a ward, by virtue of his legal status, was automatically deemed to be legally incapable of executing a deed. A similar conclusion is likely in the context of contractual capacity. However, the need for a functional test for testamentary capacity has been held to continue notwithstanding the testator's admission to wardship.[48]

In terms of personal decisions, a ward is statutorily prohibited from marrying by the Marriage of Lunatics Act 1811. The Act renders void a marriage contract entered into by a person found to be a "lunatic" by inquisition.[49] The LRC has recommended that this legislation should be repealed[50] and it is arguable that the 1811 Act would not survive a constitutional challenge on the basis that it automatically denies the ward's right to marry without reference to her actual capacity in this regard.[51]

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[46] Section 3 Lunacy Regulation (Ireland) Act 1871.
[47] [1905] 1 Ch 160.
[48] See *Roe v. Nix* [1893] p.55.
[49] Under section 2 of the Lunacy Regulation (Ireland) Act 1871, a "lunatic" is defined as "any person found by inquisition idiot, lunatic, or of unsound mind, and incapable of managing himself or his affairs". Thus, the Marriage of Lunatics Act 1811 extends beyond the category of "lunatic" (as the term was used to designate somebody with a mental illness) to encompass all wards of courts regardless of the basis for their admission to wardship.
[50] L.R.C. 83-2006 (Dublin: Law Reform Commission, 2006), para. 3.18.
[51] In *O'Shea v. Ireland*, High Court, unreported, 17 October 2006, Laffoy J. affirmed the existence of the right to marry in the context of the Deceased Wife's Sister's Marriage Act 1907. She held that where a legislative provision restricted the right to marry, it had to be justified either as being necessary in support of the constitutional protection of the family and the institution of marriage, or having regard to the requirements of the common good. On the constitutional right to marry, see further Hogan and Whyte, *JM Kelly: The Irish Constitution* (4th ed., Dublin: Butterworths, 2003) pp.1468-1469 and p.1832. Note also Article 12 of the ECHR which protects the right to marry and to found a family "according to the national laws governing the exercise of this right."

The LRC has suggested that, under the current law, a ward is also deemed automatically incapable of giving consent to medical treatment.[52] However, it is difficult to see how this can be the case. The only authority cited by the LRC in this regard is a comment by Denham J. in *In Re a Ward of Court*[53] that "where the patient is a ward of court, the court makes the decision."[54] However, as noted by the LRC,[55] in the case in question, the patient was clearly incapable (she was in a permanent vegetative state). Therefore, it would be a mistake to read too much into Denham J.'s comment in relation to patients who are not in such extreme circumstances. Failure to apply a separate test for consent to medical treatment could result in an undermining of the ward's rights to autonomy and privacy arising under the Constitution[56] and under the ECHR.[57] Ahern argues that there is "a level of unease" with an automatic designation of incapacity to make healthcare decisions on the basis of admission to wardship.[58] She suggests that this is evident in the fact that it is accepted practice, where a ward who is capable of indicating consent does not consent to a medical procedure, to refer the matter to the President of the High Court for consideration. However, in the writer's view, this does not go far enough in protecting the ward's rights. Rather, if, following a separate assessment of capacity to make healthcare decisions, the ward is found to be capable, her right to make her own decision in this respect should subsist and should not be determined by the fact that she is a ward.

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[52] CP *Vulnerable Adults and the Law: Capacity* (L.R.C. C.P. 37-2005), para. 4.24; CP *Law and the Elderly* (L.R.C. C.P. 23-2003), para. 4.49.

[53] [1996] 2 I.R. 79 (S.C.).

[54] [1996] 2 I.R. 79, at 156 (S.C.).

[55] CP *Law and the Elderly* (L.R.C. C.P. 23-2003), para. 4.49.

[56] For recognition of these rights in the context of medical treatment, see *In Re a Ward of Court* [1996] 2 I.R. 79 (S.C.).

[57] As protected by Article 8 of the ECHR: see *Pretty v. United Kingdom*, European Court of Human Rights, 29 April 2002.

[58] "Healthcare Decisions: Recognising the Decision-making Capacity of Older People to Consent to and Decline Medical Treatment" in O'Dell (ed.) *Older People in Modern Ireland: Essays on Law and Policy* (Dublin: First Law, 2006), p.210.

### *B. The Impact of Compulsory Admission under the Mental Health Act 2001*

The Mental Health Act 2001 ("MHA") sets out the legal framework for the compulsory admission and the treatment of patients with a mental disorder.[59] In order to be compulsorily admitted to a psychiatric facility, a patient must be shown to suffer from a mental disorder[60] and must fulfil one of two conditions set out in section 3(1).[61] There is nothing in the MHA to suggest any degree of displacement of the functional approach to capacity. Indeed, the MHA itself requires that patients covered by the MHA be subject to a separate assessment of their capacity to consent to treatment for the mental disorder.[62] The need for a separate functional assessment notwithstanding a patient's compulsory status was recognised by the European Court of Human Rights in *Winterwerp v. Netherlands*.[63] Thus, in brief, compulsory admission to a psychiatric facility has no impact on the requirement for a functional test for capacity.

