MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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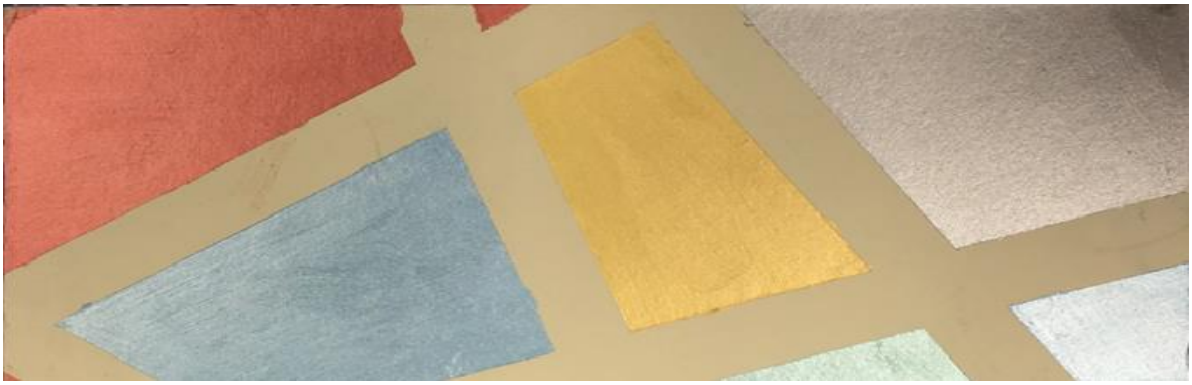

Welcome to the November 2017 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal considers parental consent to confinement, CANH withdrawal and the courts, and the latest DOLS figures;

(2) In the Property and Affairs Report: personal injury payouts and s.117 MHA 1983, calling in bonds and court approval of compromises through a human rights lens;

(2) In the Practice and Procedure Report: the Court of Protection Rules 2017 and what we can learn from the new Family Procedure Rules and PD concerning vulnerable witnesses;

(3) In the Wider Context Report: re-framing *Gillick* competence through MCA eyes, MHA changes coming into force, and CRPD developments and resources;

(4) In the Scotland Report: critical comments on practice rules, counter-proposals for guardians and parental consent to confinement from a Scottish perspective, .

You can find all our past issues, our case summaries, and more on our dedicated sub-site here, and our one-pagers of key cases on the SCIE website. On our website, you can also find updated versions of our capacity and best interests guide, and new guide to without notice applications before the Court of Protection.

His fellow editors also take this opportunity to congratulate Neil on his very well-deserved nomination for the Bar Pro Bono award 2017.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

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Reframing *Gillick* competence through the prism of the MCA?

Re S (Child as parent: Adoption: Consent) [2017] EWHC 2729 (Fam) (Family Division (Cobb J))

Mental capacity – assessing capacity

Summary

We briefly mention this decision because it is the first time MCA-concepts and language have been expressly endorsed and adopted when assessing the *Gillick* competence. In short, S was under 16 and had given birth to a baby by caesarean section under general anaesthetic. The central issues were whether she had the competence to make decisions as to her child being (a) voluntarily accommodated under section 20 of the Children Act 1989 and (b) adopted.

It was not in dispute that, given her age, S's competence was to be assessed by reference to *Gillick*. That is, whether she had achieved *"a sufficient understanding and intelligence to enable … her to understand fully what is proposed."* Cobb J held that in so doing, "*I regard it as appropriate, and indeed helpful, to read across to, and borrow from, the relevant concepts and language of the Mental Capacity Act 2005*" (para 15). His Lordship went on to state:

> *16. I do so, cognizant of some fundamental differences between the assessment of a child's competence at common law, and the assessment of capacity of a person over the age of 16 under the MCA 2005. Most notable of the differences is that the assumption of capacity in a person aged 16 or over in section 1(2) of the MCA 2005 does not apply (in relation to the equivalent issue of competence) to a young person under that age. Furthermore, there is no requirement to consider any 'diagnostic' characteristic of a young person under 16 (i.e. impairment of, or a disturbance in the functioning of, the mind or brain) in the assessment of their competence, as there is under section 2(1) of the MCA 2005 in respect of those aged 16 and over.*
>
> *17. It seems to me, nonetheless, that the following principles relevant to decision-*

making under the MCA 2005 *can usefully be applied to Gillick decisions:*

(i) The determination of a child's competence must be decision-specific and child-specific. It is necessary to consider the specific factual context when evaluating competence, for "removing the specific factual context from some decisions leaves nothing for the evaluation of capacity to bite upon" (City of York Council v C [2013] EWCA Civ 478; [2014] Fam 10 at [35]);

(ii) Just because S lacks litigation competence in the placement order proceedings for example does not mean that she lacks subject matter competence (say, in relation to consent): Sheffield City Council v E [2004] EWHC 2808 (Fam) at [23] ("someone can have capacity for one purpose whilst simultaneously lacking capacity for another purpose");

(iii) The assessment of competence must be made on the current evidence, and in respect of this current and specific decision, as is the approach under the MCA 2005: see §4.4 Mental Capacity Act Code of Practice ("the Mental Capacity Code").

