RISK AND CAPACITY: DOES THE MENTAL CAPACITY ACT INCORPORATE A SLIDING SCALE OF CAPACITY?

DANIEL SHIPSIDES, ALEX RUCK KEENE & WAYNE MARTIN*

ABSTRACT

The law places considerable weight on the question of whether a person has, or lacks, mental capacity. But approaches differ over whether and how capacity assessments should be sensitive to risk. Should a more stringent test be applied where risk is high? The question has generated considerable debate among bioethicists and jurists. In this paper, we review the literature and consider the standard of capacity defined in the Mental Capacity Act 2005 in England/Wales (MCA). While the MCA has been extensively discussed, the question of whether it adopts a 'sliding scale' for assessments of capacity has not been squarely addressed. We review the knotty legal history of the statute regarding this issue, and argue that the MCA is best understood as adopting neither a risk-ability nor a risk-evidence sliding scale. We show that the MCA nonetheless accommodates risk-sensitivity in capacity assessment in at least three different ways. The first derives the MCA's approach to decision-specificity, the second from a risk-investment sliding scale, the third from what Law Commission once described as a 'general authority' for carers to act. We argue that the resulting approach steers around two objections that critics have levied against sliding scales for capacity assessment.

Keywords: capacity assessment, civil standard of proof, decision-making capacity, Mental Capacity Act, risk, sliding-scale

I. INTRODUCTION

In this paper we consider whether and how the assessment of decision-making capacity under the Mental Capacity Act 2005 (the 'MCA') should be sensitive to information about the degree of risk involved with the decision. To frame the issue that shall concern us, it will be useful to begin with three simplified scenarios:

> Scenario 1: A and B are recovering from head injuries incurred in accidents. Each expresses an intention to make a high-risk-high-gain unsecured investment with a portion of their financial assets. Family members express concern about whether, in light of continuing cognitive impairments consequent upon their accidents, A and B have the capacity to make investment decisions. For A, the amount of the proposed investment is small, and amounts to only a tiny fraction of the overall value of his savings. For B, the amount of the proposed investment is large, and amounts to nearly the totality of his assets.
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> Scenario 2: C and D face medical decisions. C has been offered a treatment that is well-tested and known to have minimal side-effects and a high chance of success. D has been offered an experimental treatment that is known to have severe side effects in a small number of patients.

* Daniel Shipsides, Research Affiliate, Essex Autonomy Project, University of Essex, Colchester (corresponding author, email: daniel@shipsides.net); Alex Ruck Keene KC (Hon), Barrister, Visiting Professor, Dickson Poon School of Law, King's College London, London; Wayne Martin, Professor, School of Philosophy and Art History, University of Essex, Colchester.

Scenario 3: E faces a medical decision. The doctors have recommended a low-risk treatment for a high-risk medical condition.

The question that concerns us arises in each of these three scenarios. A and B each face a financial decision. But the risks faced by A are negligible while those faced by B are substantial. Should both be assessed by the same standard of decision-making capacity? Or does it make sense to use a lower standard in assessing A's ability to make a low-risk decision, while holding B to a higher standard, given the higher stakes? The same question arises with respect to C and D, in the context of their medical decisions. In the case of E we have one patient, facing a choice between consent or refusal. But the risks of consenting are low while the risks of refusal are high. So is it reasonable and lawful to apply a higher standard of capacity to E's refusal than to E's consent?

In what follows we argue that the assessment of decision-making capacity under the MCA can and should be sensitive to information about risk, but that it does not rely on the kind of 'sliding scale of capacity' that has been endorsed by some authorities and criticised by others. We survey the history of debate on this topic, reconstruct the genesis of the MCA's distinctive approach, survey its advantages and limitations before setting out how risk can be considered within the framework of the MCA.

II. BACKGROUND AND SCOPE

Reliance on the assessment of decision-making capacity (or 'competence' or 'mental capacity' or simply 'capacity') is an increasingly familiar feature of the legal landscape all over the world. [1] The presence or absence of the ability to make a decision functions as a legal threshold. With a few notable exceptions, those who have capacity enjoy the right to make a decision for themselves; where capacity is found to be absent, even after support has been provided, the decision is made by someone else, typically on the basis of an assessment of their interests (whether framed as 'best interests' or otherwise).

This paper is not concerned with the application of the best interests standard or other modes of proxy decision-making. Our focus is the legally antecedent question as to whether mental capacity is present or absent. Although the issue with which we are concerned has legal relevance in many jurisdictions around the world, our focus shall be the law in England and Wales, in part because the relevant legislation (the MCA) continues to be a point of reference internationally. [2] Under the MCA, mental capacity

[1] Under the United Nations Convention on the Rights of Persons with Disabilities, the concept of 'capacity' and the use of capacity-based legislation has been called into question. This paper, however, will sidestep the issues raised by the Convention because capacity-based legislation is likely to remain in place in many jurisdictions (including England and Wales) for the foreseeable future (see A Ruck Keene, N Kane, S Kim & G Owen, 'Mental capacity—why look for a paradigm shift?' (2023) Medical Law Review).

[2] For statute and case law influenced by the MCA, see Singapore's Mental Capacity Act (2008), the Republic of Ireland's Assisted Decision Making (Capacity) Act 2015, and Australia's *PBU & NJE v Mental Health Tribunal* [2018] VSC 564. International academic discussions of capacity also use the MCA as a point of reference, e.g. see S Kim, N Kane, A Ruck Keene & G Owen, 'Broad concepts and messy

is legally defined as being person-, time- and decision-specific, and it is treated as a binary matter of fact. That is, for any particular person, time and decision falling within its scope,[3] the MCA stipulates that the person either has or lacks mental capacity to make the decision for themselves. No grey area is recognised in the law.

Mental capacity is defined in the MCA indirectly – through the definition of its opposite, mental incapacity:

> For the purposes of this Act, 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. (MCA sec. 2.1)

Extending the *via negativa*, the Act goes on to define the inability to make decisions as follows:

> [A] person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision … (MCA sec 3.1)

It is worth noticing that at least three of these four 'statutory abilities' can vary by degree. A person's understanding of information can range more-or-less continuously from broad-and-superficial to detailed-and-profound. A person might have greater or lesser retentional abilities. And they might have a more or less fine-grained ability to use and weigh the relevant information. So where along these analogue gradients do we locate the digital tipping point between capacity and incapacity? And in identifying this tipping point, should an assessor apply a fixed standard that applies across the board – regardless of the risk involved? Or should the assessor be looking for a higher degree of understanding, for example, in cases where risks are high, while being content with a lower degree of understanding in a low-risk context?

III. SUPPORT FOR A SLIDING SCALE

The issue that concerns us was extensively discussed in the American bioethics literature in the 1980s and 1990s, where we find widespread (although not universal) support for what has come to be known as a *sliding scale approach* in the assessment of capacity. In 1982, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research endorsed a sliding scale approach in its landmark report on *Making Health Care Decisions*:

realities: optimising the application of mental capacity criteria' (2022) 48 Journal of Medical Ethics 838-844.