While the preceding section has argued that the requirement for a separate assessment of capacity is necessary for wards of court, at least in respect of consent to medical treatment, and for patients covered by the MHA in all respects, it is

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[59] Compulsory patients currently comprise approximately 15% of patients receiving treatment in Irish psychiatric facilities (see the annual reports of the Mental Health Commission, available at www.mhcirl.ie).

[60] A mental disorder is defined in s.3 of the MHA 2001 as: "mental illness, severe dementia, or significant intellectual disability" with these terms being defined in more detail in section 3(2).

[61] These are that: " (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could only be given by such admission."

[62] Section 56 of the MHA. Although note that the MHA allows treatment to be provided to an "unwilling" capable patient in certain circumstances: see sections 59 and 60. See further Donnelly "Treatment for a Mental Disorder: The Mental Health Act 2001, Consent and the Role of Rights" (2005) 40 *Irish Jurist* 220, 234-238.

[63] See discussion in text to note 32 *supra*.

undoubtedly the case that there will sometimes be a degree of overlap in incapacities. A ward of court, who is of unsound mind and incapable of handling her affairs, may well have difficulty in understanding, using and weighing information necessary to establish capacity to consent to medical treatment. The same may be true of a patient admitted under the MHA.[64] However, there is also a risk that an individual's status as ward or compulsory patient, while not legally determinative, may lead to a perfunctory application of the functional test and an inevitable finding of incapacity. In order to minimise this risk, a rigorous approach to the process of capacity assessment is especially important in these situations.

## III. THE PROCESS OF CAPACITY ASSESSMENT

The preceding discussion has shown the importance of a task-specific, functional test for capacity. While theoretically coherent, this requirement puts a considerable degree of pressure on the assessment process. Given the absence of Black J.'s "X-ray contrivance,"[65] the process of capacity assessment remains a human endeavour. It relies on expert evidence and ultimately on judicial decision-making. In such circumstances, the process employed is crucial to the outcome reached.[66] Factors such as the existence and quality of legal representation[67] and the participation of the individual whose situation is being considered[68] appear to have a significant impact on the way in

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[64] Note that under the admission criteria set out in s.3(1) (and outlined in note 61 *supra*), patients who are not at serious risk of harm to themselves or others may only be admitted if they have "impaired" judgment.

[65] See text to note 10 *supra*.

[66] This has been recognised in relation to other aspects of the law and in particular, in relation to the criminal trial process: see Lacey, Wells and Quick *Reconstructing Criminal Law: Text and Materials* (3rd ed., London: Lexis Nexis Butterworths, 2003), pp.93-94; Ashworth *The Criminal Process: An Evaluative Study* (2nd ed., Oxford: Oxford University Press, 1998).

[67] See Perlin "Is it More than 'Dodging Lions and Wastin' Time'? Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases" (1996) 2 *Psychology, Public Policy and Law* 114, 120.

[68] Galligan, *Due Process and Fair Procedures: A Study of Administrative Procedures* (Oxford: Clarendon, 1996), pp.131-132 argues that participation

which cases are resolved. The importance of process is also recognised in the right to a "fair and public hearing" in the determination of one's civil rights and obligations as protected by Article 6 of the ECHR.

The process employed may have other important consequences for the individuals involved. Empirical studies show that the nature of the process employed may impact on the way in which individuals respond to a decision reached about them[69] and on their general well-being. The view that the law should take account of the broader therapeutic impact of legal rules on the individuals involved is sometimes referred to as "therapeutic jurisprudence." This approach is described by Winick as follows:

> Therapeutic jurisprudence suggests the need for an assessment of the therapeutic impact of legal rules. [It argues that] a sensible policy analysis of law should take into account its consequences for the health and mental health of the individuals and institutions it affects.[70]

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by the individual involved provides the decision-maker with access to more and better information about the decision which, in turn, "helps the decision-maker to have a more complete and balanced view of the facts and the issues relating to the facts."

[69] See in particular the work of Tyler, *The Social Psychology of Procedural Justice* (New York: Plenum, 1988) and *Why People Obey the Law* (New Haven: Yale University Press, 1990). In the area of mental health treatment, the MacArthur Coercion Study (Dennis and Monahan (eds.), *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law* (New York: Plenum Press, 1996) found that the process employed at the stage of admission to a psychiatric facility had an important impact on the patient's perception of her subsequent treatment. The authors of the study found (at p.24) that: "Patients who had a 'good' admissions process – who reported that others acted out of concern for them, treated them fairly, with respect, and without deception, gave them a chance to tell their side of the story, and considered what was said in making the admission decision – were much less likely to feel coerced, particularly when the decision ultimately made was not the one they preferred."

