MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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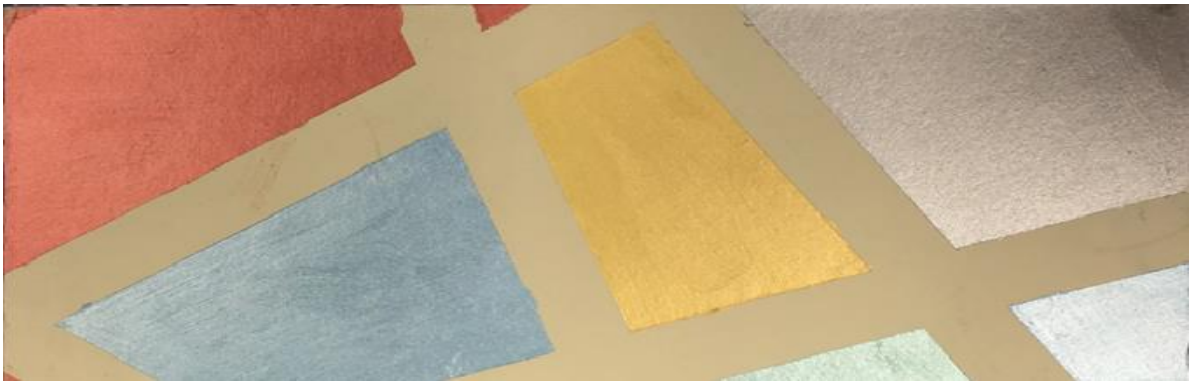

Welcome to the September 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: fluctuating capacity, and two important decisions on the scope of the inherent jurisdiction at the border of the MCA 2005;

(2) In the Property and Affairs Report: appointing a charitable trust corporation as a deputy and donating/tax-planning in PVS;

(3) In the Practice and Procedure Report: procedure in medical treatment cases; disclosure from proceedings to the police; and an update from relevant associations

(4) In the Wider Context Report: guidance on advance decisions and covert medication; alcohol, capacity and vulnerability; the FCA and vulnerable customers;

(5) In the Scotland Report: the Scott Review terms of reference; guardianship and (the failure of?) legal representation; and the apparent downgrading of the Mental Health Tribunal for Scotland.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here. If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

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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.

Contents

Advance Decisions: Uncovering what GPs need

Compassion in Dying undertook a 10-week research project with 10 practising GPs across England to better understand the knowledge and experience of GPs have of advance decisions to refuse treatment ('ADRT'). The headline finding from their report was that none of the 10 felt comfortable helping someone to create an ADRT. And most had not received formal training on it since medical school. Five themes emerged from the research:

1. GPs had significant gaps in knowledge about ADRTs and how they can benefit people

This included a lack of awareness that a valid and applicable advance decision is legally binding and must be followed.[1] There was a common belief that ADRTs were only for those unwell, older or near end of life and some GPs could not see their benefits by way of personalised treatment and peace of mind. They saw it as a 'legal process' rather than a medical one, wrongly assuming it required a solicitor. But, rather than paying around £500 in legal fees, charities such as Compassion in Dying offer free support to make an ADRT, thereby avoiding unnecessary time and financial barriers being raised to people recording their decisions for future care.

2. GPs imposed a financial barrier by charging for appointments to discuss ADRTs

Some GPs classified supporting a person to make an advance decision as chargeable private work which fell outside their General Medical Services. But, the charity says, it is unacceptable that anyone should face a financial barrier to making treatment decisions as a result of GPs charging to discuss a person's future health in this way.

3. GPs felt that conversations about death, dying and planning for the end of life would be too upsetting or difficult

This resulted in some GPs failing to initiate conversations about people's wishes for end-of-life care and treatment and opportunities to

[1] Eg see *NHS Cumbria CCG v Rushton* [2018] EWCOP 41 where the GP failed to ensure the ADRT was known about and respected by the medical team.

support people to express and documenting their wishes being missed. As a result, instead of such conversations happening well ahead of time when people have space to reflect on the information presented to them, they often happen in stressful situations which can leave people feeling anxious. Some GPs did not feel in a position to properly advise on ADRTs, one stating for example, "*I don't know all of the treatments someone is given after a stroke*".