[3] The MCA 2005 does not cover all situations where a person's legal capacity has to be considered by reference to their mental capacity. Examples where the MCA's test does not apply include such situations as to whether person has capacity to enter into a contract, which remains governed by the common law. However, the MCA 2005 is, in practice, the governing framework for considering capacity in most health and welfare contexts.

> When little turns on the decision, the level of decisionmaking capacity required may be appropriately reduced (even though the constituent elements remain the same) and less scrutiny may be required about whether the patient possesses even the reduced level of capacity.[4]

Shortly thereafter, two US academics who had worked on the Commission's report defended the same conclusion in a widely cited article that was later re-published as an influential book:

> [T]he degree of expected harm from choices made at a given level of understanding and reasoning can vary from virtually none to the most serious, including major disability or death. … The standard of competence ought to vary in part with the expected harms or benefits to the patient of acting in accordance with the patient's choice[.][5]

One advocate for this approach summed it up with a pithy slogan: *The greater the risk, the stricter the standard*.[6] Proposals for implementing the sliding scale approach varied. Some advocated for a 'tiered' assessment procedure, defining distinct standards of capacity for decisions with different risk profiles.[7] Others defended a 'movable fulcrum' approach, in which the level or quantity of decision-making abilities required for a finding of capacity varies continuously as a function of the risk-to-gain ratio associated with a choice.[8]

A number of rationales have been offered in support of the sliding scale approach. Some defences are frankly descriptive, being predicated on the claim that such an approach reflects the practices of capacity-assessment that have emerged in case law and informal practice.[9] But a more directly normative consideration has also played a role. It is often claimed that a primary purpose for the practice of capacity assessment is to strike a balance between two sometimes competing policy objectives: respect for autonomy and protection of well-being.[10] Standards of decision-making capacity are intended to allocate due recognition to both of these values by generally protecting a person's right to make their own decisions, while nonetheless allowing limitations of that right in the service of the person's health, safety and well-being when appropriate. Given this rationale, a risk-sensitive framework for capacity assessment has clear attractions. Where a person faces only a small chance of a small loss in well-being, the sliding scale approach makes it more difficult to justify an interference in

[4] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research *Making Health Care Decisions Volume One: Report* (US Government Printing Office 1982), 60. The Commission's report does not use the expression 'sliding scale', but this terminology quickly became common in the literature that it prompted. See for example J Drane, 'The Many Faces of Competency' (1984) 15:2 The Hastings Center Report 295-297.
[5] A Buchanan and D Brock, 'Deciding for Others' (1986) 64 The Millbank Quarterly 17-94 [34]. See also A Buchanan and D Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge University Press 1990) [51].
[6] Drane (n 4) [17].
[7] For a three-tiered approach, see Drane (n 4) and J Drane, 'Competency to Give an Informed Consent' (1985) 252 JAMA 17-21.
[8] For the metaphor of the movable fulcrum, see T Grisso and P Appelbaum, *Assessing Competence to Consent to Treatment* (Oxford University Press 1998) [Ch. 7].
[9] See for example Buchanan and Brock (n 5) [39].
[10] President's Commission (n 4), 60; Drane (n 7) [17]; Buchanan and Brock (n 5) [28-34]; Grisso and Appelbaum (n 8) [130-140].

autonomy; where there is a high chance of a large loss in well-being, interference in autonomy is proportionately easier to justify.

Support for the sliding scale approach is by no means confined to the US context. In pre-MCA case law in England and Wales, it found a forceful endorsement in Lord Donaldson's memorable dictum in a 1992 Court of Appeal case: 'The more serious the decision, the greater the capacity required'.[11] Five years later Dame Elizabeth Butler-Sloss offered a much-quoted variant on the same thought: 'The graver the consequences of the decision, the commensurately greater the level of competence is required to take the decision'.[12]

Despite this widespread support, the sliding scale approach has not escaped criticism. Two themes predominate among the critics. One line of criticism concerns the *asymmetry* between consent and refusal that can result from a sliding scale approach. In our third simplified scenario at the outset, for example, reliance on a sliding scale could mean that E has the capacity to consent to, but not to refuse, the recommended treatment. Critics object that such an outcome is conceptually muddled:

> Insofar as a choice between these options [accepting and forgoing treatment] requires an ability to comprehend and to weigh the consequences of both, it seems odd to maintain that accepting treatment calls for significantly less decision- making ability than refusing treatment.[13]

A second cluster of objections focuses on the impact of a sliding scale upon the *autonomy* of the person whose capacity is being assessed. In a wide-ranging 1991 paper on 'Competence to Refuse Treatment', Saks described the sliding scale approach as 'simply unsound' on the grounds that it 'impermissibly encroaches on the decision-maker's freedom to evaluate the worth and importance of decisions for herself'.[14] The most challenging among Saks' objections pertains to a practical matter that arises in calibrating a sliding scale. On the sliding scale approach, the standard of capacity depends on the risk of harm involved with the decision. But the degree of harm associated with a particular outcome is in no small part a function of what is viewed as valuable. So how should a sliding scale be applied in circumstances where the assessor and the patient differ over what is viewed as valuable, and hence over what is viewed as harm? Saks claims:

> The [sliding scale] view treats 'good' decisions as inconsequential and 'bad' decisions as consequential, and, by raising the level of competency for 'bad' decisions, would protect those who would harm themselves. The critical problem is, who is to define harm?[15]

[11] *Re T* [1992] EWCA All ER 649 [para 28].
[12] *RE MB* [1997] EWCA Civ 3093 [para 30].
[13] M Wicclair, 'Patient Decision-Making Capacity and Risk' (1991) 5:2 Bioethics 91-104 [103-4]. For further discussion of the asymmetry objection, see Buchanan and Brock (n 5); M Wicclair *Ethics and the Elderly* (Oxford University Press 1993); I Wilks 'Asymmetrical Competence' (1999) 13:2 Bioethics 154-159.
[14] E Saks, 'Competency to Refuse Treatment' (1991) 69:3 North Carolina Law Review 945-999 [998].
[15] ibid [996].

In a later discussion of the matter, Saks qualified her opposition to sliding scales, allowing for a risk-sensitive approach in assessing the capacity to make 'extremely consequential' decisions,[16] but she continued to argue that competency doctrine has 'its foundation in autonomy', and that employment of a variable standard 'sets up someone else – the evaluator – as the judge of the goodness or badness of the decision'.[17]

Although the sliding-scale approach was much discussed between the 1980s and early 2000s, its place within the MCA itself remains unclear. There is no language in the MCA itself which prescribes such an approach, nor do the formal Explanatory Notes address the issue.[18] The original MCA Code of Practice (under review at the time of writing) comes closest to the question that concerns us in its section on 'professional involvement' in the assessment of mental capacity. Paragraph 4.53 indicates that professional involvement 'might be needed' in cases where 'the decision that needs to be made is complicated *or has serious consequences*'.[19] This is fine as far as it goes, but it does not address the question of the sliding scale, which is not about *who* should be involved in an assessment but about the standard of capacity that should be applied. Looking to the Law Commission's 1995 report on *Mental Incapacity*,[20] which laid the groundwork for the statute that followed, we find more silence on the question that concerns us. Although the report surveys a broad range of issues and cites academic literature in which the sliding scale plays a central role, it says nothing about whether the standard of capacity should vary with the risk associated with the decision. Since its passage in 2005, the MCA has generated an extensive academic literature. But to the best of our knowledge, none of this literature squarely engages the question of whether the MCA adopts a sliding scale – although some authors implicitly assume that it does so.[21]

