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Perspective Piece

Challenges in decision-making capacity in the acute hospital setting: two years on from the implementation of the Assisted Decision-Making (Capacity) Act 2015

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Abstract

Two years on from the implementation of the Assisted Decision-Making (Capacity) Act (ADMCA) 2015, significant legal uncertainty persists in Ireland's acute hospitals for the care of people who lack capacity to consent to treatment. Consultation-liaison psychiatrists must navigate a legal landscape where clear lacunae have emerged in the regulation of frequently encountered clinical scenarios. We identify three of these – eating disorders requiring refeeding, refusal of life-saving treatment, and unsafe discharges – where neither the ADMCA nor the Mental Health Act 2001 provide legal authority to intervene. In such cases, the Inherent Jurisdiction of the High Court has become the default mechanism for authorising treatment or deprivation of liberty, raising serious concerns about proportionality, clinical delays and uncertainty, cost, and consistency. We also consider a fourth category of patients who require immediate life-saving treatment, and the legal status of Advance Healthcare Directives in this context. Many of the patients who fall into these categories will have an established or suspected mental illness requiring the clinical input of a consultation-liaison psychiatry team.

We contrast Ireland's evolving capacity legislation with developments in England and Wales. Reflecting on these comparisons, we consider the proposed Protection of Liberty Safeguards may provide some clarification but also contain potential risks of becoming unwieldy and bureaucratic and still fail to provide a workable statutory basis for authorising medical *treatment* in acute hospital settings. A proportionate, patient-centred, and clinically usable legal framework remains urgently needed.

Keywords: Capacity; Ireland; mental health; psychiatry; treatment

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Introduction

The Assisted Decision-Making (Capacity) Act 2015 (ADMCA) represents a landmark change in Irish capacity law, moving from the Victorian-era Wardship regime to a rights-based approach rooted in the UN Convention on the Rights of Persons with Disabilities (CRPD). Although enacted in 2015, most provisions only commenced in April 2023. Two years on, doctors in acute hospitals are navigating the practical and legal challenges of this new regime and encountering clear lacunae in the law.

The ADMCA introduces legally binding advanced healthcare directives and codifies the test for capacity. It moves from the informal and traditional concept of "best interests" to prioritise the "will and preference" of patients and introduces a hierarchy of arrangements to support decision-making. The Act's guiding principles emphasise the presumption of capacity, the importance of minimising restrictions, and proportionality in interventions. It formally abolished Wardship for new cases and rejected informal "next-of-kin" consent (which never had true legal standing) in favour of legally-appointed decision-makers. However, critical gaps remain: there is no statutory framework for deprivation of liberty in acute hospital settings, despite provisions being drafted and consulted on as far back as 2019 (DoH 2019). The interface with the Mental Health Act (2001) was also poorly considered, particularly for those detained under its provisions but lacking mental capacity to consent to physical healthcare or those who are mentally ill but being treated in an acute hospital. Despite the abolition of Wardship there has therefore been a continued reliance on the High Court's Inherent Jurisdiction to make decisions in these cases.

The test for capacity, as defined in the ADMCA, formalises what was already usual practice in Irish healthcare and closely mirrors that of other jurisdictions, such as England and Wales. This requires that there is a presumption of capacity, unless compelling grounds to doubt this exist, as outlined by Mr Justice Kelly in *Health Service Executive v JM, A Ward of Court [2017] IEHC 399:*

"every competent adult has the right to withhold consent to medical treatment."

Where there is a question about a patient's capacity to make a decision about their healthcare, this is assessed using the

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framework codified in the ADM(C)A 2015 and deriving from *Fitzpatrick v. FK and another[2008} IEHC 104, [2009] 2 IR 7* (Gulati *et al.* 2020). This assessment utilises four tests: can the person understand the information, can they retain the relevant information for long enough to make a decision, can they weigh the relevant information along with its consequences in the balance, and can they communicate their decision.

