MENTAL CAPACITY REPORT: THE WIDER CONTEXT

September 2017 | Issue 79

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

(1) In the Health, Welfare and Deprivation of Liberty Report: alcohol and best interests, the price for failing to support, patient choice from the other side of capacity, and Bournewood brought to life;

(2) In the Property and Affairs Report: Denzil Lush and LPAs, the Law Commission consultation on wills, professional deputies run amok and OPG updates;

(2) In the Practice and Procedure Report: s.21A, medical treatment and the role of the courts, the extension of the pilots, and guidance on CoP visitors;

(3) In the Wider Context Report: mental capacity in (in)action in SARs, litigation friends in tribunals, legal services and vulnerability, and the Committee on the Rights of Persons scrutinises the UK;

(4) In the Scotland Report: a Scottish perspective on powers of attorney problems and attorney registration updates.

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.

We also take this opportunity to say goodbye to our fellow editor Anna Bicarregui and thank for all her dedication in producing contributions against the odds – we will miss you.

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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

CURRENT PRACTICE

Mental capacity in (in)action: Thematic Review of SARs in London Region

[*Editorial note: we are very grateful to Professors Suzy Braye and Michael Preston-Shoot for providing us with this article summarising the review that they have just published*]

Mental capacity features prominently in a thematic review of Safeguarding Adult Reviews (SARs) commissioned and completed by Safeguarding Adults Boards in London since implementation of the Care Act 2014. The review was commissioned by the London Safeguarding Adult Board and undertaken by Professors Suzy Braye and Michael Preston-Shoot, and their report has just been published by London ADASS.

The sample comprises twenty seven published and unpublished SARs. Analysis focuses firstly on the nature of the reviews – case characteristics (such as gender, ethnicity and trigger for review), SAR characteristics (such as methodology, type of abuse or neglect) and number and type of recommendations. Key themes from the content of the reviews are then presented, focusing on four domains that enable cross-case systemic analysis:

- Direct practice with the individual adult;
- Organisational factors that influenced how the practitioners worked;
- Interprofessional and interagency practice;
- The SAB's interagency governance role.

Finally, themes emerging from SAR recommendations are analysed.

Organisational abuse and neglect, and self-neglect dominate the cases reviewed, where men slightly outnumber women, and ethnicity is usually unrecorded. Shortcomings in mental capacity practice are regularly highlighted, the focus falling on failures to assess and/or to review assessments, or poorly performed and/or recorded assessments. Sometimes reviews are critical of insufficient testing of the presumption of capacity and of missed opportunities to balance a person's autonomy and self-determination with a duty of care. Unsurprisingly, therefore, SARs also contain recommendations to promote understanding of, and to develop practitioner skills in mental capacity assessments.

Closely connected to mental capacity, particularly in cases of self-neglect, reviews are critical of how practitioners have responded to the challenges of engagement, often taking at face value and leaving unexplored a person's reluctance to engage. Reliance on the notion of lifestyle choices comes in for particular criticism.

A cornerstone of good practice is, of course, assessment, not just of mental capacity but also of risk and needs. SARs are particularly critical of the absence or inadequate of risk assessments, with some containing recommendations designed to improve performance. With a particular focus on the commissioning of, and then care within, care homes, SARs also comment on the lack of personalised assessments and care or, conversely, the prioritisation given to a person's wishes to the exclusion of considerations of risk. Good assessment practice should also contain an understanding about a person's history and relationships. Some SARs offer recommendations in this area of direct practice too.

Direct practice, of course, takes place within an organisational and inter-agency context. Here SARs are equally critical. Within organisations, particular emphasis is given to the absence of supervision and managerial oversight, poor recording that means that crucial information is missing or underused, and inadequate resources, reflected in workloads, staffing levels and the availability of specialist placements. Several SARs are critical of the absence of legal literacy, resulting in a failure to scrutinise different options for lawful intervention and to pay attention to requirements on mental capacity, or safeguarding literacy, sometimes resulting in a failure to appreciate patterns of risk. Particular faith in terms of recommendations is placed by SARs in developing or reviewing guidance and in measures to improve assessments.

When focusing on the inter-agency context SARs are especially concerned about silo working and the failure to share information. The absence of legal literacy and safeguarding literacy emerges here too. SARs offer recommendations in particular on coordination of complex cases and communication and information-sharing.