4. GPs had negative preconceptions about refusing treatment

They were concerned about repercussions if an advance decision they supported a person to make was followed at a later date. One worried that "*some long lost son is going to turn up and say you got mum to sign this*". Some GPs also felt an ADRT could be in conflict with their duty to provide medical care and with medical culture.

5. GPs had practical concerns about the ease and process of supporting a person to make an advance decision

They felt a standard appointment slot did not provide enough time to support someone to create an ADRT and that it was often too difficult to translate a person's vague wishes into a robust care plan. There was also a lack of familiarity with template ADRT forms.

Recommendations

On the back of this research, the charity put forward the following recommendations:

1. Signpost people to free support to make an ADRT

Third sector organisations are ready to help. GPs, community link workers and social prescribers should also know who they are and to signpost to them.

2. Primary care needs to continue to work towards a change in medical culture where end-of-life care is personalised and based on what matters to each person

GPs should support people to consider and document their wishes and preferences, embrace people's right to make decisions about their treatment and care, and be more prepared to talk about death and dying. CCGs and GP practices need to ensure their GPs have protected learning time available to support them to develop their knowledge, skills and confidence around supporting people to plan ahead. Primary Care Networks offer a new opportunity to foster multi-disciplinary team leadership.

3. GP practices should sign up to The Daffodil Standards

Developed by the Royal College of General Practitioners and Marie Curie, these (2019) standards provide a free, evidence-based approach to improving end-of-life care.

4. GP practices should not charge for appointments to discuss an advance decision and the British Medical Association (BMA) should review its guidance on this

National guidance should make it clear to GPs that discussing, reviewing, signing and keeping a copy of Advance Decisions are core services which should not be charged for.

Covert medication guidance

SCIE and NICE have produced a quick guide to giving medicines covertly, aimed primarily at

care home managers and home care managers providing medicine support sets out the essentials, namely:

(1) Person with capacity

If declining medication, care staff to record this and the reason if given. If this happens regularly or may present a risk to the person's health, ask the prescriber to review the person's treatment. It may be possible to stop the medicine or prescribe an alternative.

(2) Person proven to lack capacity

A medicines policy, including a process for giving medicines covertly, should be in place which covers:

- Mental incapacity: an appropriate person (e.g. the prescriber) should carry out a mental capacity assessment;
- Best interests: the prescriber, in discussion with care staff, a pharmacist, and someone who can communicate the views and interests of the person, such as a family member or advocate, should decide whether the medicines can be stopped or given in a different form, or whether it is in the person's best interests to be given the medicines without their knowledge. Check whether the person has made an advance decision. Medicines should not be given covertly unless agreed at this meeting.
- Keeping records: record capacity assessment and best interests decision and update care plan, to provide clear authorisation to care staff to give medicines covertly if that is in the person's best interests.
- Making a plan: seek advice from pharmacist for how to administer the medication.
- Regular reviews: the appropriate people (e.g. including the prescriber) should regularly review the decision to give medicines covertly to check whether it is still needed.

For urgent decisions, the guide says these can be made in discussion between the care staff, prescriber and family or advocate, as long as a formal best interests meeting is arranged as soon as possible.

(3) Involving others:

The guide says care staff should be aware of the role of other professionals in any decision to give medicines covertly:

- Prescriber (the person prescribing a medicine e.g. a doctor, pharmacist or nurse) to complete a medication review, which may help avoid the need for covert administration if the medicine can be stopped or given in a different form; to undertake a mental capacity assessment; and to lead on the best interests decision.
- Pharmacist to help make the best interests decision and to give advice as to how the medicines can safely be given without the person's knowledge. They can also undertake medicines reviews.
- Attorney appointed for health and welfare decisions to represent the person and their preferences (lasting power of attorney).
- Independent mental capacity advocate (IMCA) to give an independent view of what is in the person's best interests, where the person lacks capacity and doesn't have

friends or family or an attorney to support them.