IV.AN ANALYTICAL TOOLBOX

Before tackling our central question head-on, it will be useful to equip ourselves with three analytical tools. Think of the first tool under the heading: *Risk Relative to What?*

[16] Saks and Jeste, 'Capacity to Consent to or Refuse Treatment and/or Research' (2006) 24 Behavioral Sciences and the Law 411-429 [423].
[17] ibid [422].
[18] Department of Health, *Mental Capacity Act: Explanatory Notes* (2005).
[19] Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) [para 4.53]; emphasis added. See also: 'If a decision could have serious or grave consequences, it is even more important that a person understands the information relevant to that decision' [para 4.19]. The latter paragraph has recently been referred to by Lord Stephens in *A Local Authority v JB* [2021] UKSC 52 – the first case in which the Supreme Court had to consider the question of capacity under the MCA [para 74].
[20] Law Commission, *Mental Incapacity* (HMSO 1995).
[21] See for example G Owen, G Szmukler, G Richardson and others, 'Mental Capacity and psychiatric in-patients: implications for the new mental health law in England Wales' (2009) 195 Psychiatry 257-263 [258]. In a paper concerned with 'patients meeting the incapacity criterion of the Mental Capacity Act', the authors indicate that they have 'followed the approach outlined by Grisso & Appelbaum. This incorporates the "sliding scale" concept whereby decisions that carry a greater risk require greater evidence of the relevant decision-making abilities. This concept is similar to the English law notion that "the graver the consequences of the decision, the commensurately greater the level of competence that is required to make it."'

As we have seen, defenders of sliding scale approaches hold that the assessment of capacity should be sensitive to the level of risk involved in the decision. As risk rises, so does something else. But what exactly is the second variable? Here we can distinguish at least three different answers. The first approach is what we will refer to as the *risk-ability sliding scale*. This is the approach that finds expression in Lord Donaldson's Dictum and related slogans: 'The more serious the decision, *the greater the capacity* required' (emphasis added). Applied to someone like Patient E, this would mean that a relatively poor ability to understand treatment information might undermine E's capacity to refuse treatment, while leaving the capacity to consent intact.

But ability is not the only candidate for the second variable in a sliding scale. An alternative is to vary the *amount of evidence* required to warrant a finding of incapacity. Applied to Patients A and B, this would mean that a judge could find A capable of making the low-risk investment based on rather meagre evidence about his decision-making abilities. When it comes to B's high-risk investment decision, however, the judge would require more and clearer evidence. We shall refer to this approach as a *risk-evidence sliding scale*. Each of these two approaches finds defenders in the academic literature. Drane prefers a tiered risk-ability scale, for example, whereas DeMarco defends a risk-evidence approach.[22]

A third variant focuses neither on the level of capacity nor on the amount of evidence but on the *investment* made in the assessment itself. On a *risk-investment sliding scale,* the assessor invests more resources (whether in time, money, staff-resources, consultation with experts, …) when risk is high. Where risk is low, a lower level of investment is appropriate. These three variants on the sliding scale are analytically distinct, and can make a difference in practice. But they are not mutually exclusive, and some proponents of a sliding scale appear to advocate for a mixed approach.[23]

A second analytical distinction is closely related to the first. As we shall see, discussion of sliding scales in England and Wales often implicates two legal questions: (a) What is the standard of capacity? (b) What is the standard of proof? In practice, these two issues are closely related. Both pertain to the broader question of what has to be established in order to warrant a finding of incapacity. But the two issues are legally distinct, and the MCA addresses them separately. As we have seen, MCA sec. 2(1) and MCA sec. 3(1) jointly specify a standard of mental capacity. The standard of proof for legal proceedings under the Act is specified separately, in MCA sec. 2(4):

> In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.[24]

[22] Drane (n 4); Drane (n 7); J DeMarco 'Competence and Paternalism' (2002) 16:3 Bioethics 231-245.
[23] See, for example, the passage quoted above from the President's Commission, which refers both to the 'level of decision-making capacity required' and to the degree of 'scrutiny [that] may be required'. Supra.
[24] MCA 2005, sec. 2(4).

This is what is known in law as *the civil standard of proof*, which is elaborated in the MCA Code of Practice as follows: 'This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question'.[25]

The third tool in our toolkit pertains to the idea of an 'outcome test' for capacity. In its 1995 report, the Law Commission distinguished three broad approaches to the definition of mental capacity, referring to the three approaches as 'status tests', outcome tests' and 'functional tests' respectively.[26] Under an outcome test, 'any decision which is inconsistent with conventional values, or with which the assessor disagrees, may be classified as incompetent'.[27] Outcome tests for capacity have been roundly rejected both in the academic and policy literature. Grisso and Appelbaum sum up the consensus position as follows:

> Virtually all legal and ethical perspectives on competence to consent to treatment agree that whether a patient's choice would be considered wise by most people is not a requirement for competence to consent to treatment.[28]

The Law Commission followed this consensus in firmly rejecting an outcome test,[29] and its position was ultimately reflected in one of the headline principles of the MCA: 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision'.[30]

It should be clear that any sliding scale approach makes outcome relevant to capacity. Think again of Patient E as an example. On a sliding scale approach, E might well have capacity to consent to a medical treatment but lack capacity to refuse it. So would a sliding scale approach represent a relapse into the roundly denounced 'outcome test' approach to capacity? This is where we need the third tool in our tool kit. The crucial point to recognise is that there are a variety of ways in which outcomes might play a role in an assessment of capacity. Accordingly, there are more and less stringent ways of rejecting an outcome test. The most stringent approach would be to insist that a capacity assessment be *blind to outcome*. Some judicial statements appear to come close to this.[31] But this is not what we find in the relevant passage of the MCA. The crucial word there is *merely*: 'A person is not to be treated as unable to make a

[25] Department of Constitutional Affairs (n 19) [para 4.10].
[26] Law Commission *Mental Incapacity* (n 20) [para 3.3].
[27] ibid [para 3.4].
[28] Grisso and Appelbaum (n 8) [33]. See also President's Commission (n 4); Law Commission *Mental Incapacity* (n 20); Donnelly *Autonomy, Capacity and the Limitations of Liberalism: An Exploration of the Law Relating to Treatment Refusal* (Thesis, University of Wales 2006) [234-237].
[29] Law Commission *Mental Incapacity* (n 20) [39-40, para 3.20].
[30] MCA 2005, sec. 1(4).
[31] 'The outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005', per MacDonald J in *Kings College Hospital NHS Foundation Trust v C & Anor* [2015] EWCOP 80 [para 29]. In context, this is a less absolute statement than it appears, tied as it is to the judge's framing of the principle in sec. 1(4), and the observation that 'the fact that a decision not to have life saving medical treatment may be considered an unwise decision and may have a fatal outcome is not of itself evidence of a lack of capacity to take that decision'.

decision *merely* because he makes an unwise decision'.[32] What is disallowed under MCA sec. 1(4) is that an assessor arrives at a determination of capacity *entirely* on the basis of the outcome. But this leaves open the possibility that variation in outcomes (and specifically in the risk associated with different outcomes) might be *relevant* in reaching a determination of capacity.

