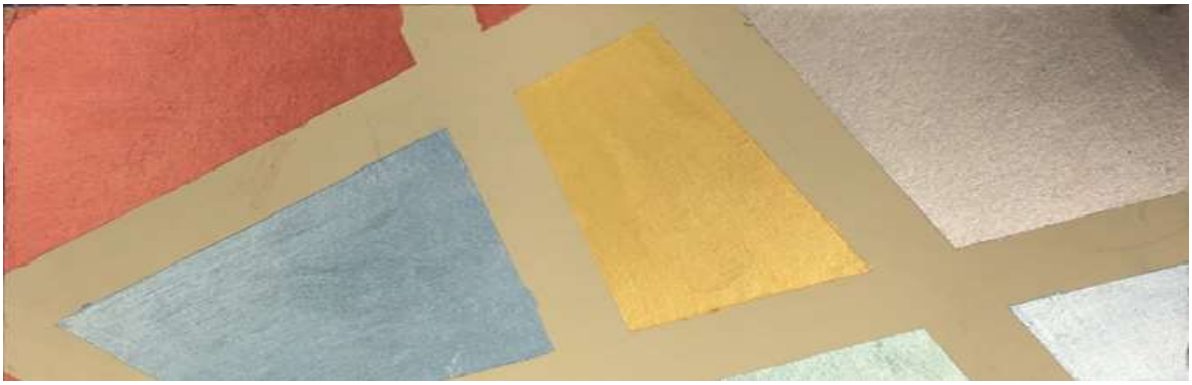
RAPID RESPONSE GUIDANCE NOTE: TESTING FOR COVID-19 AND MENTAL CAPACITY

DECEMBER 2020



A: Introduction

1. The Court of Protection team has been asked to advise on a number of occasions as to the legal position in relation to testing for COVID-19, especially as testing (a) starts to be more generally available; and (b) is increasingly been rolled out as mandatory in certain settings.

2. What follows is a general discussion, as opposed to legal advice on the facts of individual cases. It primarily relates to the position in England in relation to those aged 18 and above; specific advice should be sought in respect of Wales and those under 18. The DHSC has addressed testing (in relatively brief terms) in its additional MCA/DoLS emergency guidance; further (much more detailed) guidance has been produced by NHSE-I and the DHSC in relation to mental health, learning disability, autism and dementia inpatient services.

B: The context

3. Testing is a key part of the Government's strategy to bring COVID-19 under control. There are a number of contexts in which testing[1] may be relevant:

    a. For clinical purposes, to determine whether a patient has or does not have COVID-19, for purposes of deciding how to address their symptoms;

[1] We do not address here testing of professionals who may have been exposed to COVID-19.

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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.

b. In the community, to determine whether a person has COVID-19 and hence whether they may be required to self-isolate, either within (for instance) a supported living placement, or within their own home.

c. Prior to entry to an institution, to determine whether the person has COVID-19 and hence whether they may be required to go into isolation upon arrival;

d. In an institution, whether that be a hospital or a care home, to determine whether a person has or does not have COVID-19 and hence whether they should be required to isolate themselves so as to secure against the risk that they transmit what is a highly contagious virus.

4. In many cases, the person in question will actively want testing, and have capacity to consent to it. In supporting a person to make the decision whether or not to be tested, it may help to have reference to our capacity assessment guide. As that guide makes clear, it is important to identify the information that it is relevant to the decision in question; it is clear – we suggest – that that information must include the consequences if the test is positive. Those consequences will vary from setting to setting, but will in all cases mean that the person will be required to self-isolate for a period of time (most likely 14 days). In terms of the test itself, it may also – in some circumstances[3] – be useful to make use of this easy-read guide to having swabs taken. The NHSE-I/DHSC guidance in relation to mental health, learning disability, autism and dementia inpatient services helpfully provides that:

> *The relevant information, which the patient will need to understand, retain, or use or weigh in order to be considered to have capacity* […]*, should include the reasons for the* […] *testing, process (such as what* […] *testing will entail), and the consequences of consenting or not consenting. Ascertaining if the individual has the relevant mental capacity* […] *should not be onerous and the person will only need to understand the salient information. The patient may have the capacity* […] *to consent, even though they may be unable to make decisions in respect of other aspects of their care and treatment.*

5. However, what happens if the person (1) does not have capacity to consent to be tested; or (2) has capacity to consent to be tested but refuses to be? We address each in turn.