Comment

This is a helpful guide and the role of the prescriber is of particular interest. But it is important to note that: (i) if there is an attorney for health and welfare decisions, it is the attorney that will be responsible for making the best interests decision, in consultation with relevant others; (ii) it is not the role of an IMCA to give a view on the person's best interests; and (iii) whilst the prescriber has a key role to play, those needing to rely upon the defence to liability in MCA s.5 will be those administering the covert medication.

Alcohol, capacity and vulnerability

Alcohol Change UK has published a report highlighting the role of alcohol being "missed or poorly managed" in the care of vulnerable adults, contributing to their death.

The report analyses all 11 Safeguarding Adult Reviews from England in which alcohol was identified as a significant factor in the person's life and/or death. The findings of the report are stark indeed. In 2017, 5,507 deaths in England were directly attributable to alcohol. Vulnerable adults were found to be particularly at risk. The overarching finding was that, perhaps unsurprisingly, most of the adults featured in the reviews had multiple complex needs in addition to alcohol misuse, including mental health problems, chronic physical health conditions, neurological conditions caused by alcohol, self-neglect, exploitation by others, unfit living conditions, and experiences of a past traumatic event such as bereavement and physical or sexual abuse. In almost all cases, support services failed to cope with that complexity. Although many of these people had dozens or even hundreds of interactions with social workers, paramedics, GPs, police, A&E departments and others, the professional working with them had not received adequate training to identify and address the alcohol elements of the situation. This meant that risks posed by alcohol were missed, under-estimated or poorly managed. In some circumstances, alcohol-dependency and self-neglect were treated as a 'lifestyle choice'. This led to further barriers in the care of these people – or even the withdrawal of care; and their untimely deaths.

Two key themes emerge from the reviews. First, a significant number of reviews (6 of 11) indicated that vulnerable adults were being exploited and abused. Their vulnerability stemmed from a range of circumstances, from severe mental health problems to disability. The cause of death in three of these cases was murder or injury from physical abuse. Second, four of the reviews involved men who had become unemployed, lived alone and lost contact with their families. The cause of death in these cases was related to self-neglect and refusal of care from services. Despite the Care Act 2014 identifying people with alcohol problems as possibly needing care and support, there is little guidance in applying this legislation, or the Mental Capacity Act 2005, to this group of people.

The report describes "*a significant gap in frontline workers' knowledge about applying the Mental Capacity Act (2005) and the Care Act (2014) to this group, linked to a lack of national guidance on this*." The report states, worryingly:

> *Eight of the reviews highlight the lack of understanding of mental capacity by frontline practitioners: both as a concept that could be applied in these cases and in terms of how to apply and assess it in practice. Mrs A's review observes that "some practitioners […] have a broad understanding of mental capacity principles […] but not detailed knowledge (p. 21). Adult A's review recommends strengthening knowledge with respect to the Mental Capacity Act (2005) and how to conduct referrals to the Office of the Public Guardian and the Court of Protection (p. 47). Carol's review comments that, "Among professionals, the understanding of mental capacity and how to assess it is not robust, which impacts upon professionals responding effectively to cases which are complex, limiting the risk assessment and professional response"* (p. 23)

Going forward, the report advises that:

> *At the national level, work is required to clarify how the Mental Capacity Act and the Care Act should be intelligently applied to vulnerable adults who are misusing alcohol. In particular, the challenges of applying the concept of self-neglect to substance misusers and applying the Mental Capacity framework to people with fluctuating capacity need to be urgently addressed if more unnecessary deaths are to be avoided.*

The report makes 10 recommendations, including the following two which are relevant to the Mental Capacity Act 2005:

- The Mental Capacity Act 2005 Code of Practice should be amended to include specific guidance for working with individuals with alcohol misuse or dependence, especially when they are likely to have complex needs.
- National guidance should be produced on applying the Mental Capacity Act 2005 to people with fluctuating capacity due to alcohol misuse.

This report makes for troubling reading. We agree that the revision of the Code of the Practice provides a golden opportunity to revisit the issues arising in alcohol-related cases, and that these issues deserve specific attention in the revised Code of Practice.