V. A KNOTTY LEGAL PREHISTORY

With these three analytical points in hand, let's turn to consider whether the MCA adopts (or permits) a sliding scale approach in the assessment of capacity. In this section we approach this question by revisiting some of the legal history of the Act, examining the Law Commission's work that helped pave the way for its eventual adoption. It is true, of course, that the draft Bill proposed by the Law Commission was not, in all particulars, the Act adopted by Parliament.[33] Nonetheless, the Law Commission's detailed work has, understandably, played a continuing role in the interpretation of the Act.[34] And, importantly for the purposes of this paper, the Law Commission's work brings to light themes that illuminate our later arguments about the ways in which risk-sensitivity is (and is not) incorporated in the later statute.

We have already observed that the 1995 Law Commission report on *Legal Incapacity* contains few clues to guide us on the issues surrounding the sliding scale. But that 1995 report was preceded by a series of Consultation Papers in which the Law Commission worked through some of the relevant options. For our purposes, the two relevant consultation papers are CP128 and CP129, both published in 1993. The Law Commission's position evolved over time, and requires some unpacking.

In its first attempts to grapple with the issues of interest in CP128, the Law Commission addresses the question of 'the amount and complexity of the information which the person might have to be able to understand'.[35] Its initial answer to the question is formulated using the idea of a *broad terms understanding*.[36] An understanding of the relevant information 'in broad terms' is legally sufficient for capacity. This approach has the flavour of a fixed, as opposed to a variable, standard for capacity. Notably, however, the paragraph concludes with a further thought, which sounds a rather different note:

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[32] Emphasis added. The crucial word 'merely' is sometimes missed in training materials on the MCA. For example, materials shared by the Social Care Institute for Excellence state the principle as follows: 'A person should not be treated as incapable of making a decision because their decision may seem unwise'. (British Institute of Learning Disabilities, publication date unknown, <https://www.scie.org.uk/files/mca/directory/bild-poster.pdf?res=true?> accessed online 9 May 2023)

[33] Notably, some of the differences between the draft Bill and the Act pertain to the precise definition of incapacity.

[34] For one notable example, see *Aintree University Hospitals NHS Foundation Trust v James* UKSC [2013] UKSC 67 [para 24].

[35] Law Commission, *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*, Consultation Paper No.128 (HMSO 1993) [para. 3.23].

[36] 'The present law generally sets the threshold of understanding quite low, by requiring only a capacity to understand what is proposed in "broad terms". We consider that this approach is consistent with the desire to enable people to take as many decisions as possible for themselves and to limit intervention to the most serious cases' ibid [para 3.23].

> It is also consistent with the view recently expressed in the Court of Appeal that *the greater the gravity of the consequences of any decision, the greater the degree of understanding required*.[37]

We can recognise here a variant of Lord Donaldson's Dictum, which had only recently been formulated in the Court of Appeal's ruling in *Re T*. On this approach, the standard for capacity is not fixed, but incorporates a risk-ability sliding scale. There appears, then, to be a tension here between fixed and variable standards. Perhaps the best understanding of the Law Commission's position at this stage is that it contemplated that a 'broad terms' standard would suffice for most decisions, but that 'grave' decisions might require a more stringent standard.

However, the Law Commission later came to be sceptical about the use of an ability-risk sliding scale. In CP129 it states:

> [W]e have some difficulty with the idea that there should be a 'greater capacity' as opposed to an ability to understand more, or more significant, information. We do not consider that more than a 'broad terms' understanding is required[.][38]

The Commission now clearly recognises that the amount and complexity of *information* that must be understood will vary from one decision to another.[39] But its considered position reached in CP129 is that the standard as regards *understanding* that information should remain a constant: 'broad understanding' should suffice. This position is tracked through into the draft Bill attached to its final report, which noted that its approach had been supported by many respondents to its consultation,[40] and provided (in clause 2(3)) that

> [a] person shall not be regarded as unable to understand the [relevant information] if he is able to understand an explanation of that information in broad terms and in simple language.

In this final position there are no echoes of Lord Donaldson's dictum – no endorsement of a risk-ability sliding scale. A person is required only to have a 'broad terms' understanding of information; information which, in relation to different decisions, may vary in amount or complexity.

Whilst the Law Commission remained sceptical about the use of a risk-ability sliding scale, it nevertheless adopted positions that opened two other ways of incorporating risk-sensitivity in capacity assessment. First, it endorsed the use of an evidence-risk

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[37] ibid [para 3.23, emphasis added].

[38] Law Commission *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*, Consultation Paper No.129 (HMSO 1993) [para 2.16].

[39] 'It is certainly true that a patient will need to be given, and understand, more information before making some decisions than others, and that a doctor faced with a refusal which will have serious consequences should offer the patient more information'. Ibid [para 2.16].

[40] Law Commission *Mental Incapacity* (n 20) [para 3.18], although it should be noted that the framing of this discussion was not by reference to the matters that we have been considering to date: 'Many respondents supported this attempt [i.e. referring to understanding 'in broad terms and simple language'] to ensure that persons should not be found to lack capacity unless and until someone has gone to the trouble to put forward a suitable explanation of the relevant information. This focus requires an assessor to approach any apparent inability as something which may be dynamic and changeable'.

sliding scale in connection with the standard of proof used in formal capacity assessments. In CP128, reporting on the results of an earlier consultation exercise, the Commission reviews three rival positions that had emerged: some had argued for reliance on the criminal standard of proof in proceedings regarding incapacity; others had argued for the civil standard of proof; and some had argued for an 'intermediate standard of proof' – higher than the balance of probabilities but lower than 'beyond a reasonable doubt'.[41] It will come as no surprise that the Law Commission endorsed the civil standard of proof.[42] But what is noteworthy is its reasoning in rejecting the third option.