Despite increasing interest in a systemic approach to case analysis, the focus of SAR inquiry and recommendations is inward-looking, into the immediate contexts surrounding the individual. Much less focus is given to exploring national contexts – the adequacy or otherwise of the legal rules in support of work with adults with or without capacity, the impact of financial austerity on health and social care services in particular, and the reliance on the market to develop provision for people with complex and challenging needs. Changes recommended by individual SARs, to be implemented by SABs and their partner agencies, may sometimes ultimately be frustrated by the legal, financial, policy and service architecture determined in Westminster.

More positively, throughout the SAR sample there are recorded examples of good practice. Although there are incidences where SABs have experienced difficulties in securing the co-operation of partner agencies in reviews, generally the review process appears to have been managed well, although not always completed within the recommended six month time frame. Here parallel processes, such as Coroner inquests, criminal proceedings and/or investigations by regulatory and inspectorate bodies, complicate the review schedule and process.

Thematic reviews offer a particular insight into the strengths and vulnerabilities within adult safeguarding. Their findings should, of course, be placed in a context where many individuals at risk of abuse and neglect are being safeguarded effectively. Nevertheless, these same findings do pinpoint issues where further scrutiny is merited by central government and by SABs with their partner agencies locally, regionally and nationally.

Suzy Braye and Michael Preston-Shoot

Litigation friends in tribunals

Two recent cases have made clear that the Employment Tribunal has the power to appoint a litigation friend (*Jhuti v Royal Mail Group* [2017] UKEAT 0062/17), as does the Asylum and Immigration Tribunal *AM (Afghanistan) v Secretary of State for the Home Department* [2017] EWCA Civ 1123.

In *Jhuti*, the Employment Appeal Tribunal found the power to order the appointment of a litigation friend for a party who lacked capacity to pursue litigation in the court's general case management powers which had to be interpreted in accordance with the overriding objective to deal with cases fairly and justly, ensuring that the parties were on an equal footing. A person who lacked capacity to litigate and was without a litigation friend could not participate in the proceedings in any real sense. There was no justification for construing the rules in a way which impeded the right of access for justice for those who lacked capacity.

In *AM,* the Court of Appeal found that although the Rules did not provide for the use of a litigation friend, they were sufficiently flexible to permit one to be appointed in the rare event that a child or incapacitated adult could not obtain effective access to justice without one.

It seems to us that these decisions must plainly be right, although their practical implications are significant. Where will these litigation friends be found? And/or will we see an extension of the approach in the Mental Health Tribunal and CoP (the ALR scheme) to enable solicitors to be appointed to act without litigation friends? Who will pay for these provisions? And what, if any, thought will be given to the recommendations regarding access to justice for persons with intellectual and/or psycho-social disabilities made by the CRPD Committee in their Concluding Observations on the UK?

Legal services and vulnerability

Summary

The Legal Services Board (LSB) has published some interesting and valuable research into the experiences of consumers in vulnerable circumstances (focusing on people with dementia/mental health problems and their carers) when they use legal services. This research provides valuable reading for those in the legal services industry to identify what can be done to improve accessibility, service experience and outcomes for consumers. The key finding is that for mental health problems and dementia, a safe space in which people feel comfortable to volunteer information or be sensitively asked about their needs is important. Other key findings/recommendations include:

For people with mental health problems

- Free initial services from third sector and regulated providers are valued.
- Customer support needs depend on the severity of the problem but include extra time for individuals to express themselves, extra communication and increased reassurance.
- It is important to feel listened to and understood, have services adapted to support them, have continuity of personnel and costs transparency.

For people with dementia

- There is a clear cluster of legal needs: wills, power of attorney and property issues.
- Those with early stage symptoms may not flag their needs in advance. Carers for those with later stage symptoms are more likely to.
- This group welcomes initial phone contact to discuss service adaptations, clear information before meeting on the legal issue, options and costs, home visits, 'dementia friendly' services, and a clear meeting record.

CQC report on specialist mental health services

The CQC has published its most recent report into specialist mental health services. The report covers the 3 years from 2014 to 2017 following inspection of specialist mental health services throughout England.

While the majority of services are found to be caring and compassionate towards patients, with 88% of NHS and 93% of independent services being rated good in this regard, only 68% more generally in the NHS and 72% of independent mental health locations are rated as good; and only 6% of NHS and 3% of independent core services were rated as outstanding. More worryingly, 36% of NHS core services and 34% of independent mental health core services were rated as requiring improvement for safety, with a further 4% of NHS and 5% of independent core services being rated as inadequate for safety.