[70] Winick, "The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis" (1994) 17 *International Journal of Law and Psychiatry* 99, 100. For further discussion of this approach to law, see Wexler and Winick *Essays in Therapeutic Jurisprudence* (Durham NC: Carolina Academic Press, 1991); Wexler and Winick (eds.) *Law in a Therapeutic Key:*

While the concept of therapeutic jurisprudence requires further development,[71] it is reasonable that, in approaching the law relating to capacity (which is essentially concerned with the rights and interests of the individuals involved), account be taken of the broader impact of decisions taken on the individuals in questions.

Given the importance of process, this section of the article will look first at the current procedural approach and then make a number of suggestions regarding how the process of capacity assessment should develop in the future.

### *A. The Current Process*

Underlying the current capacity assessment process is the presumption that individuals are capable and that the burden of establishing incapacity lies on the party asserting this.[72] In an uncertain area, such as capacity assessment, the importance of evidentiary presumptions is clear. The LRC Report appropriately recommends that this common law position be given a statutory basis in any new capacity legislation.[73]

As noted above,[74] it was traditionally accepted that the presumption of capacity was displaced where an individual had already been found incapable and instead it was presumed that her incapacity subsisted (a presumption of continuance). The existence of such a presumption was decisively rejected by the Court of Appeal in *Masterman-Lister v. Brutton & Co*.[75] Kennedy L.J. held that "if there is clear evidence of incapacity for a

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*Developments in Therapeutic Jurisprudence* (Durham NC: Carolina Academic Press, 1996).

[71] Slogobin, "Therapeutic Jurisprudence: Five Dilemmas to Ponder" (1995) *Psychology, Public Policy and Law* 1933 argues that therapeutic jurisprudence leaves significant questions unexplored; for example, who determines what is 'therapeutic' and how are differences regarding what constitutes a 'therapeutic' approach to be resolved in a legal setting?

[72] The long-established presumption (discussed in text to note 21 *supra*) has been confirmed in modern times in *In re Glynn Deceased* [1990] 2 I.R. 326 (S.C.) (testamentary capacity); *Re T (adult: refusal of medical treatment)* [1992] 3 W.L.R. 782 (capacity to refuse medical treatment); *Masterman-Lister v. Brutton & Co* [2002] E.W.C.A. Civ. 1889 (capacity to litigate).

[73] *Vulnerable Adults and the Law: Capacity* (L.R.C. C.P. 37-2005) para. 2.39.

[74] See text to note 22 *supra*.

[75] [2002] E.W.C.A. Civ. 1889.

considerable period of time then the burden of proof may be more easily discharged".[76] However, he insisted that the presumption of capacity remains intact and the burden remains on the party asserting incapacity.[77]

The Irish courts have not had the opportunity to assess the current status of the presumption of continuance in Irish law. The Supreme Court decision in *In bonis Corboy*: *Leahy v. Corboy*,[78] could be used to support the existence of such a presumption, in a testamentary context at any rate.[79] The testator in question had suffered from recurrent convulsions throughout his life and was described by the Court as a "chronically sick man" who clearly sometimes lacked testamentary capacity. The Court held that the presumption of capacity did not apply and that the burden of establishing that the will was drafted during a lucid period fell on the person asserting the will's validity. However, an additional factor in the case in question was that the person asserting the testator's capacity had drafted the disputed codicil to the will, which had increased the legacy she was set to receive.[80] Therefore, the Court's suspicions had clearly been aroused and this may have influenced the approach taken to the presumption. Furthermore, it might legitimately be argued that a presumption of continuance is wholly at odds with a modern functional approach to capacity and therefore that this aspect of the decision in *Corboy* should be reconsidered.

Beyond the recognition of the presumption of capacity, the most developed procedural guidance regarding the assessment of

[76] [2002] E.W.C.A. Civ. 1889, para. 17.

[77] See also *Dixon v. Were* [2004] E.W.H.C. 2273 (Q.B.), para. 47, *per* Gross J.

[78] [1969] I.R. 148 (S.C.).

[79] The matter of the presumption was not considered in the more recent case of *In the Estate of Andrew O'Donnell: O'Donnell v. O'Donnell* High Court, unreported, 24 March 1999, Kelly J (which concerned the testamentary capacity of a man who suffered from paranoid schizophrenia). Counsel for the plaintiff was prepared to accept that the burden of proving the testator's capacity fell on the plaintiff as executor.