In addition to the long delay in implementing the ADMCA, the rollout of associated structures, such as the Decision Support Service, was slower than anticipated, with backlogs in registering decision-support arrangements. The Circuit Courts also experienced an influx of cases and lengthening delays. However, contrary to initial fears, the more cumbersome features of the ADMCA have not been frequently required within the acute hospital setting. For most clinical decisions, even those involving patients lacking mental capacity to make healthcare decisions, it is only invoked selectively while fidelity to the core principles, such as "will and preference," is maintained. Even the shift to will and preference from best interests has been more subtle than initially thought, with patient preference already considered part of pre-existing best interests decision-making. The ADMCA procedures are most relevant when disagreement, ambiguity, or legal uncertainty arises, such as when a patient appears to assent to care or discharge planning, but whose family objects, perhaps with concerns about risk or finances. The ADMCA is also engaged in financial and legal decisions, particularly where nursing home placement or Fair Deal applications are complicated by familial conflict, although third-party applications are permitted under the Fair Deal scheme. The formal use of tiered decision-support arrangements, such as Decision-Making Assistants and Co-Decision-Makers, and applications to the Circuit Court for the appointment of a Decision-Making Representative are relatively uncommon.

In contrast to the Mental Capacity Act, 2005, of England and Wales, and its associated DoLS, the ADMCA does not provide for the treatment of people who lack capacity to make decisions regarding their healthcare but who do not assent to such treatment or who wish to leave hospital. This cohort of patients is also not covered by the Mental Health Act, 2001, either, which applies only to people admitted to Approved Centres (registered psychiatric wards or hospitals) and only to their psychiatric treatment. Those patients in an acute hospital setting who lack capacity to agree to their admission and treatment and who resist it still lack an adequate statutory framework within which to treat. Prior to the ADMCA and repeal of the Lunacy Regulation (Ireland) Act 1871, supplemented by the Courts (Supplemental Provisions) Act 1961, such patients would usually be treated under the auspices of Wardship. Now, in the absence of Wardship the High Court has had to step in and use its powers under Inherent Jurisdiction. Originally envisaged to be used only in the most exceptional circumstances, the absence of a clear framework to manage these not uncommon clinical scenarios has led the High Court, to some extent, to recreate the Wardship provisions through its Inherent Jurisdiction.

Under Wardship, if a patient in a medical setting required treatment which they lacked capacity to decline, but which their treating teams felt was necessary for their health and well-being (even life), the treating service would obtain a second opinion (usually from a consultant psychiatrist or consultant geriatrician) and apply to the High Court for a Court Order to perform any necessary interventions under Wardship. Two reports from consultants involved would be required to support the application.

Since the introduction of the ADMCA in 2023, and the abolition of new Wardship proceedings, the practicalities of the process on the ground still look very similar. The treating physician, having formed the opinion that a patient lacks capacity, obtains a second opinion – usually from a consultant psychiatrist, sometimes from a consultant geriatrician. While this is usual practice is not a legal requirement, there are no formal structures. The hospital then applies to the High Court for a Court Order to perform whatever intervention is required, not under Wardship, but under the Inherent Jurisdiction of the High Court.

The Inherent Jurisdiction of the High Court refers to the power of the High Court to make orders where there are no legislative provisions covering the situation at hand (often with reference to *DG v Eastern Health Board [1997] 3 IR 511*). The process for seeking an order under the Inherent Jurisdiction of the High Court for capacity-related questions has been set out by the President of the High Court, Justice Barniville (Barniville, 2024). This outlines the process for seeking orders on an *ex parte* and on an urgent basis, the latter facilitating the hospital in obtaining emergency orders when needed. While the introduction of the ADMCA has not affected the High Court's powers it has changed the way they are exercised, including adopting a decision-specific functional capacity test (e.g. *In the Matter of KK [2023] IEHC 565*). However, its decision-making can still be relatively paternalistic and take more of a best interests approach (e.g. *In The Matter of TP, A Ward of Court [2024] IEHC 175*).

There are three discrete categories of patients who are affected by this in the acute hospital setting: (a) people with eating disorders who require refeeding; (b) patients who require an intervention such as a surgical procedure, haemodialysis, or chemotherapy; (c) those who require continued hospitalisation pending a step down residential or rehabilitation facility but who wish to go home. There is also a fourth category of patients; and (d) who require immediate life-saving treatment but who are unable to consent to their care, or are refusing care and lack capacity to do so. We will discuss these four categories in turn, as well as the process by which people lacking decision-making capacity receive essential treatments. Many of the patients who fall into these categories will have an established or suspected mental illness and will usually require the clinical input of a consultation-liaison psychiatry team. The consultant psychiatrist on the consultation-liaison psychiatry team is frequently the person providing a second opinion on the patient's decision-making capacity, in addition to clinical involvement in care.