The FCA and vulnerable customers

The Financial Conduct Authority (FCA) is publicly consulting on guidance for firms on the fair treatment of vulnerable customers. It will proceed in two stages. The first stage sets out the draft Guidance in three main sections:

1. Understanding the needs of vulnerable consumers.
2. Ensuring staff have the skills and capabilities needed.
3. Translating that understanding into taking practical action.

The second stage is to consult on revised draft Guidance, publishing a cost-benefit analysis alongside it. The consultation is currently at the first stage.

The consultation document defines a vulnerable consumer as "*someone who, due to their personal circumstances, is especially susceptible to detriment, particularly when a firm is not acting with appropriate levels of care*." This definition is deliberately broad and the Guidance applies to

persons who either are, or may be, in vulnerable circumstances, which is to be welcomed.

The draft Guidance relies on a number of Principles requiring firms to treat all customers fairy, including those who are, or are potentially, vulnerable. The principles include the requirement to pay due regard to the interests of its customers and treat them fairly. The draft Guidance does not itself provide a checklist of required actions but provides options for ways in which firms can comply with the Principles, such as:

- Understanding the needs of vulnerable customers: Firms should understand the needs arising from different vulnerabilities.
- Skills and capability of staff: Firms should ensure that staff have the appropriate skills and capability to understand the needs of individual vulnerable customers and respond appropriately to the needs of vulnerable customers.
- Product and service design: Firms should consider the positive or negative impacts of a product or service on vulnerable customers and should consider the needs of vulnerable customers at all stages of product and service design.
- Customer services: Firms should ensure their customer service provision meets the needs of vulnerable customers, delivering good flexible customer service that responds to the needs and situations of the customer, and provide specialist services where appropriate.
- Communications: Firms should take steps to ensure vulnerable customers are not disadvantaged in understanding products and services, and should take into account vulnerable customers' information needs.
- Monitoring and evaluation: Firms should regularly monitor the extent to which they are doing what they should under the Principles in terms of treating vulnerable customers fairly.

Whilst this draft Guidance is undoubtedly to be welcomed for focusing the spotlight on vulnerable customers, particularly those who may be at risk of financial abuse, it remains to be seen whether it really has enough "teeth" to protect vulnerable consumers. The aspirations are laudable but the Guidance itself is just that: guidance. It is not legally binding and does not create any additional obligations on firms. Nonetheless, we hope that it concentrates minds on the specific interests of vulnerable, or potentially vulnerable, customers and leads to positive changes in best practice across the financial sector.

Readers who would like to comment on the first stage of the FCA's consultation are encouraged to respond by 4 October 2019 by email to: ApproachtoConsumers@fca.org.uk or by post to: Consumer Strategy Team, Financial Conduct Authority, 12 Endeavour Square, London, E20 1JN.

RESEARCH CORNER

We highlight here recent research articles of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must be open access, both because many readers will not have access to material hidden behind paywalls, and on principle.

This month, we highlight:

1. The fascinating and important article collection in Frontiers Compulsory Interventions in Psychiatry: an Overview on the Current Situation and Recommendations for Prevention and Adequate Use.
2. The papers/presentations by Professor Anselm Eldergill to the Academy of European Law on the ECHR, the UNCRPD and the legal rights of citizens suffering mental ill-health; the rights of persons with disabilities in criminal proceedings; and the ECHR and mental health.

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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Conferences

Conferences at which editors/contributors are speaking

Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019

Alex is chairing and speaking at a conference about the LPS on Monday 23 September in London, alongside speakers including Tim Spencer-Lane. The conference is also be held on 5 December in Manchester. For more information and to book, see here.

Clinically Assisted Nutrition and Hydration Supporting Decision Making: Ensuring Best Practice

Alex is speaking at a conference about this, focusing on the application of the BMA/RCP guidance, in London on 14 October. For more information and to book, see here.

Taking Stock

Neil is giving the keynote speech at the annual national conference on 15 November jointly promoted by the Approved Mental Health Professionals Association (North West England and North Wales) and the University of Manchester. For more information, and to book, 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 next edition will be out in October. 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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