C: Lack of capacity to consent

6. If the person cannot consent, then, unless there is a health and welfare attorney or deputy who can consent on their behalf,[4] the relevant professionals will have to decide whether they

[3] Not least depending upon the type of test being used.
[4] If the attorney or deputy refuses, then there will be a serious question mark as to whether they are acting – as they are required to – in the best interests of the person; at that point, unless they change their stance, an application to the Court of Protection will be required.

reasonably believe that to test the person is in their best interests.[5]

7. There cannot be a blanket decision that testing is in the best interests of a group of residents or patients, as this would be contrary to the requirement of the MCA 2005 that it is the best interests of that particular person at that particular time which are determinative.[6] However, with one exception and bearing in mind that it really does depend on the circumstances, it is likely that a test would be in the person's best interests for the following reasons:

    a. In many cases, it may be possible to identify that the person, were they able to, would consent to testing if they had capacity, in which case the decision is an easy one, as there would be an alignment between 'what P would have done' and the outcome that would be in their best interests;[7]

    b. In other cases, it might well be clear that the person would wish to be tested so as to know whether they would have to be isolated upon arrival into a care home. More generally, testing positive or negative will determine which care arrangements are appropriate to meet an individual's needs which most people would want to know;

    c. Also, very often, if the person does not have a test, there will be consequences for them in terms of their residence and care. For instance, perhaps it may make a difference as to where they can be accommodated, or perhaps their regular carers will refuse to work with them;

    d. In some cases, testing (and potentially also self-isolation) will be needed for the purposes of procedures like elective surgery. It might well therefore be in the person's best interests to follow infection control procedures mandated by the hospital, in order to ensure that the procedure goes ahead. As the DHSC's Emergency MCA/DoLS guidance makes clear, "[j]*oint working and communication will be important in these cases, as the hospital will be dependent on these decision-makers, in care homes and other settings, to ensure that these decisions are taken and implemented at the right time*;"

    e. The best interests checklist provides for 'other factors that he would be likely to consider if he were able to do so' which might, depending on the person, include the effect the decision will

[5] We do not consider that the question of advance decisions will be relevant here. It is difficult to see that a test for COVID-19 would fall to be considered a 'medical treatment' for purposes of s.24 MCA 2005. In any event, even if a person did purport to make an advance decision to refuse a COVID-19 test, then they would be in the same position, legally, as a capacitous individual refusing to undergo a test: as discussed in the next section, such capacitous refusal is not a bar to testing.

[6] See *Aintree v James* [2013] UKSC 67 at paragraph 39 (all case references here are hyperlinked to case-law summaries).

[7] See *Briggs v Briggs (No. 2)* [2016] EWCOP 63. The DHSC Emergency MCA/DOLS guidance states "[f]*or many people, a best interests decision to test for COVID-19 will align with the decision that we could have expected the person to have taken themselves if they had the relevant capacity. It is reasonable to conclude that most people leaving hospital for a care home, with the relevant mental capacity to take the decision, would have agreed to testing, for the protection of their own health, and others around them.*"

have on those around them.[8] We suggest that, in asking whether the person would have consented, it will frequently be relevant to consider whether they would see themselves as a 'responsible citizen'[9] more broadly, and hence would wish to ensure that it was known whether or not they had COVID-19 so as to enable others to be protected.

8. Even if it is clear that the person would not wish to be tested, the best interests test is – ultimately – not a pure 'substituted judgment' test, and it is legitimate to take into account other factors, including the potential that the person might cause a risk of harm to others,[10] in deciding whether to override the person's known wishes. On the basis that it is rarely sensible to say 'never,' we cannot rule out that there may be a situation where there is simply no realistic prospect that the individual will come into contact with anyone (or least no-one not properly equipped with PPE), such that their risk of transmission of COVID-19 is non-existent. However, in general, we suggest that it is legitimate for the relevant professionals to take into account the public health risks in play in determining best interests even in the face of a known desire not to undertake the test.

9. Although the test may be uncomfortable and invasive, in many cases it will be possible to carry out the test in such a way that it cannot sensibly be said that any restraint of the individual will be required.[11] If restraint – which would not necessarily need to involve physical force – is required, then consideration will have to be given as to whether the conditions in s.6 MCA 2005 are met. We note that the conditions include a specific focus upon whether the act in question is necessary to prevent harm to the person[12] (as opposed to others). On one view, this would mean that it would be improper to restrain the person if the primary reason to test them were for the protection of others. In most cases, we consider that it will be possible to advance sufficient reasons related to the person's own interests to satisfy the s.6 test. However, if it is clear that (1) the person will resist requiring the use of force necessary to bring about the test; and (2) the primary reason for testing is for the protection of others (which would be extremely rare), we suggest that consideration should be given either:

   a. To invoking the public health powers set out in the next section; or

   b. To making an application to the Court of Protection.