> Some commentators have argued for an intermediate standard of proof, higher than the normal civil standard[:] the 'clear and convincing' standard. In fact, however, although the normal civil standard is the 'balance of probabilities', this is qualified by the requirement that *the graver the consequences the greater the standard of proof required*. We consider that this is entirely appropriate[.] (emphasis added)[43]

In rejecting an intermediate standard as unnecessary, the Law Commission makes clear that it understands the civil standard of proof to be 'qualified', incorporating a version of the sliding scale. And what kind of sliding scale? Despite the rhetorical echoes of Lord Donaldson's dictum, the proposed sliding scale is not Lord Donaldson's risk-ability approach; it is a risk-evidence sliding scale: more compelling evidence should be required where consequences are potentially 'grave'. In its final report the Law Commission maintained, although without detailed discussion, its stance in relation to the use of the civil standard of proof in legal proceedings.[44]

A second way of incorporating a form of risk-sensitivity left open by the Law Commission concerns capacity assessments undertaken outside of formal legal proceedings. Alongside considering the role of capacity assessments in the courts, the Law Commission at the same time proposed that there be a codification of the common law doctrine of necessity to provide a statutory authority for carers (both professional and informal) to act without any recourse to the courts.[45] In its final position, in what it proposed to call a 'general authority', the Law Commission's recommended that:

> In the absence of certifications or authorisations, persons acting informally[46] can only be expected to have reasonable grounds to believe that (1) the other person lacks capacity in relation to the matter in hand and (2) they are acting in the best interests of that person.[47]

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[41] Law Commission Consultation Paper 128 (n 35) [para 3.42].
[42] It should be noted that the Law Commission's endorsement of the civil standard comes in the context of its consideration of *legal proceedings*. We consider below the Law Commission's proposals for distinct provisions regarding capacity assessments undertaken outside such proceedings.
[43] Law Commission Consultation Paper 128 (n 35) [para 3.42].
[44] Law Commission *Mental Incapacity* (n 20) [para 3.2]. Note that in endorsing the civil standard of proof the Law Commission explicitly refer back to their discussion in Consultation Paper 128 which endorses the 'qualified' civil standard of proof.
[45] Law Commission Consultation Paper 128 (n 35) [paras 2.10-2.13].
[46] I.e. without recourse to a court – such a person could be a professional involved in the care of the person, as can be seen by reference to the example of the 'district nurse [giving] a regular injection and nursing care' as the sort of person who could be covered by this authority: Law Commission *Mental Incapacity* (n 20) [para 4.4].
[47] ibid [para 4.5].

The Law Commission did not amplify what it meant by having 'reasonable grounds to believe' that the other person lacks capacity, but the importance of this position is three-fold. First, external to legal proceedings, informal determinations of capacity are not required to be adjudicated by the civil standard of proof, rather, they are only required to be adjudicated in terms of a person's 'reasonable grounds to believe' that the other person lacks capacity in relation to the matter in hand. Second, by emphasising that the person could 'only' be expected to have such grounds, the Law Commission could be seen as implying that this was a bar which could be crossed relatively easily. Third, although risk is not mentioned in its discussion of 'general authority', the position here is consistent with the idea that risk may play a role in informal determinations of whether the other person lacks capacity.

To conclude this section, there are three themes that can be extracted from the knotty prehistory to illuminate the role of risk-sensitivity which we will shortly argue is incorporated in the MCA. First, the Law Commission was sceptical of a risk-ability sliding scale but remained sympathetic towards the idea that decision-making requires a 'broad terms' understanding of information that may vary in amount or complexity. Second, the Law Commission endorsed a risk-evidence sliding scale which it held to be congruent with the ('qualified') civil standard of proof. Third, although not discussed in detail, the Law Commission outlined how informal proceedings on the basis of the 'general authority' were to approach matters, an approach based upon 'reasonable grounds to believe' in incapacity. In Section VII, we argue that analogues of the first and third of these themes are tracked through into the MCA and ground two ways in which the statute incorporates risk-sensitivity. The second theme, however, as we show in the next section, is not one that is tracked through into the statute.

VI. UNRAVELLING THE ENHANCED CIVIL STANDARD OF PROOF

Up to this point we have found considerable support for a 'sliding scale' approach to the assessment of capacity (§2), together with a proposal from the Law Commission (§4) about how such a sliding scale might operate for purposes of legal proceedings by combining a single, functionally-defined standard of capacity with a variable, risk-sensitive standard of proof. But not long after the MCA came into force, this strategy for incorporating risk-sensitivity into the assessment of capacity encountered a substantial obstacle – in the form of a landmark legal ruling on standards of proof in civil proceedings.

To understand the ruling in question, we need first to appreciate that the period in which the MCA was drafted and adopted coincided with what, in retrospect, we can recognise as a kind of high-water mark for the idea of a variable civil standard of proof. We have already encountered prominent formulations of this idea in dicta from Lord Donaldson and Dame Elizabeth Butler-Sloss. But the popularity of the idea of a variable civil standard was by no means confined to capacity law. Judges coined a variety of names for the approach, dubbing it variously as the 'heightened civil standard', the 'enhanced civil standard', the 'flexible civil standard', or 'the civil standard, flexibly applied'. The cases in which this idea turned up involved, *inter alia*,

anti-social behaviour orders, the sex offender register, deportation, and the nullification of citizenship. One particularly high-profile discussion appeared in the context of Lord Saville's public inquiry into the events known as 'Bloody Sunday'.[48]

In 2008, the issues pertaining to the enhanced civil standard came before the judges of the House of Lords in a case pertaining to the removal of a child from its parents. At issue was the question of the appropriate standard of proof to apply in determining whether a child is at risk with its parents or guardians; the case was heard by a five-judge panel, which was unanimous in its ruling. The main judgment was written by Lady Hale, who memorably wrote:

> My Lords, for that reason I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold … is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts.[49]

This is not the place to undertake a detailed analysis of the reasoning that led Hale to her strongly worded conclusion.[50] Much of her reasoning was specific to the context of children's law, involving, *inter alia*, a construction of the relevant statutory language in the Children Act and an unpicking of a rather tangled set of authorities in case law pertaining to removal orders and related proceedings. But one part of Hale's reasoning has particular relevance for the correlative issues pertaining to capacity law. Hale allows that there 'are some proceedings, though civil in form, whose nature is such that it is appropriate to apply the criminal standard of proof'. But she goes on to insist that

> [C]are proceedings are not of that nature. They are not there to punish or to deter anyone. The consequences of breaking a care order are not penal. Care proceedings are there to protect a child from harm.[51]

Elsewhere she describes the relevant statute as establishing a threshold, the purpose of which is 'to protect both the children and their parents from unjustified intervention in their lives'.[52] Although Hale is here describing care proceedings under the Children Act, it is clear that much of her description would apply equally to the MCA. Judgments

[48] Lord Bingham of Cornhill had invoked the idea of a 'flexible' civil standard in a 2001 case pertaining to a sex offender order, writing: 'The civil standard is a flexible standard to be applied with greater of lesser strictness according to the seriousness of what has to be proved and the implications of proving those matters' (*B v Chief Constable of the Avon and Somerset Constabulary* [2001] WLR 340 [para. 30]). The term 'heightened civil standard' was used, *inter alia*, by Lord Steyn in *Clingham v Royal Borough of Kensington and Chelsea* HL 17 Oct 2002, para 37, a case that concerned anti-social behaviour orders. Lord Saville used the expression 'enhanced civil standard' in his ruling on the standard of proof relevant to his inquiry (A2.41: Ruling, 11th October 2004: 'The Requisite Standard of Proof for Inquiries of this Nature'). The terminology of 'flexible application of the civil standard' dates back at least to the ruling by Lord Fraser of Tullybelton in *R v Secretary of State for the Home Department, Ex p Khawaja* [1984] AC 74 [para. 76] – a case that concerned a deportation order.

[49] *Re B* [2008] UKHL 35 [para 70].

[50] For analysis, see C Bendall 'The Demise of the Enhanced Standard of Proof in Child-Protection Cases' (2009) 31:2 Journal of Social Welfare & Family Law 185-191.