[80] This would constitute a situation which would "excite the suspicion of the Court" (*Barry v. Butlin* (1838) 2 Moo P.C.C. 480, at 482-3 *per* Baron Parke).

capacity arises in the context of admission to wardship.[81] The Lunacy Regulation (Ireland) Act 1871 sets out a number of routes for admission to wardship, of which the most commonly employed is an application under section 15.[82] Under this procedure, a petition for admission to wardship is presented to the President of the High Court[83] in the form of a sworn affidavit, attested by the petitioner's solicitor and accompanied by the supporting affidavits of two registered medical practitioners.[84] Following receipt of the petition, the President determines whether the petition should proceed to the next stage.[85] If the President considers that the matter should proceed, he will make an "inquiry order". This order requires a medical visitor (appointed from a pre-existing panel) to examine the prospective ward and report to the President. In this event, the petitioner's solicitor is required to serve personal notice on the prospective ward, informing the ward of the hearing and of the fact that she has seven days in which to object to admission to wardship.

If the prospective ward does not object to admission (as is normally the case), the matter will generally proceed on the basis of the report from the medical visitor. If there is an objection (either by the prospective ward or by another interested party), the prospective ward may seek an inquiry before a jury. This is not an

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[81] For a more detailed discussion of procedural issues in the wardship context, see O'Neill, "Wardship Law and Procedure" in O'Dell (ed.) *Older People in Modern Ireland: Essays on Law and Policy* (Dublin: First Law, 2006).

[82] According to the LRC Consultation Paper on *Law and the Elderly* (L.R.C. C.P. 23-2003), para. 4.20, this procedure was employed in 156 out of 191 applications in 2001 and in 118 out of 131 applications in 2002.

[83] The section itself refers to the Lord Chancellor, whose powers now vest in the President. The President may either hear the matter personally or assign the matter to another Judge of the High Court.

[84] See further Order 76 of the Rules of the Superior Courts (S.I. No. 15 of 1986).

[85] The other procedural routes either leave out or reduce the initiating steps outlined in the text. The section 12 procedure involves emergency situations and involves the immediate appointment of a medical visitor (without the originating petition and medical affidavits); the section 68 procedure applies where the ward's estate is small (under €6348.69 or where the estate yields an annual income of less than €380.92) and requires only one medical affidavit; the section 103 procedure covers temporary wardship (for up to six months) and does not require the initiating medical evidence to be in affidavit form).

automatic right, however. It will not be granted if the President of the High Court considers that the prospective ward lacks the capacity to form and express a wish in this regard and that it is "unnecessary or inexpedient" for a jury inquiry to take place. In such circumstances, the admission will be the subject of a judicial inquiry. At the hearing, the President shall "take such evidence, upon oath or otherwise" and "if it should seem to him necessary, require the production before himself of, and personally examine, the alleged lunatic."[86]

In *Eastern Health Board v. M.K.*,[87] the Supreme Court recognised the importance of procedural fairness in the operation of the wardship jurisdiction.[88] Denham J. noted:

> Wardship proceedings must be fair and in accordance with constitutional justice … Due process must be observed by the court in exercising this unique jurisdiction. Consequently if a legal right or a constitutional right is to be limited or taken away by a court, this must be done with fair procedures.[89]

The availability of the full range of procedural devices in the wardship context was confirmed by the Supreme Court in *In re Wards of Court and In re Francis Dolan*.[90] The appellant, who had cerebral palsy, had received a settlement of £3 million following a medical negligence action. The bulk of this settlement was retained by the court pending a wardship application. However, the appellant's parents objected to the admission of their son to wardship, arguing first, that their son was not "of unsound mind", although conceding that he was "incapable of handling his affairs"[91] and secondly, that they, rather than the

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[86] Section 15.
[87] [1999] 2 I.R. 99 (S.C.).
[88] The specific issue before the Court in the case in question related to the introduction of hearsay evidence in a hearing to determine whether children should be admitted to wardship.
[89] [1999] 2 I.R. 99, at 111 (S.C.).
[90] Supreme Court, unreported, Geoghegan J., 4 July 2007.
[91] In *In the Matter of Catherine Keogh*, High Court, unreported, October 15 2002, Finnegan P. had held that both parts of the admission requirement must be met and where, as in the case in question, an individual was incapable of

President of the High Court should have control over the property and person of their son. Thus, in essence they objected to the fundamentals of the wardship jurisdiction. The appellant sought a hearing in advance of the jury inquiry to ascertain whether an alternative mechanism to protect the settlement monies by means other than admission to wardship could be established. Geoghegan J., speaking for the Supreme Court, held that, as the wardship jurisdiction was vested in the High Court and not in the President of the High Court personally, all the normal procedural devices for litigating issues were available. He therefore returned the case to the High Court to determine if an alternative to wardship could be found in the circumstances.