People with eating disorders who require refeeding

Severe anorexia nervosa can require urgent refeeding, often via nasogastric tube, to mitigate life-threatening malnutrition and dehydration (RCPsych 2022). With few public-sector eating disorder inpatient beds in Ireland, nasogastric refeeding for adults is delivered on acute medical wards, with support from dietetics and liaison psychiatry (Kim *et al.* 2025; Prosser & Leslie, 2024; RCPsych 2022). Some centres operate "pop-up" multi-disciplinary teams to meet this need (McHugh *et al.* 2018). Anorexia nervosa meets the definition of a mental disorder under the Mental Health Act 2001, but the vast majority of nasogastric refeeding occurs in acute hospitals. The High Court has ruled that while nasogastric feeding constitutes "treatment" for a mental disorder, there are insufficient safeguards for its administration under the Mental Health Act 2001 (*Health Service Executive v HH [2024] IEHC 564*). In his judgement, Justice Dignam stated:

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"I have concluded that the administration of nasogastric feeding under restraint is not provided for under Section 57."

In this case, as in many others, the High Court granted an order under the Inherent Jurisdiction of the High Court, and this has evolved into the default treatment pathway for people with eating disorders who are unable to consent to nasogastric feeding. Such patients do not benefit from the protections afforded by Mental Health Commission rules regarding physical restraint, as these rules only apply to patients in an Approved Centre, and there is no comparable framework for acute hospitals.

By contrast, in England and Wales, the Mental Health Act 1983 allows nasogastric feeding for anorexia as a recognised psychiatric treatment permissible under detention orders. Most UK acute hospitals can admit MHA-detained patients, enabling consultation-liaison psychiatrists to lawfully supervise nasogastric refeeding on medical wards under mental health legislation. (Fuller & Philpot, 2020; RCPsych 2022)

Anorexia nervosa is a mental illness in the clinical and legal sense, so a minority of patients may be transferred from an Approved Centre under the Mental Health Act 2001 for oral or nasogastric refeeding. This can create a fragmented and potentially confusing interface between the Mental Health Act 2001 and the Inherent Jurisdiction of the High Court with the former authorising detention and the latter medical treatment. In practice, most psychiatrists will bypass the Mental Health Act 2001 and instead apply to the High Court for both detention and treatment despite the incompatibility with the intrinsic principle of Inherent Jurisdiction – that it is only applied when there is no relevant legislative framework available. The ADMCA does not cover young people under 18, a not infrequent group of those requiring refeeding, leaving the unclear position that was present prior to the ADMCA, but now with the additional loss of Wardship. The MHA interfaces with common law and parental consent ambiguously for children, particularly in the 16 – 17 year age group, who in practice often present to acute hospitals without specialist paediatric units, or specialists in child and adolescent psychiatry. Therefore, the Inherent Jurisdiction of the High Court is again often the default in these patients.

People who require immediate life-saving treatment but who are unable to consent to their care

In emergency medical scenarios, patients may lack capacity for reasons ranging from acute delirium or intoxication, through to unconsciousness. Under Irish common law, doctors are permitted to provide urgent treatment to a patient who lacks capacity and is unable to consent, where delay would place them at significant risk of death or serious deterioration. This is commonly referred to as the "doctrine of necessity" and, as outlined in *AC v CUH*, applies where a patient lacks capacity to make decisions about urgent medical treatment, and therefore doctors must make the decision in the patient's interests and only for as long as is necessary to invoke more formal legal processes. The HSE's Consent Policy defines the doctrine of necessity in Section 6.8 as "a legal rule which applies in some situations in which it is necessary to take an action is respect of a person who lacks capacity to consent to the intervention, and the interventions is one that a reasonable person would take in the circumstances," and notes in Section 6.9.2 that, in patients whose will and preference are against treatment, legal advice should be sought. However, it acknowledges in section 6.8 that "there is currently no comprehensive legislative framework (nor any Irish case law directly on this point) to govern this situation." The ADMCA does not help resolve this, as will and preference, and current expressed wishes are not well distinguished. The *Guide to Professional Conduct and Ethics* of the Medical Council (IMC 2024) states:

"In an emergency situation, it may not be possible to obtain consent from a patient. In such circumstances, you should (subject to paragraph 8 Providing care in emergencies) provide such treatments as are immediately necessary to save the patient's life or prevent serious harm to their health, unless you are aware of a valid and applicable advance refusal of such treatment."