[51] *Re B* [2008] UKHL 35 [para 69].

[52] *Re B* [2008] UKHL 35 [para 54; see also para 59].

as to the presence or absence of capacity are not intended to 'punish or deter'; there are no penal consequences; and the purpose of the relevant legal threshold is to protect the relevant person both from harm and from unjustified intervention. In these respects, there is quite a close analogy between the two legal domains.

Hale's judgment in *re B* pertained specifically to the standard of proof in the Children Act, but Lord Hoffmann, in a concurring opinion, went further:

> [T]he time has come to say, once and for all, that there is only one civil standard of proof and that is proof that the fact in issue more probably occurred than not.[53]

Like Hale, Hoffmann allows that there may be some civil proceedings in which it may be appropriate to rely on the criminal standard of proof. What he disallows is the possibility of some third intermediate standard. And he concurs with Hale in elaborating the civil standard in terms of a straight balance of probabilities.

Hoffmann's concurring opinion is decisive for the MCA for two reasons. First, unlike the Children Act, the MCA is explicit in specifying that the civil standard of proof shall govern proceedings under the Act. As we have seen, those who originally framed the Act may well have had in mind a variable civil standard for purposes of legal proceedings, but Hoffmann's judgment makes it clear that there is only one civil standard of proof. The only alternative standard of proof available would be the criminal standard, and this is clearly ruled out by MCA sec 2(4). Second, this appears to entail that the use of evidence-risk sliding-scale capacity assessments is forbidden by the MCA. If the evidentiary threshold for capacity assessments is set by the civil standard of proof – that is, by the mere balance of probabilities alone – then sliding-scale approaches that modify this threshold in relation to risk are legally impermissible, at least in relation to determinations to be put before the court.

The significance of *re B* for the application of the MCA has been recognised by the Court of Protection. A recent example can be found in a 2020 case:

> The presumption of capacity serves to place the burden of proving incapacity squarely on the shoulders of the applicants. The burden of proof remains the balance of probabilities, nothing more nothing less (see *Re: B* [2008] UKHL 35). In some cases, the evidence will tip the balance significantly in one direction. In other cases, such as this, the balance will be more delicately poised, though still identifiably weighted to one side.[54]

Other examples of reliance on *re B* in the Court of Protection can be found, *inter alia*, in: *LBX v TT & Ors* [2014] EWCOP 24, *PL v Sutton Clinical Commissioning Group & Anor* [2017] EWCOP 22, *A North East Local Authority v AC & Anor* [2018] EWCOP 34 and *Local Authority v SE* [2021] EWCOP 44.

VII. INCORPORATING RISK-SENSITIVITY INTO MCA CAPACITY ASSESSMENTS

At this point it may seem that we have reached a kind of impasse. Despite considerable support in principle for the idea of a risk-sensitive approach in the assessment of

[53] *Re B* [2008] UKHL 35 [para 13].
[54] *Avon and Wiltshire Mental Health Partnership v WA & Anor* [2020] EWCOP 37 [para 85].

capacity, the twists and turns of legal history may seem to leave little room for one in England and Wales, at least in relation to matters which may go to court. The Law Commission expressed scepticism about a risk-ability sliding scale, and no express provision for such an approach was included in the standard that was adopted by Parliament. As we have seen, there is evidence that the Law Commission understood itself to be proposing a risk-evidence sliding scale, but the legal space required for such an approach subsequently collapsed between the joint pressures of MCA sec 2(4) and Hoffmann's concurring opinion in *re B*. So where does that leave us? In the last analysis we believe that there is scope within the MCA to incorporate sensitivity to information about risk. [55] But its principal legal mechanism for doing so is best understood as neither a risk-ability nor a risk-evidence sliding scale.

In order to make this out in detail, we need to attend to two key provisions of the Act. The first of these comes in the context of the MCA's elaboration of the so-called functional test for decision-making capacity. We have already reviewed the four functional abilities enumerated in MCA sec 3(1): understand, retain, use/weigh, communicate. In its initial elaboration of these abilities, the scope of these abilities is specified quite generically: 'to understand the information relevant to the decision'. But MCA sec 3(4) goes on to elaborate on the matter of scope as follows:

> The information relevant to a decision includes information about the reasonably foreseeable consequences of: (a) deciding one way or another, or: (b) failing to make the decision.

Consider first how this provision applies in the scenario of A and B, the two individuals who face decisions about investing some of their assets. It should be clear that the 'reasonably foreseeable consequences' of the investment decisions vary substantially between the two cases. For A, the range of foreseeable consequences is quite narrow. If the investment proves unsuccessful, then he might end up with a slightly smaller nest egg. If it is successful then he will be very modestly better off. An assessor would need to probe A's understanding of such prospects, but the information about foreseeable consequences that is relevant for A is circumscribed and simple. In B's case, by contrast, the 'reasonably foreseeable consequences' are much more far-reaching, and there is accordingly much more information that B must be able to understand, retain, use and weigh. The foreseeable consequences in B's case encompass a potentially devastating financial setback, which would itself have significant consequences. These consequences notably include his ability to pay for his future care needs. The consequence: B only has the capacity to make the investment decision if he is able to understand information about those needs, their costs, and the impact of an investment loss on his ability to pay for them. There is quite simply *more information* to understand in B's case, and the information itself is considerably *more complex*. The same point applies, *mutatis mutandis*, to the scenario involving C and D.

[55] We do not discuss here the position in relation to those tests of capacity which remain governed by the common law (see n 2 above), save to note that any court which sought to maintain a sensitivity to risk in this context could not do so by reference to any 'heightened' civil of standard of proof, as this avenue has been eliminated in the way we have discussed above.

Note the consequence for an assessor: applying the provisions of MCA sec. 3(4) to these cases, an assessment of capacity will be *indirectly sensitive* to the degree of risk. Depending on the particular facts of the case, an assessor might well conclude that A has decision-making capacity to make his small investment while B lacks capacity to make the large one – even if their underlying abilities and impairments are identical. This is *not* because the assessor is applying a more stringent legal standard of capacity to B than to A. Nor is it because the assessor demands more evidence concerning B's capacity than concerning A's. We submit that the MCA (in its post-2008 legal configuration) is best understood as articulating a single legal standard of mental capacity and (where a court is involved) a single standard of proof that applies for all the decisions that fall within its scope. The potential for these divergent outcomes ultimately derives from the MCA's principle of decision-specificity in conjunction with the provisions of MCA sec. 3(4). A's investment decision differs from B's, not only in its monetary scale but in the range of foreseeable consequences that it implicates – *and hence in the cognitive load that it imposes*.