In capacity assessment in other respects, the procedural route to be employed has been the subject of much more limited consideration. In particular, the lack of reported case law regarding capacity to consent to medical treatment makes it difficult to assess the process employed. However, two broadly relevant decisions, *In re a Ward of Court* [92] and *J.M. v. St Vincent's Hospital and Others*,[93] may be of help. Although neither case involved the assessment of capacity, they do provide some indication of the overall framework for healthcare decision-making for adults who are unable to make decisions themselves. In assessing the ward's best interests in *In re a Ward of Court* (in the context of an application regarding the withdrawal of life-sustaining treatment), the High Court clearly envisaged that the assessment would involve an adversarial hearing. Lynch J. appointed the General Solicitor for Wards to act as guardian *ad litem* for the ward with the specific function of contradicting the case being made by the ward's family.[94] The onus of proving the

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handling her affairs but was not of unsound mind, she could not be admitted to wardship. However, this does not seem to have been the approach taken by Kelly J. in the High Court in *Re Dolan*, 19 March 2004 (*ex tempore*), who told the parents that, in a wardship context, the term "unsound mind" meant nothing more than incapable of handling one's affairs. Kelly J.'s approach appears to have found the favour of the Supreme Court which referred to the "special meaning" to the term "unsound mind" in the wardship context (although without reference to *Keogh*).

[92] [1996] 2 I.R. 79.

[93] [2003] 1 I.R. 321 (H.C.).

[94] [1996] 2 I.R. 79, at 89.

need for the intervention lay on the party proposing the intervention and evidence to this effect had to be "clear and convincing".[95] Two members of the Supreme Court also favoured the adversarial approach.[96] However, one member of the Court, Blayney J, appeared to favour a more inquisitorial model where, if the court required further evidence, it was free to seek this evidence and was not bound by the evidence produced in court.[97]

In *J.M.*, the High Court considered an application under its *parens patriae* jurisdiction to override an advance refusal of blood products by an unconscious woman. It was undisputed that the woman had legal capacity at the time of the refusal. However, her refusal was overridden on the basis that her decision was not a "real" one.[98] The application in *J.M.* was brought in emergency circumstances by the patient's husband and it proceeded on the basis of a draft plenary summons and oral evidence on oath from the husband and the doctor charged with the patient's care.[99] The patient herself was a notice party to the proceedings and, although she was unconscious, it appears from the judgment that she was not separately represented.[100] The procedural approach taken in *J.M.* must be understood in light of both the urgency and novelty of the situation. However, for future cases, it is necessary to develop the procedural framework within which these matters may be considered. A number of suggestions regarding such a framework are outlined below.

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[95] [1996] 2 I.R. 79, at 92.

[96] See [1996] 2 I.R. 79, at 127 *per* Hamilton C.J. who also (*ibid.*) favoured the requirement for "clear and convincing proof"; and at 155 *per* Denham J. who favoured the "balance of probabilities" as the relevant standard of proof, although she noted that "the Court should not draw its conclusions lightly".

[97] Blayney J. [1996] 2 I.R. 79, at 145 relied on the decision in *In re Birch* (1892) 29 L.R. Ir. 274 where Lord Ashbourne L.C. had set out at 276 the Lord Chancellor's prerogative to direct "such inquiries and examination as justice to the idiots and lunatics may require."

[98] Finnegan P. reached this conclusion on the basis of evidence put forward by the woman's husband that the woman's decision to refuse treatment was taken "because of her cultural background and her desire to please her husband and not offend his sensibilities" [2003] 1 I.R. 321, at 325 (H.C.).

[99] A plenary summons was issued on the day following the hearing and both applicant and second respondent subsequently filed affidavits. [2003] 1 I.R. 321, at 322 (H.C.).

[100] [2003] 1 I.R. 321, at 322 (H.C.).

### *B. An Appropriate Procedural Framework*

In setting out an appropriate procedural framework for capacity assessment, it is important to recall that sometimes, especially in the context of refusal of medical treatment, capacity assessment may have to take place in highly pressured emergency circumstances.[101] The judge in a leading American case[102] described his feeling that the surgeons were waiting by the telephone with their scalpels in hand.[103] Therefore, an appropriate procedural framework needs to be able to operate on two levels; first, where there is time for careful consideration and, secondly, where there are significant time pressures.

Three factors are essential to an appropriate procedural framework. These are, first, a suitable hearing and the facility for separate legal representation of the individual involved; secondly, a rigorous review of expert medical evidence presented; and, thirdly, an opportunity for the individual whose capacity is assessed to participate in the process. Each of these aspects of the process will be considered in turn. In this context, useful lessons may also be learned from the procedural approaches adopted in England and Wales and in Australia.