18. The approach outlined in [14]-[17] above is advanced by the Local Authority in this case, though not wholeheartedly supported on behalf of S or T. That said, it is agreed by all parties that in order to be satisfied that a child is able to make a Gillick competent decision (i.e. has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed": see Lord Scarman in Gillick above), the child should be of sufficient intelligence and maturity to:

(i) Understand the nature and implications of the decision and the process of implementing that decision;

(ii) Understand the implications of not pursuing the decision;

(iii) Retain the information long enough for the decision-making process to take place;

(iv) Weigh up the information and arrive at a decision;

(v) Communicate that decision.

19. For my part, I consider it helpful to test Gillick competence in the way outlined in [18]. As I have said above, while it is abundantly clear that the MCA 2005 does not apply to those under 16 years of age, there is an advantage in applying relevant MCA 2005 concepts and language to the determination of competence to the under-16s, for this will materially assist in maintaining consistency of judicial approach to the determination of capacity or competence of a parent to give consent to adoption or placement, whether that parent is under or over 16 years of age. The capacity to give consent under the ACA 2002 for the over-16s is specifically to be determined by reference to the MCA 2005: see section 52(1)(a); it would be illogical if the court applied a materially different test of capacity/competence depending on which side of their 16th birthday the parent fell.

His Lordship identified the information relevant to the section 20 accommodation decision (para 62(vi)) and the adoption decision (para 62(vii)) in a most useful, concise summary of his reasoning.

Comment

This is a particularly important judgment for anyone working with those under 18. It very much implements that which is advocated in the MHA Code of Practice, namely the fleshing out of the common law *Gillick* competence test with the clarity of the MCA, recognising the fundamental differences where appropriate. The concepts embedded in the MCA were very much more fully embraced in this decision than they were by the Court of Appeal in *Re D* [2017] EWCA Civ 1695. And the greater degree of clarity should assist practitioners.

One potential area of confusion is the distinction drawn "*between the competence to make a decision, and the exercise of decision-making*" (para 59). At least in MCA-terms, it is the person's ability to decide that counts rather than the wisdom of their decision. But decision-making ability includes the ability to "use" the relevant information and to communicate the decision. If, by "exercising" decision-making, the court had in mind the need to be provided with all the salient details of the decision so that the decision is an informed one, that would avoid confusion.

CQC state of care report

The CQC has published its report "The state of health care and adult social care in England 2016/17."

The report concludes that:

- Health and care services are at full stretch
- Care providers are under pressure and staff resilience is not inexhaustible
- The quality of care across England is mostly good
- Quality has improved overall, but there is too much variation and some services have deteriorated
- To put people first, there must be more local collaboration and joined-up care

The report is wide ranging, considering acute hospitals, mental health and adult social care. Of particular interest is the section on DOLS. We set out below the key points:

- There is variation in the practical application of the Deprivation of Liberty Safeguards (DoLS) with uneven use across the health and social care sector, thus while most care home providers comply with DoLS legislation there is a wide variation in the its implementation and use.
- DoLS should not be one-size-fits-all – good practice in person-centred care is at the heart of ensuring decisions made around the Mental Capacity Act and DoLS are in the person's best interests. Concerns were raised about gaps in knowledge about the practicalities of DoLS and how these could impact on a person's care and the fact that DoLS is often viewed as a paper exercise with the application as the end point, rather than the beginning of the care planning process.
- There are however examples of good practice that providers can learn from, for

example personalised ways to assess capacity, and using new technology to increase people's independence.

- While staff training levels are relatively good, translating this knowledge into practice is still less effective and needs to improve.
- Across all sectors there was a lack of understanding about what constitutes a restrictive practice or restraint and how to recognise them. This led to instances where people's rights and wishes were not being respected. Further problems arose from:
    - Staff not fully understanding aspects of the legislation, partly due to its complexity, and also as a result of not enough training or translating that training into practice. This can lead to the use of overly restrictive practices; generalised decisions around a person's capacity; and a lack of person-centred care. Where there are staff shortages and pressures, this can also lead to restrictive practices to help save time
    - Blanket restrictions in adult social care and hospital settings. These were either where a restriction that could potentially be a deprivation had not been identified as that, or where a restriction had been applied to a group of people, rather than on an individual basis. Examples included: people being locked in communal living areas or wards; people not allowed to take part in certain activities; the use of bed-rails to restrict people without a proper risk assessment; and the use of anxiety medication as a chemical restraint
    - Delays to the processing of DoLS applications is noted to be a continuing problem, although some providers have found ways to work together with local authorities to manage the situation. During 2016/17 there remained a backlog of DoLS applications – according to the ADASS budget survey 2017, "*Only 29% of directors who responded to the survey are fully confident of being able to deliver all of their statutory duties this year (including for DoLS), falling to just 4% who think they can do so next year*." Against this, the providers who had notified the CQC of the outcome of a DOLS application or if they withdraw an application increased by 33% in 2016/17 from the previous year. It still, however, remains on the lower side of what the CQC was expecting given the increased applications to local authorities over the years (this number is higher than the notifcations the CQC receive).