10. The one caveat to the position set out at paragraph 7 above is where there is proper reason to consider that the process of carrying out the test, itself, would cause the person serious distress

[8] Best interests might include "*altruistic sentiments and concern for others*": see Report on Mental Incapacity (1995) Law Com No 231 at para 3.31; see also *Aintree v James* [2013] UKSC 67 at [24].
[9] See, for the idea of being a responsible citizen, *SSHD v Sergei Skripal; SSHD v Yulia Skripal* [2018] EWCOP 8 and the MCA Code of Practice at paragraphs 5.47-48.
[10] See e.g. *Birmingham CC v SR* [2019] EWCOP 28 at paragraph 41.
[11] This is discussed, along with wider issues, in a webinar about testing recorded in July 2020 for the National Mental Capacity Forum: Webinar recording: Testing, capacity and COVID-19 – shedinar | National Mental Capacity Forum (scie.org.uk).
[12] Section 6(2).

or other harm – for instance if they cannot tolerate a swab being taken. The NHSE-I/DHSC has very detailed guidance in relation to the inpatient mental health setting (in Annex F), which notes that:

> *In assessing the best interests of the patient, clinicians should pay close attention to the risks of attempting to swab someone who is not compliant. As in the case of those with capacity, these risks include traumatising or physically injuring the patient, as well as the difficulty of obtaining an accurate sample without compliance. In light of these risks, it is unlikely that enforced testing will be in the best interests of a potentially infectious, non-compliant patient, though it depends on their particular circumstances.*

11. We suggest that this advice is equally relevant outside the inpatient mental health setting. If it is nonetheless considered that testing should proceed, and if there is no other way of securing testing in an acceptable fashion, we **strongly** advise seeking legal advice about making an application to the Court of Protection.[13]

12. We have been asked whether testing for COVID-19 constitutes serious medical treatment for purposes of s.37 MCA 2005, which would mean that it would be necessary for any NHS body carrying out the test[14] to instruct an IMCA if the person is 'unbefriended.' It is not immediately obvious that a test in fact constitutes 'medical treatment,' but if it does then, ordinarily, it is not obvious that it would fall within the definition of **serious** medical treatment for the purposes of the MCA and the associated regulations. However, if there is a specific reason to consider that the very process of carrying out the test (for instance to overcome any resistance on the part of the person) would be likely to "involve serious consequences for the patient" or "there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail", then it may be that an IMCA should be instructed. In any event, however, and as set out above, this is a situation in which it is suggested that an approach to the Court of Protection is likely.

13. There is a very important corollary to our suggestion that – in the majority of cases – it can be said that testing for COVID-19 is in the best interests of the person – 'P'. That is, that if the test is **positive**, then the steps that are then taken to isolate P are taken in such a way that reflects the principle of least restriction and minimises the impact of any restrictions upon him or her.

14. In some cases, these steps may amount to a deprivation of their liberty and, if they do, lawful authority must be obtained if it is not already in place. The DHSC's Emergency MCA and DOLS guidance addresses this,[15] and, importantly, emphasises (at paragraph 30) that: "*(d) If the reasons*

[13] See the Serious Medical Treatment Guidance issued by the Vice-President in January 2020 ([2020] EWCOP 2).
[14] Not every test will be carried out by NHS bodies. There is therefore a gap in the law in relation to a situation where the test is to be carried out by someone else as the duty to instruct an IMCA would not arise.
[15] But does not address in terms the question of whether, if a person is already lawfully deprived of their liberty (under a DoLS authorisation or under the Mental Health Act 1983), the additional restrictions upon them will amount to an **additional** deprivation of their liberty requiring separate consideration. Alex has discussed this here; note that

for the isolation are purely to prevent harm to others or the maintenance of public health, then [Public Health Officers] powers should be used." In other words, the DHSC is making clear, a DoLS authorisation could not be used in such a situation, and the powers under the Coronavirus Act 2020 would have to be used to bring about the lawful deprivation of the person's liberty arising from their isolation.

D: Capacitous refusal

15. Schedule 21 of the 2020 Act provides public health officers, constables and (in some circumstances) immigration officers with the means to enforce public health restrictions, including returning people to places that they have been required to stay. Where necessary and proportionate, constables and immigration officers can direct individuals to attend, remove them to, or keep them at suitable locations for screening and assessment. If a person is at a place suitable for screening and assessment, paragraph 10 of Schedule 21 provides that a public health officer[16] may (a) require the person to be screened and assessed, and (b) impose other requirements on the person in connection with their screening and assessment.

16. Those requirements may (in particular) include requirements to provide a biological sample or to allow a healthcare professional to take a biological sample by appropriate means.[17] Failure to comply with such a direction without reasonable excuse constitutes a criminal offence.[18]

17. In most cases, being directed (and, as required,[19] being informed of the potential consequences of not doing so) will be sufficient to bring about compliance. But what about the position where the person refuses to comply?

18. We suggest that it is likely to be unlawful to use force to bring about testing in most situations absent recourse to court. The Coronavirus Act 2020 specifically envisages the use of reasonable force in relation to the operation of powers under Schedule 21, but only by a constable or immigration officer in the exercise of a power conferred by the Schedule[20] and a constable or immigration officer cannot carry out testing or obtain a biological sample. Whilst a constable or immigration officer could be present at or outside the testing room to ensure the individual does not abscond from the room, it is difficult to see how they could themselves lawfully deploy reasonable force to bring about the testing itself.