#### *1. The Hearing and Independent Representation*

In developing an appropriate procedural approach in this regard, it is useful to begin by looking at the *Practice Direction (Declaratory Proceedings: Incapacitated Adults)* issued by the Official Solicitor for England and Wales.[104] The Practice Direction is based on the guidance issued by the Court of Appeal

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[101] Much of the extensive English case law on capacity has originated in this context. See the many cases involving refusal of caesarean sections, including *Re MB (an adult: medical treatment)* [1997] 2 F.C.R. 541; *Bolton Hospitals NHS Trust v. O*. [2003] 1 F.L.R. 824.

[102] *Department of Human Services v. Northern* (1978) 563 S.W. 2d 197 (Tenn., Ct. of Appeals).

[103] As recounted in Abernethy "Judgments About Patient Competence: Cultural and Economic Antecedents" in Cutter and Shelp (eds.), *Competency: A Study of Informal Competency Determinations in Primary Care* (Kluwer Academic Publishers, 1991), p.220.

[104] [2002] 1 W.L.R. 325.

in *St. George's Healthcare NHS Trust v. S.*[105] The first instance decision in this case provides a graphic example of procedural inadequacy and this motivated the Court to issue guidance for future situations. The initial application in the case sought a judicial declaration that it was lawful to proceed with a caesarean section notwithstanding the patient's refusal. The patient had not been informed that an application for declaratory relief was to be made and had no opportunity to be present or to be represented at the hearing. The application had not been properly instituted by the issue of a summons, no expert evidence was introduced and no provision was made for the patient to apply to vary or discharge the order. The judge was told certain things which were not true (that the patient had been in labour for 24 hours at the time of the application) and was not told of relevant factors (that the patient was believed by the doctors to be capable of refusing treatment, that she had consulted a solicitor, and that she had not been told of the application).[106] The Court of Appeal held that, in light of the procedural inadequacies, the fact that a judicial declaration that it was lawful to proceed had been granted was ineffective to prevent the defendants from being held liable in the tort of trespass.

Drawing on the Court of Appeal's guidance, the *Practice Direction* states that the assessment of capacity (and of "best interests" if the case requires) is to take place through an adversarial hearing with the National Health Service Trust or other responsible body acting as claimant and the individual whose capacity is at issue acting as defendant. The defendant must be represented either by her own counsel or solicitor or by the Official Solicitor acting as a "litigation friend".[107] Even if the Official Solicitor does not act as litigation friend, the Official Solicitor may be joined by the court as *ex officio* defendant or may be invited to act as a friend of the court. Unless the matter is urgent, the Official Solicitor is given a period of time (no less than eight weeks) during which to "conduct inquiries, obtain

[105] [1998] 3 W.L.R. 936.
[106] [1998] 3 W.L.R. 936, at 967.
[107] See *Practice Direction (Declaratory Proceedings: Incapacitated Adults)* para. 9. A litigation friend acts as the equivalent of a next friend in Irish law.

expert evidence and file [a] statement or report".[108] As part of this function, the Official Solicitor must meet with the patient, her carers, family members and other people close to the patient and must inquire regarding the wishes and feelings of the patient. If the application is unopposed, the final hearing may be disposed of without the presentation of oral evidence.[109]

There are a number of aspects of the procedure set out above which could usefully be adopted in the current Irish context. Of particular importance is the fact that it ensures that the individual always has some form of independent legal representation. If she does not have her own counsel, she is represented by the Official Solicitor. In this jurisdiction, this could be provided through the adoption in the capacity context of Lynch J.'s recommendation in *Re a Ward of Court* that a guardian *ad litem* be appointed to act for the individual involved unless she has her own legal representation.[110] Even in an emergency situation, the person whose rights are at stake should have independent representation. Secondly, the obligation to consult the individual herself and other interested parties should ensure that a broader range of factors are taken into account and provide the court with a fuller picture of the individual involved. This may supplement the available medical evidence and may address some of the possible deficiencies in such evidence which are identified in the next section. Obviously, this degree of consultation is possible only in a non-urgent situation. Nonetheless, the need to create as clear and detailed a picture as possible of the individual involved remains, regardless of the circumstances of the assessment.