Modern slavery, coercion and control

On 28 July 2016, the Home Secretary commissioned Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services to inspect the police's response to the implementation of the Modern Slavery Act 2015 in England and Wales. The inspection took place between November 2016 and March 2017 and the Report entitled 'Stolen freedom: the policing response to modern slavery and human trafficking' has just been published.

The report notes that "*modern slavery and human trafficking takes many forms, but all of them involve coercion and result in the erosion of individual volition and freedom*." Of particular interest for those who work in the mental capacity field is

the importance placed on identifying victims outside the communities often associated with slavery and trafficking. The report makes it clear that those with vulnerabilities such as age or learning difficulties are more prone to exploitation in this field and less able to seek help, even if they have freedom of movement. Thus those of us that work in this field must be astute to the possibility of modern slavery when coming across vulnerable adults who appear to have been coerced into either working for little or not pay, or perhaps to handing over their benefits.

The two conclusions of particular relevance for our purposes are:

- The failure to identify victims remaining a significant problem, with frontline officers having only a patchy, inconsistent understanding of signs and indicators of this type of offending. In some cases attitudes remain that modern slavery and human trafficking is rare and not an issue in their areas.
- A prevalent desire to close cases early once the victim has been safeguarded, leaving the perpetrator free to continue victimising more people. This reflects a general lack of understanding about the perpetrators of these crimes, and what will stop their offending.

All this of course calls for joined up working between those whose primary duty is to safeguard and protect victims, and those whose primary duty is to apprehend perpetrators.

Legal literacy, capacity, and the 'thinness' of autonomy

The recently published Safeguarding Adults Review into the death of Mr A written by Professors Suzy Braye & Michael Preston-Shoot makes sobering reading as to the lack of legal literacy amongst the health and social care professionals involved in the case of a man who was consistently (but query? without capacity) refusing medical treatment. However, putting to one side the details of this depressingly familiar story, it can also be seen as a challenge to the "thin" model of autonomy advocated by some proponents of the CRPD. On one view of the facts of this case (summarised expertly in the Community Care story on the report), treatment could and should never have been provided to Mr A because such would have contravened his rights under Articles 12, 14 and 17 CRPD. On another view, such would have meant Mr A was left to die (with maggots infesting the wounds in his legs) with his rights on.

Mental Health Act changes coming into force on 11 December

The changes to ss.135 and 136 MHA introduced by the Crime and Policing Act 2017 are coming into force on 11 December. The effect of these changes, together with links to the associated regulations and (non-statutory) guidance is all usefully summarised here in a letter sent out by NHS England. The admirable Mental Health Cop Michael Brown OBE has also summarised the effect for front-line professionals in a post on his website here.

In this context, further:

1. The Angiolini report (the Independent Review of Deaths and Serious Incidents in Police Custody) finally published at the end of October reminds us of the risks involved

and the human cost of individuals with mental health difficulties being detained by police officers.

2. The private members Mental Health (Use of Force) Bill also represents an attempt both to regulate and ensure the better reporting of force in hospitals and care homes in the context of those with mental disorders (it should be noted that the definition of 'physical restraint' is very similar to that contained in s.6 MCA 2005, which may well be something that needs to be addressed if it does make further Parliamentary progress.

Short note: personality disorder and deprivation of liberty

In *Nawrot v Poland* [2017] ECHR 922, the Strasbourg court again noted its doubts about whether deprivation of liberty on the basis of personality disorder can be justified.

Mr Nawrot had been charged with a number of criminal offences, but following the receipt of a psychiatric opinion which concluded that he suffered from a chronic psychotic disorder of a delusional type related to organic lesions in his central nervous system, and also from a personality disorder which meant that at the time of the offences he would not have been aware of and could not have controlled his actions, the criminal proceedings were discontinued. The criminal court however held that Mr Nawrot should be held in a psychiatric hospital.

Mr Navrot subsequently made an application for his release from hospital on the basis that he was simulating suffering from a mental illness. This was supported by a subsequent psychiatric opinion that had been obtained in conjunction with further criminal proceedings brought against him, which concluded that he was not suffering from a mental illness, but a personality disorder.