The report notes that a lot of care remains overly restrictive and institutional in nature with significant examples of outdated care. It draws particular attention to the high number of people in "locked rehabilitation wards", far from home, leading to social isolation and institutionalisation rather than rehabilitation and a return to independence.

It is pointed out that long-term out of area care in hospitals whether through individuals with learning disabilities spending lengthy periods in hospital or in locked rehabilitation wards risks isolation and institutionalisation, but is also very expensive: better alternatives need to be found.

Finally, the report highlights concerns regarding the great variation in the use of physically restraint for challenging behaviour across the country. It notes the need to send a clear message to providers that services which resort frequently to the use of restraint and other restrictive interventions will find themselves under rigorous scrutiny.

Reviewing care plans

In a report published in August 2017, the service user watchdog, Healthwatch England proposed that care plans should be reviewed more than once a year to ensure that they are properly responding to service users' changing needs.

The report recommends that automatic notification systems could be introduced to update staff about important changes to care plans, or prompts could be left around people's homes as a reminder of their preferences.

The report also suggests local authorities needed to be more realistic in care plans about how much is achievable in the limited time available in most home care visits. It found that only just over half of people responding in one area felt there was sufficient time for care staff to complete all tasks set out in the care plan. Some service users also reported that care staff frequently lacked basic cooking and cleaning skills.

LOOKING TO THE FUTURE

Capacity, consent and mental health

Showing once again that distance can sometimes lend perspective, we draw readers' attention to a fascinating speech by Mark Hinchliffe, Deputy Chamber President FTT (HESC) – or, in English, the senior judge in day-to-day charge of the mental health tribunal jurisdiction in England, given in Hong Kong. In particular, he took the opportunity to ask himself whether the current mental health legislation "*embody the sort of respect and regard for modern principles of non-discrimination, autonomy, personal choice and self-determination that, in this day and age, should underpin the way we look at someone with a mental health problem?*" In answering the question, he sought to look, in particular, at whether capacity-based legislation would be the right way forward, giving a cautious 'yes,' so long as the relevance of dangerousness to others is considered – concluding that "*if we had a blank piece of paper, and could begin again, I fear that getting the balance right would be as ethically difficult and legally challenging now, as it was when we started down this road, nearly sixty years ago*."

Paradigm shifts or mirages?

We have deliberately left to last in this Report discussion of the concluding observations of the Committee on the Rights of Persons with Disabilities on the compliance of United Kingdom with the CRPD. We have done so because it seems to us to be useful to see those observations against a not untypical snapshot of issues in the mental capacity/mental health zone.

The report makes a very substantial number of hard-hitting, difficult to read (or refute) observations and recommendations about the ways in which the United Kingdom is letting down the rights of the disabled. The report can also, usefully, be read with the newly-adopted General Comment on Article 19: the right to independent living, with its host of detailed observations as to how states can and should take steps to ensure that individuals with disabilities are given a genuine choice as to how and where they wish to live their lives (at time of writing the General Comment has yet to appear in its final form on the Committee's website, but will do here).

For present purposes, we focus on the areas where the Committee – unsurprisingly – took on our mental health and mental capacity regimes where, respectfully, the recommendations are much more problematic. In material part, the Committee observed:

> *Equal recognition before the law (art. 12)*
>
> *30. The Committee is concerned about:*
>
> *(a) The legislation restricting legal capacity of persons with disabilities on the basis of actual or perceived impairment;*
>
> *(b) The prevalence of substituted decision-making in legislation and practice, and the lack of full recognition of the right to individualized supported decision-making that fully respects the autonomy, will and preferences of persons with disabilities;*
>
> *(c) The insufficient support to all asylum seekers and refugees with psychosocial and/or intellectual disabilities, in exercising their legal capacity; and*
>
> *(d) The high number of black people with disabilities compulsorily detained and treated against their will.*
>
> *31. The Committee recommends that the State party, in close consultation with organisations of persons with disabilities, including those representing persons from black and minority ethnic groups and in line with the Committee's general comment no. 1 (2014), abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in line with the Convention to initiate new policies in both mental capacity and mental health laws. It further urges the State party to step up efforts to foster research, data and good practices of, and speed up the development of supported decision-making regimes. It further recommends that the State party ensure that asylum seekers and refugees with disabilities can exercise all rights enshrined in the Convention.*
>
> […]
>
> *Liberty and security of the person (art. 14)*
>
> *34. The Committee is concerned that the State party legislation provides for involuntary, compulsory treatment and detention both inside and outside hospitals on the basis of actual or perceived impairment.*
>
> *35. The Committee recommends that the State party:*
>
> *(a) Repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment; and*
>
> *(b) Take appropriate measures to investigate and eliminate all forms of*