The provisions of MCA sec. 3(4) have a rather different significance for the case of E, who faces a decision about a low-risk treatment for a high-risk medical condition. Recall that critics of risk-sensitive sliding scales complained that they threaten to produce an objectionable asymmetry between capacity-to-consent and capacity-to-refuse. Views diverge as to whether such asymmetry is justifiable.[56] But notice the way in which an approach guided by MCA sec. 3(4) steers around this controversy. Firstly, as we have just seen, the MCA standard is not *directly* sensitive to risk; its indirect approach relies on the amount and complexity of the relevant information as a *proxy* for risk. But notice also the way in which it defines the scope of a capacity assessment with reference to the reasonably foreseeable consequences of deciding *one way or another*. Symmetry is thereby preserved, since the scope of the 'relevant information' (and hence the 'ability-load' associated with the decision) is the same regardless of whether E wishes to consent or to refuse. In either case E must be able to understand, retain, use and weigh information about the reasonably foreseeable consequences of *both* consent *and* refusal. This feature of the MCA approach can be seen in a recent High Court ruling, which emphasises that the question addressed by the courts does not separately concern the capacity to accept or to refuse, but *the capacity to make a decision*.[57]

At the outset of this section, we noted that there were two key provisions of the MCA that shape its approach to risk-sensitivity in the assessment of mental capacity. So far we have focused on MCA sec. 3(4). However, given that most cases do not come to

[56] For two different defences of asymmetry between consent and refusal, see Buchanan & Brock (n 5) and D Brudney & M Siegler, 'A Justifiable Asymmetry' (2015) 26:2 Journal of Clinical Ethics 100-103. For criticism see G Cale 'Continuing the Debate Over Risk-Related Standards of Competence' (1999) 13:2 Bioethics 131-147.

[57] 'In relation to those falling within the scope of the Mental Capacity Act 2005 …, the courts do not examine separately capacity to consent and capacity to refuse medical treatment. Rather, the courts proceed by examining the question of whether the person has the capacity to make a decision in relation to the treatment' (Sir James Munby, writing in *An NHS Trust and X* [2021] EWHC 65 (Fam) [para. 78]). This approach to the framing of the question of capacity has recently been echoed by the Supreme Court in *A Local Authority v JB* [2021] UKSC 52.

court, of equal – if not greater – practical importance is MCA sec. 5, which enacted (in slightly different form) the proposed 'general authority' considered by the Law Commission at the same time as it was considering the knotty questions of standards of proof. In line with the Law Commission's approach, MCA sec. 5 protects any person ('D') from liability for actions undertaken to provide care or treatment – *provided that certain conditions are met*. The key conditions are laid out in MCA sec. 5(1) as follows:

> (a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and
> (b) when doing the act, D reasonably believes –
> (i) that P lacks capacity in relation to the matter, and
> (ii) that it will be in P's best interests for the act to be done.

In principle, any person relying upon the defence in sec.5 should be prepared to defend their conclusions as to capacity before a court, and should therefore be prepared to adduce evidence meeting the civil standard of proof. However, in practice, very few such situations will come to court – by design.[58] It is therefore particularly important to note the reliance in these provisions on the words 'reasonable' and 'reasonably'. D enjoys sec. 5 protection from liability only if D has undertaken *reasonable steps* to address the questions of capacity, and *reasonably believes* that the person lacks capacity in the matter at hand. These concepts are not further elaborated in the statute, leaving open justiciable questions about what constitutes reasonable steps, and when a belief about incapacity is reasonably held. The Court of Appeal has emphasised the extent to which '[a] striking feature of the statutory defence is the extent to which it is pervaded by the concepts of reasonableness, practicability and appropriateness',[59] accepting in so doing that a person may be able to benefit from the defence even if they were not aware of the terms of the terms of the Act but had the 'prescribed state of mind' for purposes of sec.5.[60] So it should not automatically be assumed that a person can only be said to have a reasonable belief in the other's lack of capacity if they have directed themselves by reference to the civil standard of proof. Further, given the time-specific nature of capacity, the fact that a person may not subsequently be able to establish before a court that the other *now* lacks capacity to make a relevant decision does not mean that they did not have, at an earlier time, a reasonable belief that they lacked it.

We have highlighted above the Law Commission's (limited) discussion about the interaction between what is now sec. 5 and what are now secs. 2 and 3. We shall not undertake to address all of the open questions to which the issues highlighted here

[58] See the description of sec.5 given by Lady Hale (judicially) in terms which unsurprisingly reflect the broad application which the Law Commission had foreseen for it: '[s]ection 5 of the 2005 Act gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court'. *N v ACCG & Ors* [2017] UKSC 22 [para. 38].
[59] *Commissioner of Police for the Metropolis v ZH* [2013] EWCA Civ 69 at [para 40].
[60] The phrase used by the first instance judge (*ZH v The Commissioner of Police for the Metropolis* [2012] EWHC 604 (QB) [para 40]). The Court of Appeal did not directly address this point, but endorsed his conclusions and thereby can be said to have endorsed this approach.

give rise,[61] but there is one point about which it is important to be clear. Determinations of capacity in the context of sec. 5 are not made in isolation. There are obligations for those who make such determinations that are not to be found within the MCA (or indeed, any equivalent legislation in other jurisdictions). These obligations are found in regional and international human rights conventions which require states to do more than simply refrain (for instance) from taking life, but rather to take active steps to secure life in the presence of a real and immediate risk.[62] Conventionally, at least in the context of physical health, the extent of those steps will be dictated in part by whether the person is said to have capacity to make the decision to accept or refuse the measures proposed.[63] The consequences of this are two-fold.

First, in the context of a high-risk situation – especially one with limited time in which to investigate – the threshold for having 'reasonable grounds to believe' in a lack of capacity will inevitably be set low when the proposed action would secure the vital interests of the person. Second, and conversely, the threshold for proceeding on the basis that the person *has* capacity where respecting that decision will give rise to serious risks will be higher. By way of example, in *Arskaya v Ukraine* the European Court of Human Rights found that there had been a breach of Article 2 ECHR where a person, S, repeatedly refused to accept life-saving treatment in circumstances where

> S, showing symptoms of a mental disorder, the doctors took those refusals at face value without putting in question S.'s capacity to take rational decisions concerning his treatment. Notably, if S. had agreed to undergo the treatment, the outcome might have been different […]. the Court considers that the question of the validity of S.'s refusals to accept vitally important treatment should have been properly answered at the right time, namely before the medical staff refrained from pursuing the proposed treatment in relying on the patient's decision. From the standpoint of Article 2 of the Convention a clear stance on this issue was necessary at that time in order to remove the risk that the patient had made his decision without a full understanding of what was involved.[64]

Otherwise put: there is a *risk-investment sliding scale* in the assessment of capacity: the higher the risk, the more investment (of time, resource, effort, etc.) required in order to arrive at a conclusion that the person's decision is to be respected.

A risk-investment sliding scale has received less attention than other types of sliding scales which were widely discussed by bioethicists and legal professionals prior to the MCA. One bioethicist who did touch on this type of sliding scale does so only tentatively and in passing in relation to criticism of one of the more widely discussed scales: 'While the risks related to a decision might be grounds for taking more care in

[61] And which are perhaps curiously unexplored in the literature, perhaps because of what appears to be a common (if – as noted – incorrect) assumption that all determinations of capacity, whether inside or outside court, are on the balance of probabilities.

[62] See, in the context of Article 2 ECHR: *Lopes de Sousa Fernandez v. Portugal* (2018) 66 EHRR 2.