Mr Nawrot's claim was for interference with his Article 5(1) and 5(4) ECHR rights. We consider here only the challenge to his Article 5(1) rights on the basis of the failure of the criminal courts to release him from psychiatric hospital despite the evidence that he was not suffering from a mental illness, but from a personality disorder.

The court reiterated the Winterwerp principles, namely that "*for the purposes of Article 5 § 1 (e), an individual cannot be deprived of his liberty as being of "unsound mind" unless the following three minimum conditions are satisfied: firstly, he must reliably be shown to be of unsound mind, that is, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; secondly, the mental disorder must be of a kind or degree warranting compulsory confinement; thirdly, the validity of continued confinement depends upon the persistence of such a disorder.*"

As to whether, once the evidence established, that Mr Nawrot was not suffering from a psychotic disorder, but only a personality disorder, he was of 'unsound mind', the Court held that it was doubtful. At paragraph 73 the Court said this:

> *Moreover, in order to amount to a true mental disorder for the purposes of sub-paragraph (e) of Article 5 § 1, the mental disorder in question must be so serious as to necessitate treatment in an institution appropriate for mental health*

> *patients…. The Court has further expressed doubts as to whether a person's dissocial personality or dissocial personality disorder alone could be considered a sufficiently serious mental disorder so as to be classified as a "true" mental disorder for the purposes of Article 5 § 1..*

Comment

The Court's conclusions, while couched in somewhat uncertain terms, adds to the debate about whether it is lawful to deprive a personality disordered patient, of their liberty pursuant to Article 5(1)(e) ECHR. Both the MHA and MCA allow (in principle) a person who is diagnosed (solely) with a personality disorder, to be deprived of his/her liberty. The key to considering whether the deprivation of liberty of a personality disordered patient may be an interference with article 5(1) rights lies, we would suggest, in whether the mental disorder is so serious as to necessitate treatment in a mental health institution.

World Guardianship Congress

The 5th World Congress on Adult Guardianship to be held in Seoul, Korea, on 23rd – 25th October 2018 (with an additional day of workshops, principally for Asian countries, on 26th October 2018). The website for the 2018 Congress is here.

Alex attended the 4th World Congress in 2016 in Germany as one of the (disappointingly few) number of attendees from the United Kingdom: it was both an extremely interesting and extremely useful insight into how others across the world seek to grapple with the same problems through different legal frameworks and in different socio-economic traditions. There is every reason to expect that the 2018 conference will provide the same.

One note – 'Guardianship' is in this context misleading for English readers. The Congress is, in fact, concerned with what we would consider to be Deputyship, as well also as broader issues of mental capacity law.

CRPD developments and resources

A resolution was passed by the UN Human Rights Committee at the end of September on Mental Health and Human Rights. It can most easily be accessed via the International Disability Alliance ('IDA') website. The website also gives an interesting perspective on the 'take' of the Alliance and the CRPD Committee on the Resolution and the negotiations leading to it. We note with some interest that the UK was one of the sponsoring states for the Resolution, and it can therefore perhaps be seen evidence of the UK's considered position as to what the CRPD in fact demands: this is some way off the Committee's view, the Committee's chair specifically noting her "*concern*" at the "*strong resistance from Member States, during the informal negotiations, to include clear mention on the prohibition of forced treatment and confinement*."

We use this opportunity also to draw to your attention some useful resources available to assist thinking through how the CRPD could be operationalised in different contexts (and also, although we emphasise this is not their primary purposes, to test the propositions that the Committee derives from the Convention). Three in particular should be singled out:

1. The IDA has published an extremely helpful compilation of the concluding observations of the Committee on the states that have reported to date, broken down both by state and – even more helpfully – individual article;

2. The report of the Special Rapporteur on the rights of person with disabilities on the provision of different forms of rights-based support for persons with disabilities, including access to adequate decision-making support when seeking to make informed health-related choices. This can be found here;[1]

3. The World Health Organisation's QualityRights website, focused on mental health, but also mental capacity, contains detailed guidance and toolkits, including one on realising supported decision making and advance planning.

[1] In passing, it is hugely ironic that UN reports and other materials relating to disability are almost with exception exceptionally difficult to find and then link to.

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Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

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Conferences

Conferences at which editors/contributors are speaking

Deprivation of Liberty in the Community

Alex is delivering a day's training in London on 1 December for Edge Training on judicial authorisation of deprivation of liberty. For more details, and to book see here.

Deprivation of Liberty Safeguards: The Implications of the 2017 Law Commission Report

Alex is chairing and speaking at this conference in London on 8 December which looks both at the present and potential future state of the law in this area. For more details, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our last report of 2017 will be out in December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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