> *abuse of persons with disabilities in institutional facilities.*
>
> […]
>
> *Protecting the integrity of the person (art. 17)*
>
> *40. The Committee is concerned that persons with disabilities, including women, intersex people, girls and boys with disabilities, are reported to continue to be subjected to involuntary medical treatment, including occurrences of forced sterilization, and conversion surgeries.*
>
> *41. The Committee recommends that the State party repeal all types of legislation, regulations and practices allowing any form of forced intervention and surgeries, and ensure that the right to free, prior and informed consent to treatment is upheld and that supported decision-making mechanisms, and strengthened safeguards are provided, paying particular attention to women, intersex people, girls and boys.* (emphasis in original)

None of what the Committee says here comes as a surprise to those who have been following developments in this area.

Nor will it come a surprise to know that that there is – as far as we can tell – no realistic prospect that either the MCA or the MHA will be ripped up, even if both may well be amended (and possibly substantially) in the years to come. So to some extent all of what follows is academic. However, it means we will be in the position where one of the original driving forces at the UN remains resolutely out of kilter with what is said to be a core set of obligations. That does matter - at least to lawyers like us for whom (international) human rights matter.

Let us start with a number of essentially procedural regrets, namely that the Committee declined to engage with a number of core issues in this field that arise in the specific context of the United Kingdom, including:

1. The different legislative regimes in the various parts of the United Kingdom (for instance, the very different regime shortly to come into force in Northern Ireland – presumably failing to meet the tests set by the Committee);
2. The proposals advanced by the Law Commission to strengthen s.4 MCA 2005 and also to introduce regulation-making powers to enable supported decision-making schemes to be brought in;
3. The very expansive interpretation given to deprivation of liberty for our domestic purposes *Cheshire West*. Put another way: does the Committee consider that MIG is deprived of her liberty with her 'mummy' in her adult foster placement? If so, on what basis could this be justified on its interpretation of Article 14? If not, then how does the Committee's interpretation of Article 14 CRPD differ from that given to Article 5 ECHR by the Supreme Court?
4. Evidence from those with (in Convention terminology) psychosocial disabilities that does not reject compulsory treatment in hospital out of hand. We note, here, in particular, the recent report of the Mental Health Alliance: *A Mental Health Act fit for tomorrow*, and would not presume to put any

form of editorial spin upon the voices and views outlined therein.

That the Committee did not, in essence, do more than recite what is now a conventional 'mantra' in relation to Articles 12, 14 and 17 might – uncharitably – be said to show a concerning lack of interest in considering evidence before it as to the present, and potential future, regimes in place in the United Kingdom.

The explanation for this may well be that, politically, there is no desire to engage with the current legislative frameworks because that would be to give them credibility at a point when we should not be seeking to shore them up, but rather to rip them up and start again.[1]

In the circumstances, however, it seems to us to be a distinct misstep (at a minimum) to fail to descend to the detail of (1) precisely what is wrong with the law and practice in the UK; (2) precisely how to achieve the goals set by the Committee; and (3) how and why these goals are, in fact, derived from the obligations imposed by the Convention.

Put another way, it is clear that the truths the Committee suggests are to be found in Articles 12, 14 and 17 are ones that do not appear to be self-evident, not only to Governments with arguably vested interests, but to courts concerned with fundamental rights (see, most recently, the decision in *AM-V v Finland*).

The failure to descend to the details, further, makes it all too easy to reject the Committee's assertions as internally inconsistent. Some of these internal inconsistencies have already identified in other reports (see, for instance, the Essex Autonomy Project's work). One particular issue here is that the Committee's interpretation of the obligations imposed by Article 12(4) is focused solely upon respecting the will and preferences of the individual concerned, whereas the actual obligations imposed by Article 12(4) are to ensure that measures relating to legal capacity respect the rights, will and preferences of the individual. Those rights can include – for instance – the right to be protected (under Article 16 CRPD) against exploitation, violence and abuse. Steps taken to secure the right under Article 16 may, on their face, infringe the individual's will and preferences. In reality, therefore (and hardly surprisingly), the obligations imposed by the CRPD on the State in respect of individuals with disabilities in this area do not all point in one direction. From a whole range of different sources, we hear an increasing groundswell of real concern at the attempt by the Committee to impose a unity of obligation here which simply does match the experiences of those seeking conscientiously to bring the Convention to life in practice.