*2. A Rigorous Approach to Expert Evidence*

Expert medical evidence plays a crucial role in the ultimate determination of capacity. This role is statutorily provided for under the Lunacy Regulation (Ireland) Act 1871[111] and, on the basis of the experience in England and Wales, is an inevitable

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[108] See the *Practice Direction*, *ibid.*, para. 10.
[109] See the *Practice Direction*, *ibid.*, paras. 11 and 12.
[110] See text following note 93 *supra*.
[111] See text following notes 23 and 85 *supra*.

feature of capacity assessment in other contexts. This is acknowledged in the *Practice Direction* which states that "[e]vidence from a psychiatrist or psychologist…is generally required."[112] The experience in England and Wales has been that the court's decision almost invariably accords with that of the medical expert.[113]

The significance of expert medical evidence regarding capacity makes it important that courts rigorously review the evidence presented. Grisso, a psychologist writing from an American perspective, notes some of the problems with the quality of expert evidence in the context of capacity. [114] First, the medical expert may be ignorant of the law and consequently fail to provide relevant testimony. Grisso uses the example of the expert who gives evidence that the individual has a mental condition such as schizophrenia and then concludes on this basis that she is incapable rather than applying the legal test for capacity for the particular task at hand.[115] Secondly, the expert may view her function not as facilitating the court in making a decision but as persuading the court to accept her view.[116] Thirdly, experts may not take sufficient care in formulating the evidence they present. In Grisso's words:

> Examiners sometimes may not obtain sufficient information about the examinee, in terms of quantity, type, or reliability of the observations, in order to reach certain conclusions credibly. In other instances, adequate

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[112] See *Practice Direction (Declaratory Proceedings: Incapacitated Adults)* para. 7.

[113] Although compare *In re Glynn Deceased* [1990] 2 I.R. 326 (S.C.) where the Supreme Court rejected the medical evidence that the testator was incapable, preferring the evidence of the witnesses to the will (one of whom was the priest who had drafted the will).

[114] Grisso, *Evaluating Competencies: Forensic Assessments and Instruments* (2nd Ed) (Dordrecht: Kluwer Academic, 2002).

[115] *Ibid.*, p.12.

[116] See for example Gutheil and Bursztajn "Clinicians' Guidelines for Assessing and Presenting Subtle Forms of Patient Incompetence in Legal Settings" (1986) 143 *American Journal of Psychiatry* 1020, 1020 who advise psychiatrists on strategies for the presentation of evidence in relation to a patient whose capacity is not obviously impaired so as to avoid "the inexperienced assessor or judge" being "taken in".

> data regarding the examinee may be available, but the interpretative meanings of the data in relation to the information needs of the court cannot be supported credibly by past research in psychiatry and psychology.[117]

The kinds of issues identified by Grisso may well arise in an Irish context. The only professional guidance available for Irish medical professionals is found in the Medical Council *A Guide to Ethical Conduct and Behaviour*,[118] which simply states that "assessment of competence and the discussion on consent should be carried out in conjunction with a senior colleague."[119] In the United Kingdom, where much more detailed guidance is available to medical professionals,[120] there is still a significant degree of confusion among professionals regarding the assessment of capacity in a legal sense.[121] Given the lack of guidance for Irish doctors, there is likely to be an even greater level of confusion in this jurisdiction.

Because of the general lack of awareness of the legal position among medical professionals, inappropriate test measures may be used to assess capacity. One notable example relates to the use of generalised psychometric tests, such as the Mini-Mental State Examination (MMSE), in assessing legal capacity.[122] The MMSE does not relate in any way to legal

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[117] Grisso, *Evaluating Competencies: Forensic Assessments and Instruments* (2nd ed., Dordrecht: Kluwer Academic, 2002), p.17.

[118] *A Guide to Ethical Conduct and Behaviour* (6th ed., Dublin: Medical Council, 2004).

[119] *Ibid.*, p.31.

[120] See *inter alia* the joint publication of the British Medical Association and the Law Society *Assessment of Mental Capacity* (London: BMA, 1995).

[121] See Jackson and Warner, "How Much Do Doctors Know About Consent and Capacity?" (2002) 95 *Journal of the Royal Society of Medicine* 601.

[122] The test (which is sometimes also referred to as the Folstein Test) is described in Folstein, Folstein and McHugh, "Mini Mental State – A Practical Method for Grading the Cognitive State of Patients for the Clinician" (1975) 12 *Journal of Psychiatric Research* 189. The test is based on a series of questions. These are intended to test (i) orientation: the patient is asked the date, day of the week, as well as addresses and other basic information; (ii) memory: the patient is required to remember names of objects; (iii) concentration: the patient is asked to perform basic arithmetical functions and to spell words backwards; (iv) language: the patient is asked to write a

standards for capacity. At most, it can point to possible cognitive difficulties that require further investigation. Similar issues arise with the use of "mental age" descriptors (*e.g*. evidence that the person has, for example, the "mental age of a six-year old"). In England and Wales, the *Practice Direction* appropriately rejects the relevance of expert evidence based on "global psychometric test results"[123] as well as evidence based on references to the patient's "mental age".[124] It is important that Irish courts would also be aware of the inappropriateness of this kind of approach.