This principle predates the ADMCA and remains unchanged, excepting the final line regarding advance healthcare directives. These have not yet become a significant feature of clinical decision-making in acute hospitals. However, their adoption is likely to grow, and this will begin to expose the tensions inherent in that legislation. There is no mechanism to ensure capacity at the time the directive is written, and an assumption is made that capacity is present. This raises concerns for patients with chronic or fluctuating mental disorders, and indeed physical disorders with a neuro-psychiatric element to their presentation.

Particularly as, apart from those few detained in an Approved Centre under the risk criteria of the MHA, no other patient's advanced healthcare directive can be overridden if appropriately written, even if it refuses life-saving treatment (Kelly, 2025). This raises likely challenges in those with severe depression, psychosis, or anorexia nervosa and evokes echoes of the Kerrie Wooltorton case in England where a young woman presented to hospital following an overdose with a note outlining her desire to be left to die, and was allowed to do so. She was found to have capacity at the time but there has been much debate as to whether her advance decision was valid (Kapur *et al.* 2010; Szawarski, 2013). A note instructing medical staff not to provide life-saving care if appropriately signed and witnessed could be interpreted as an advance directive under the ADMCA, when it might be better regarded as a "final act" in preparation for death by suicide (Nowland *et al.* 2019).

In *Governor of a Prison v X.Y (2023) IEHC 361* the High Court ruled that a prisoner refusing food/drink had a valid AHD which must be respected should he lose capacity. Conversely, in England/Wales, Re E (Medical treatment: Anorexia) [2012] EWHC 1639 (COP) a woman with anorexia was deemed by the courts to not have capacity when she wrote an AHD: the court subsequently ruled for her to be fed against her wishes. Given the absence of any requirement to establish capacity at the point of making an AHD and the medicolegal risks involved it is highly likely that clinicians in Ireland will seek involvement of the High Court in such cases.

People who require a non-emergency intervention and cannot consent

Patients with decision-making capacity who decline medical treatment to preserve their life or health retain the authority to do so. If there is a question about capacity to consent or refuse treatment then a similar process is followed to a patient with an eating disorder. First, a functional assessment of capacity is completed as per the ADMCA by the treating specialist, and if they are found not to have capacity for that specific decision, even with assistance, then a second opinion is sought from a relevant specialty, usually consultation-liaison psychiatry. If both assessments agree on the lack of capacity, the medical necessity of treatment, and the absence of less restrictive alternatives then the hospital seeks an order under the Inherent Jurisdiction of the High

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Court for the necessary treatment. This mirrors the previous procedure under Wardship. The High Court holds sittings every working day except during the summer, so orders can be obtained quickly and *ex parte* applications facilitated with urgent authorisation. If there is the potential for the patient to regain decision-making capacity, this should be considered and facilitated if possible. Treatment orders are usually lifted in a similar fashion to Wardship once no longer required.

An example of treatment authorised under the Inherent Jurisdiction of the High Court is illustrated in a case published in the Irish Times (O'Riordan, 2023). A woman at 35 weeks' gestation was detained under the MHA to an Approved Centre required transfer to a maternity hospital for elective Caesarean section due to serious obstetric risk. She objected to this treatment but was assessed to lack capacity to make this decision. The High Court granted an *ex parte* order allowing the hospital to proceed with the Caesarean section and confirmed the primacy of the Inherent Jurisdiction of the High Court in such cases.

Deprivation of liberty in a general hospital setting

A common cohort in acute hospitals comprises patients who wish to return home but cannot safely be discharged due to insufficient supports, often those with progressive neurological conditions (e.g. dementia) or acquired brain injury (traumatic or related to severe Wernicke–Korsakoff's syndrome). Such patients usually wish to return home, but after failed trials of home-care, the clinical team may conclude that continued inpatient supervision is necessary to prevent serious harm pending transfer to a step-down residential or rehabilitation facility. This is the situation that DoLS are intended to regulate, but in practice it arises only if the person objects to being kept in hospital. In the absence of these and following the case of *AC v Cork University Hospital [2020] 2 IR 38* the courts have strongly implied that beyond the immediate situation (when the doctrine of necessity can be used pending taking the appropriate legal steps) the only legal grounds for depriving a patient of their liberty for more than a few days on account of lack of capacity are found in the MHA or Wardship procedures (now replaced by the Inherent Jurisdiction of the High Court).