We note here another internal inconsistency arising from the concluding observations. In a point that was not presaged in the list of issues, the Committee had this to say in relation to the right to life guaranteed by Article 10 of the CRPD

> *26. The Committee observes with concern the substituted decision-making in matters of termination or withdrawal of life-sustaining treatment and care that is inconsistent with the right to life of persons with disabilities as equal and contributing members of society.*

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[1] See in this vein also the recent statement by the Human Rights Commissioner of the Council of Europe on the failure of member states of the Council to 'internalise' the new paradigm.

> *27. The Committee recalls that the right to life is absolute from which no derogations are permitted and recommends that the State party adopt a plan of action aimed at eliminating perceptions towards persons with disabilities as not having "a good and decent life", but rather recognising persons with disabilities as equal persons and part of the diversity of humankind, and ensure access to life-sustaining treatment and/or care.* (emphasis in original)

It is not obvious precisely what the Committee were referring to by "substituted decision-making" here. If they were referring to situations in which (for instance) DNACPR notices have been placed in the records of individuals with disabilities (egregious examples including those with Down's Syndrome) without consultation and on the basis of pre-conceptions by medical and other professionals, we could not agree more that such is wrong. But the courts have already made clear that such is wrong – see, for instance, the decision in *Winspear*, and on a proper analysis these do not represent substituted decisions but impositions.

On its face, though, the Committee's observations would seem to go further to encompass, for example, the case of Mr Briggs, and then into in a very difficult place indeed.

Mr Briggs self-evidently could not give "free, prior and informed consent" to the invasive treatment (CANH) that he was receiving. On the basis of the Committee's interpretation of Article 17, he should not have been provided with this treatment. But on the basis of the Committee's interpretation of Article 10 he had to be given this treatment – and should have been indefinitely ("the right to life is absolute from which no derogations are permitted") – notwithstanding the fact that those who loved him most were clear that this was the last thing that he would have wanted.

Assuming that the Committee is not advocating for this frankly terrifying situation, it is arguable that the only coherent way through is to recognise the reality of the situation. Mr Briggs was not functionally capable of making the decision whether to continue to receive CANH. His legal capacity – his agency – had to be exercised by another. It was, in this instance, exercised by the Court of Protection on his behalf, through a decision-making process that sought to construct a decision on his behalf which took as its starting point his identified wishes and feelings (his 'will and preferences'). The MCA 2005 and the mechanisms it contains therefore did not deny him legal capacity but responded to his lack of mental capacity to support his legal capacity.

The blanket statements by the Committee, however, seem to rule this approach out. This leaves those who are sympathetic to the goals of the CRPD without any very sensible way forward to draft laws which are not intellectually dishonest ('100% supported decision-making') or take health and social care professionals and lawyers into zones which appear to them not just problematic but actively unethical, without any countervailing and convincing ethical justification. The seemingly incredible (in the true sense of the word) claims made by the Committee in this regard, further, undermine the position of those who are seeking to uphold the real goals of the CRPD and gains that it promises.

In the circumstances, however, we are hopeful that with work that continues to be done to operationalise in a grainy and grounded fashion[2] the real task of securing full recognition for those with cognitive impairments (from whatever source) as subjects, not objects, we can move forwards on solid ground, not pursuing potentially illusory – if not actively dangerous – mirages.

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[2] See, for instance, the Mental Health and Justice project.

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Conferences

Conferences at which editors/contributors are speaking

The Legal Profession: Back to Basics

Adrian is speaking at the Annual Conference of the Law Society of Scotland in Edinburgh on 19 September 2017.

JUSTICE Human Rights Law Conference

Tor is speaking at JUSTICE's Annual Human Rights Law Conference in London on 13 October.

Mediation Awareness Week

Tor is taking part in a panel on 16 October on "Mediating Medical cases after Charlie Gard" as part of Mediation Awareness week.

Adults with Incapacity: the Future is Now

Adrian is speaking at this half-day LSA conference on 18 October in Glasgow. For more details, and to book, see here.

National Advocacy Conference

Alex is speaking at the National Advocacy Conference in Birmingham on 19 October. For more details, and to book tickets see here.

National IMCA Conferences

Alex is speaking at the two Irwin Mitchell/Empowerment Matters National IMCA Conferences in Sheffield on 20 October and London on 10 November.

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

Alex is chairing this conference in London on 8 December.

Taking Stock

Neil is speaking at the annual AMHPA conference in Manchester on 19 October.

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 Report 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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