[63] See, for a neat encapsulation of the position in respect of life-saving medical treatment, *Kings College Hospital NHS Foundation Trust v C* [2015] EWCOP 80, [2016] COPLR 50.

[64] [2013] ECHR 1235. The ECtHR ruling and the risk-investment scale can be seen as the implicit working out of the principles set out in the MCA. The assumption of capacity (MCA sec.1(2)is maintained; the fact that the decision appears to be unwise is not taken to show that they lack capacity (MCA sec.1(3)), but, rather, emphasis is placed on the correlate duty to investigate (and potentially establish) whether a person lacks capacity and, if they do, what steps to take in their best interests (MCA sec. 1(5)).

assessing a person's competence, they should not provide grounds for increasing the standards by which a person's competence is assessed'. [65] And yet, as noted above, a risk-investment sliding scale has started to gain traction in the European Court of Human Rights. In a case subsequent to *Arskaya,,* which reviewed the circumstances surrounding the death of a woman following her participation in the second-leg of a clinical trial, the court ruled:

> [I]n view of their vulnerability, it is important that mentally ill patients enjoy a heightened protection and that their participation in clinical trials be accompanied by particularly strong safeguards, with due account given to the particularities of their mental condition and its evolution over time. It is *essential*, in particular, that such patients' decision-making capacity be objectively established in order to remove the *risk that they have given their consent without a full understanding of what was involved* (compare Arskaya v. Ukraine, no. 45076/05, §§ 87-90, 5 December 2013). The facts of the case reveal that Ms A.T.'s mental illness worsened during the first clinical trial […]. Yet there is no evidence in the case file that, when inviting her to take part in the second clinical trial and accepting her consent thereto, the doctors in charge duly assessed whether the applicant's daughter was indeed able to take rational decisions regarding her continued participation in the trial.[66] (emphases added)

Noting the serious consequences for the patient following the first clinical trial (her mental illness had worsened), the court criticised the medical team for failing to invest in assessing the patient's capacity to consent to the second trial.[67] The ruling indicates that high levels of investment in assessing a person's decision-making capacity are required when the risks associated with a decision are particularly serious. In light of this ruling, there is a case to be made that the risk-investment sliding scales must be used in determinations of capacity to ensure that states discharge their positive obligations under Article 2 ECHR (or its equivalents at UN treaty level).

VIII. CONCLUSION

We have argued that the MCA adopts a distinctive approach for incorporating information about risk into the assessment of decision-making capacity. Unlike other widely discussed approaches, its approach generates risk-sensitivity without relying on a risk-ability or risk-evidence sliding scale. Under the MCA's principle of decision-specificity, an assessment of capacity is *indirectly sensitive* to risk. Because high risk decisions characteristically have more complex and more far-reaching 'reasonably

[65] Cale (n 56) [148]. See also Brudney & Siegler (n 56), although it is not clear here if they intend to refer to a risk-evidence or a risk-investment sliding scale: 'The higher the stakes for the patient, the more the physician should be sure that the patient has capacity because the downside of getting that judgement wrong could be the death of an incapacitated patient'.

[66] Traskunova v. Russia [2022] ECHR 631 [para 79].

[67] This touches on a tension between the concept of information disclosure when viewed from a capacity perspective versus a clinical negligence perspective. The latter pushes towards giving the person more and more information (to protect clinicians from charges that they have withheld material information) whereas the former pushes towards stripping back and presenting only the most salient information (to maximise chances that that the person is able to make their own decision). This issue is worthy of further consideration but reaches beyond the scope of this paper. The issue is touched on in E Cave 'Valid consent to medical treatment' (2021) 47 Journal of Medical Ethics; see also T O'Shea:
(2011) Green Paper Report: Consent in History, Theory and Practice. Essex Autonomy Project: <https://autonomy.essex.ac.uk/wp-content/uploads/2016/11/Consent-GPR-June-2012.pdf>
(accessed online 9 May 2023)

foreseeable consequences' than low-risk decisions, both the quantity and complexity of the relevant information will typically be higher with respect to a high-risk decision than with respect to a low-risk one, so the cognitive load required in understanding, retaining, and using/weighing that information will accordingly be higher. In addition, the MCA sustains a *risk-investment* sliding scale, under which a greater investment of resource (whether in staff time, evidence-gathering, consultation, etc.) is justified in cases where risk is high than in cases where risk is low. Finally, the framing of the MCA's liability protections, especially when read by reference to the external obligations upon professionals, are formulated in a way which has the effect of generating risk-sensitivity. But all these principles operate within the MCA's unified overall approach, which adopts a single legal standard of capacity which applies to all decisions that fall within its statutory ambit.

The MCA's approach to risk is not without limitations. Notably, its indirect approach to risk sensitivity effectively tracks risk only insofar as risk varies in proportion to complexity.[68] In circumstances like those of A and B, this proportionality obtains. B has capacity to make the high-risk decision only if he has the ability to understand, retain, use and weigh a large amount of fairly complex information. But it cannot be assumed that risk and complexity always track one another in this way.[69] If circumstances arise where the foreseeable consequences of a high-risk decision are fairly straightforward to understand, the MCA's indirect approach fails to be sensitive to risk.

Balancing this intrinsic limitation, however, we find a number of advantages of the MCA's approach. As we have seen, there has been widespread support among bioethicists and jurists for incorporating information about risk into the assessment of decision-making capacity. The MCA provides indirect, even if imperfect, ways of doing so. Moreover, the MCA's approach manages to steer around the two principal objections that have been laid against the so-called 'sliding scale' approach. Recall that the first objection focused on the asymmetry between capacity-to-consent and capacity-to-refuse that can result from reliance on a risk-sensitive sliding scale of capacity. But as we have seen, the MCA establishes neither a risk-ability nor a risk-evidence sliding scale. MCA secs. 2(1) and 3(1) serve to establish a single standard of capacity, and the framing of MCA sec 3(4) preserves symmetry between capacity-to-consent and capacity-to-refuse. So the MCA's approach avoids the first objection.

What about the second objection, which centred on Saks' insistent question: *Who is to define harm?* Saks objected that risk-sensitive approaches to capacity assessments encroach upon autonomy by requiring the assessor to impose her own values in determining what constitutes harm, and therefore what constitutes risk of harm. Saks' objection raises a number of complex and far-reaching questions that go beyond the scope of the present paper. But Saks' insistent question fails to get traction against the MCA's distinctive approach. This is because the MCA standard of capacity makes

[68] More exactly: the MCA approach to capacity assessment is sensitive to risk only insofar as the level of risk associated with a decision is proportionate to the quantity and/or complexity of the information about the reasonably foreseeable consequences of deciding one way or the other.
[69] See T Buller, 'Competence and Risk-Relativity' (2001) 15:2 Bioethics 93-109; Owen and others (n 21) [99].

no express reference to harm or risk of harm. In formal terms, assessors should be asking: 'What are the reasonably foreseeable consequences of deciding one way or another?' The legally decisive issue is then not so much about whether those foreseeable consequences are *harmful* or not (which is the question that engages Saks' question), but about whether the person is able to understand information pertaining to those consequences, and to retain, use and weigh that information in making their own choice.[70]

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