19. We further suggest that it would be challenging to bring the situation within the "*general power*

if the person is already subject to the MHA 1983, they could not be subject to a separate DoLS authorisation providing for their isolation (by operation of Sch 1A to the MCA 2005).
[16] Defined in paragraph 3(2) of Schedule 21.
[17] Paragraph 10(2).
[18] Paragraph 23(1)(a).
[19] Paragraph 11(2)(b).
[20] Paragraph 20(4).

[which exists at common law] *to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm*."[21] Whilst COVID-19 undoubtedly has the potential to cause significant harm, it is not immediately obvious that a failure to consent to a test by a person would give rise to an immediate risk to others in the same way (say) as restraining an individual about to assault another.[22] It would certainly be difficult to see how the common law powers could be relied upon if the person is not in close proximity to others and there is no likelihood of them being in such proximity.

20. The NHSE-I/DHSC has very detailed guidance in relation to the inpatient mental health setting (in Annex F), which notes that:

> *we strongly advise against swab testing in the absence of valid consent from the patient who has the relevant capacity or competence, as carrying out the test without the patient's cooperation is likely to be highly traumatic to the patient and could lead to physical injury. Swab testing, or any other form of invasive test for COVID-19, should not, be undertaken using physical restraint.*
>
> […]
>
> *It may not always be straightforward to tell whether someone is compliant. There may also be cases where a patient has fluctuating compliance, and this should be taken into account when determining whether it is in the patient's best interests to be tested. If a patient switches continuously between compliance and non-compliance, then the dangers associated with non-compliance (trauma, injury and inaccuracy) may be present, and this should be factored into the clinician's decision. Again, the fact that a patient is non-compliant or has fluctuating compliance does not in itself preclude enforced testing. However, it is unlikely that it will be in the best interests of such a patient to be swabbed. An individualised assessment will have to be made. Refer to paragraphs 13.51 and 14.20 of the MHA Code of Practice for guidance on establishing whether a person is objecting and is not compliant.*

21. The Guidance also (we suggest correctly) states that both s.63 MHA 1983 and the implied powers[23] of control "are less likely to extend to testing" – in other words, not only is it not likely to be a good idea clinically, the power to do so cannot be found within the MHA 1983.

22. If, for some reason, and despite all the strong advice to the contrary (which we suggest applies equally outside the inpatient mental health setting), it is considered to be necessary to bring about a test, we note that it might be possible for an application to be made to the High Court for an order

[21] *Munjaz v Mersey Care National Health Service Trust & Ors* [2003] EWCA Civ 1036 at paragraph 46 per Lady Justice Hale.
[22] It might be easier to make this argument if the person was symptomatic, but given that, at that point, the person should be being isolated on the basis of their symptoms alone, it is still a stretch to argue that the failure to consent to the test, itself, is causing the immediate risk.
[23] See *Munjaz* at paragraph 40.

under its inherent jurisdiction specifically to bring about the use of force to test the individual, there being no statutory provision governing this situation. It seems to us that, in principle, and especially given the expansive approach that has been adopted by the High Court to this jurisdiction recently,[24] such an order could be made even in respect of a capacitous adult refusing to undergo a test.[25] It is very likely that the measures taken to enforce the test would amount to a deprivation of liberty,[26] but such could be justified by reference to Article 5(1)(e) ECHR which enables detention for the prevention of the spreading of infectious diseases. The High Court would, though, require considerable persuasion as to why such an intervention – even if necessary – could be said to be proportionate.

F: Useful resources

23. Useful free websites include:

- www.39essex.com/resources-and-training/mental-capacity-law – database of guidance notes (including as to capacity assessment) case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Report, to which a free subscription can be obtained by emailing marketing@39essex.com.
- www.mclap.org.uk – website set up by Alex with forums, papers and other resources with a view to enabling professionals of all hues to 'do' the MCA 2005 better. It has a specific page of resources relating to COVID-19 and the MCA 2005.
- www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.
- www.scie.org.uk/mca-directory/ - the Social Care Institute of Excellence database of materials relating to the MCA.

[24] As to which, see our guidance note.
[25] And we anticipate that the High Court would describe that the adult's refusal was in some way infected by irrationality so as to render it – if not incapacitous – open to doubt. As a matter of practical reality, and even if it should not be the case, we anticipate that this is more likely to be the case where the person is detained under the MHA 1983.
[26] See the Commission decision in *X v Austria* (8278/78, decision of 13 December 1979) in which the Commission held that "enforcing a blood test on a person is a deprivation of liberty even if this deprivation is of very short length" (paragraph 2).

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