The LRC has recommended that the Minister for Health appoint a Working Group to formulate a code of practice for professionals in assessing capacity to make healthcare decisions.[125] The recommendation is to be welcomed (although it is difficult to see why its remit should be restricted to healthcare decisions only). A detailed engagement with the matter by the legal and medical professions may lead to the development of appropriate and accessible guidance for medical professionals. In the meantime, courts should be rigorous in evaluating the quality of expert evidence in this regard.

### *3. The Participative Element*

A final element in an appropriate assessment process relates to the participation in the process of the individual whose capacity is being assessed. In addition to leading to better decision-making, participation in the process may also serve to minimise the negative impact of the process for the individual involved. In developing an appropriate model in this regard, Carney and Tait's examination of guardianship tribunals in the Australian states of New South Wales and Victoria is

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sentence; (v) visual-spatial ability: the patient is asked to copy a drawing. Scoring is out of a total of 30; it is recommended that patients who score below 23 should be referred for further assessment.

[123] Although the *Practice Direction* does not expand on what this category of results includes, it may be assumed that the remarks were directed towards general tests such as the MMSE.

[124] [2002] 1 W.L.R. 325, at 327.

[125] Consultation Paper on *Vulnerable Adults and the Law: Capacity* (L.R.C. C.P. 37-2005), para. 3.26.

instructive.[126] In both states, the relevant legislation[127] requires a hearing before a tribunal before an individual is admitted to guardianship. Carney and Tait found that the tribunals studied tended to adopt an inquisitorial rather than adversarial approach to the hearing either by gathering the evidence in advance or by direct questioning at the hearing.[128] During the hearing process, the tribunal members sought to incorporate the person whose guardianship was under consideration into the hearing, making efforts to welcome her and to explain the nature of the hearing[129] and to involve her in the process.[130] The tribunal members also sought to "develop alliances" between themselves and the individual whose application was under consideration.[131] Medical evidence was carefully scrutinised, at times to the chagrin of doctors who, according to Carney and Tait, were displeased to see their professional judgements treated as no more authoritative than the evidence of their patients.[132]

Carney and Tait attempted to measure the success of the approach they describe using a number of standards, including whether the individuals involved were satisfied with the process and its ultimate outcome.[133] In about half the cases, the individuals involved (including carers) were happy with the process and the outcomes and in another third, they were partly

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[126] *The Adult Guardianship Experiment* (Annandale, NSW: Federation Press, 1997).

[127] See the Guardianship and Administration Act 1986 (Victoria) and the Guardianship Act 1987 (originally the Disability Services and Guardianship Act 1987) (New South Wales).

[128] *The Adult Guardianship Experiment* (Annandale, NSW: Federation Press, 1997), p.192.

[129] *Ibid.*, p.118.

[130] This included asking the person's views at various stages in the process and summarising medical evidence and giving the person the opportunity to comment on this (*ibid.*, pp.119-120).

[131] *Ibid.*, pp.120-121. Tribunal members also tried to minimise the impact of negative images emerging from professional evidence by stressing the similarities between the individual and the tribunal board members (*ibid.*, pp.118-119).

[132] *Ibid.*, p.123.

[133] They also considered other indicia of success which were, first, whether the issue referred to the tribunal had been resolved, and secondly, whether the individual's living conditions had improved. See generally, *ibid.*, Chapter 9.

satisfied.[134] It is difficult to know what to draw from these statistics because an individual's dissatisfaction with an outcome may not necessarily mean that the outcome was inappropriate and also because of the absence of comparable studies.[135] Nonetheless, the model described by Carney and Tait appears more likely to improve the experience of the person whose capacity is assessed and contains useful lessons regarding the approach to the hearing process.

## CONCLUSION

The need to develop an appropriate legal framework relating to capacity and guardianship has, for too long, been excluded from the law reform agenda. Recently, in *In re Wards of Court and In re Francis Dolan*,[136] Geoghegan J. described it as being "more than understandable that parents would take umbrage at the terminology" of the Lunacy Regulation (Ireland) Act 1871. The problems with the current legislative approach extend well beyond terminology. The current position is clearly untenable and it is essential that the legislature engages with the reform process initiated by the Law Reform Commission. Regardless of how the law develops, the capacity assessment process will be pivotal. This article has identified a number of factors as important in delivering a suitable assessment process. These include a rigorous application of the functional test, the provision of independent representation for the individual involved, a careful review of medical evidence and the development of a participative element to involve the individual in the process insofar as this is possible. It is essential that care is taken to ensure that the process of capacity assessment operates in a way that is most appropriate for the individual whose capacity, and ultimately whose rights, are at stake.

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[134] *Ibid.*, p.156.

[135] In particular, it is not possible to determine whether the tribunal approach could operate equally well in a court setting depending on judicial attitudes.

[136] Supreme Court, unreported, Geoghegan J., 4 July 2007.