Take the case of a 65-year-old man with type 2 diabetes on insulin, who has an evolving vascular dementia, and is admitted with severe and life-threatening hyperglycaemia. His family are concerned that his cognition is deteriorating and that he sometimes forgets to take his insulin. In hospital, staff have intervened when he goes to take his insulin twice after a meal, and deemed that he requires supervision with insulin. As he lives alone, the multi-disciplinary team are concerned that this may result in his untimely death, and is indeed worsening his cognition. He is determined to return home, and the team agree to a trial of discharge with a home-care package. He is readmitted one week later with a severe episode of hypoglycaemia. If this gentleman wished to return home despite medical advice and was considered to lack the capacity to make that decision, then in the short term, he could be kept in hospital against his wishes under the doctrine of necessity. But if his attempts to leave the hospital persisted, it is clear that Inherent Jurisdiction is the only legal framework available to the hospital: he would not be detainable under the MHA.

Discussion

Given that the definition of Inherent Jurisdiction is the power of the High Court to make orders where there are no legislative provisions covering the situation at hand, it suggests that this should be a rare situation. However, in practice, it is not rare, as the situations listed above arise not infrequently and occur with some degree of predictability. It certainly seems to be a problem that there is such a gap in our legislation, which is designed to cover questions of capacity, when such matters need to be resolved in court. The ADMCA, which is the first statutory codification of capacity in Irish law, does not cover these common clinical scenarios, and as a result, these cases must be heard in court.

Following the *Bournewood* judgement (*HL v UK [2004]*), a similar legal vacuum was recognised in England and Wales, leading to the creation of Deprivation of Liberty Safeguards (DoLS). However, the system proved bureaucratic and unwieldy, particularly after the *Cheshire West* case *(P v Cheshire West & Chester Council [2014]),* and the streamlined, but still delayed, Liberty Protection Safeguards (LPS) were developed in response. The Department of Health in Ireland is now consulting on Protection of Liberty Safeguards (PoLS), which may bring long-overdue clarity to the question of deprivation of liberty for individuals lacking capacity (DoH 2025). We hope that lessons have been learned from both the English and recent Irish experience, and that a more streamlined and proportionate framework will emerge here.

The *Ferreira* decision in the English Court of Appeal (*R (Ferreira) v HM Senior Coroner for Inner South London [2017]*) held that patients receiving life-saving treatment, such as in intensive care, are not deprived of their liberty. In contrast, the current PoLS proposals for Ireland do not appear to provide any such distinction. On a strict reading, authorisation would be required for intensive care and similar acute settings. This suggests that learning from the English experience is far from guaranteed.

However the PoLS legislation develops, it is clear it will not provide a statutory framework for authorising medical *treatment* in acute hospital settings. This is very disappointing because, while some rare and complex cases will always require judicial oversight, a functioning mental health and capacity legal framework should not default to the courts for routine decision-making. It should offer clear and straightforward pathways that allow clinicians to provide necessary care and treatment within consistent and predictable safeguards. While resorting to the courts may satisfy the minimum requirements of the UN CRPD, the High Court's Inherent Jurisdiction is not designed for real-time clinical decision-making. Over-reliance on it creates delay, cost, inconsistency, and ethical uncertainty that should be addressed within the provisions of functioning capacity legislation. It risks normalising judicial intervention in clinical decision-making, something that has also been raised as a concern in relation to proposed changes to the MHA: (Kelly, 2024)

"This would be deeply ironic: doctors deciding who is detained and judges deciding who is treated. At worst, one might have imagined the opposite scenario, but certainly not this one."

Given the current dependence on Inherent Jurisdiction to authorise treatment in acute hospitals, there is an urgent need for legislative reform, in order to provide much needed clarity and consistency. Following the example of England and Wales, a potential mechanism might involve amendment to the ADMCA to provide statutory authority for treatment in cases of incapacity. If greater safeguards are required, a tiered framework could distinguish between:

- Short-term emergency interventions. That is, those currently permitted under the doctrine of necessity;

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- Urgent but not immediately life-saving treatments, which might align with timeframes of interim authorisations under PoLS (up to 21 days)
- More prolonged or complex interventions, requiring structured oversight and possibly court approval.

In addition, any future changes to the Mental Health Act 2001 should make provisions to allow the administration of life-saving NG feeding for weight restoration in eating disorders. Weight restoration is an evidence-based treatment for severe eating disorders, and occurs under the provisions of the MHA in England and Wales.(Fuller & Philpot, 2020; RCPsych 2022) Similar provisions in the Irish MHA would provide appropriate safeguards without the distress and delays of a High Court hearing.

The consideration of such a framework, grounded in clinical reality and designed to minimise legal uncertainty, would significantly reduce the need for judicial intervention in the routine care of patients who lack capacity.

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