MENTAL CAPACITY REPORT: THE WIDER CONTEXT

November 2018 | Issue 90

Welcome to the November 2018 Mental Capacity Report, including from the newest recruit to the editorial team, Katherine Barnes. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an update on the Mental Capacity (Amendment) Bill; sex, risk and public anxiety; and a slew of significant decisions relating to medical treatment;

(2) In the Practice and Procedure Report: Sir James Munby addresses the LAG Community Care Conference and updates from the Court Users Group;

(4) In the Wider Context Report: relevant developments from around the world, including an important decision from Australia reflecting back on practice under the MCA;

(5) In the Scotland Report: a report from the World Guardianship Congress, and the impact in Scotland of an important case concerning disability discrimination and autism.

There is no Property and Affairs Report this month as our editor is having a well-earned break; but he would relay to you if here the frustrating news of the delay to the Law Commission's project on wills.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here.

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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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ENGLAND AND WALES

Litigation capacity – some definite don'ts

Mr & Mrs Z v Kent County Council [2018] EWFC B65 (Family Court (HHJ Lazarus))

Mental capacity – litigation – other proceedings – family (public law)

Summary

This case concerned a wide range of issues in the context of family proceedings which had gone badly wrong, of which for present purposes the most relevant is the issue of litigation capacity. HHJ Lazarus took the opportunity to conduct a detailed review of how this issue should be considered and approach. She noted that the presumption of capacity was not included in the MCA to obviate examination of whether a party to proceedings lacked capacity, and that it could not have been Parliament's intention to place a vulnerable person in danger of their lack of capacity being overlooked at the expense of their rights by a slack reliance on the presumption. The judge considered the relevant guidance and caselaw and noted that while it was usually the case that medical evidence as to incapacity would be required, if it was not possible to obtain an assessment (for example because the party refused to participate), then the court would have to do the best it could on the evidence available to it:

> *t) Such a determination could be based on a careful review of the other relevant material that may be available, such as a report from a clinician who knows the party's condition well enough to report without interviewing the party (if available and appropriate), other medical records, accounts of family members, accounts of the social worker or other agency workers who may be supporting the parent, and occasionally direct evidence from a parent.*
>
> *u) Any such finding made without expert assessment evidence that leads to a declaration of protected party status due to lack of litigation capacity could always be reviewed upon expert evidence being obtained to suggest that the finding was incorrect, and by ensuring that the question of assessment is regularly revisited with the protected party by their litigation friend, their solicitor and the court.*

In the particular case, there had been a failure to assess or determine the issue of the mother's capacity to conduct the proceedings despite her known personality disorder and alcohol misuse, which had led ultimately to the wrong decisions being made for the child.

Having rehearsed the case-law, which she correctly identified as containing some internal tensions, HHJ Lazarus set out what she considered to be obviously impermissible steps that could be found from those cases, namely:

> - *failure to grasp the nettle fully and early,*
> - *ignoring information or evidence that a party may lack capacity,*
> - *purporting to 'adopt' the Presumption of Capacity in circumstances where capacity has been questioned,*
> - *making directions addressing the capacity issue, but discharging them or failing to comply with them and thereby leaving the issue inadequately addressed,*
> - *failing to obtain evidence (expert or otherwise) relevant to capacity,*
> - *use of 'unless' orders,*
> - *similarly, using personal service or 'warning notices' on that party,*
> - *relying on non-engagement by that party either with assessments or the proceedings,*
> - *proceeding with any substantive directions, let alone making final orders, in the absence of adequate enquiry and proper determination of the capacity issue,*
> - *treating a party as having provided consent to any step, let alone a grave and possibly irrevocable final step, where capacity has been questioned but the issue not determined.*

Comment

Although made in the context of family proceedings, the observations of HHJ Lazarus are of wider application, in any proceedings where it becomes clear that there may be an issue as to one party's capacity to conduct them. At that point, the court is into difficult territory, trying to navigate a path which secures competing rights. Those rights are, importantly, competing from the perspective of the person concerned, including balancing the right not to be deprived of legal capacity without a proper process against the right not to have substantive decisions taken in proceedings they cannot, in truth, conduct. The observations made by HHJ Lazarus are useful in identifying what steps cannot be taken at that stage, even if they leave open the question of what can be done.

Children and deprivation of liberty

Another in the growing list of cases considering the application of *Cheshire West* to younger children (in this case 13) can be found in the decision in *Re HC (A Minor: Deprivation of Liberty)* [2018] EWHC 2961 (Fam). Standard orders following those proposed by the former President in *Re A-F (Children)(No 2)* [2018] EWHC 2129 (Fam) have also been approved, although at present appear only to be available behind paywalls. We recall also that these orders do not make reference to the basis upon which the child is deprived of their liberty – is it on the basis of Article 5(1)(d) (educational supervision) or Article 5(1)(e) (unsoundness of mind)? We would respectfully suggest that they need to make this clear, not least to direct the nature of the evidence required.

Short note: the inequities of healthcare for those with learning disabilities

The Institute of Health Equality has published a summary report on A Fair, Supportive Society, commissioned by NHS England, which shockingly highlights that those with learning disabilities will die 15-20 years sooner on average than the general population. Many of the early deaths of people with learning disabilities could be reduced through improved healthcare and preventative actions. Children with learning disabilities are also at increased risk of mental health conditions, including depression; and half of the increased risk of mental health difficulties is attributable to poverty, poor housing, discrimination and bullying.

In response to this appalling state of affairs, the report makes 11 important recommendations:

1. NHSE, with PHE, DHSE, DWP, the Association of Directors of Children's Services (ADCS), HMT, the Home Office and Other Government Departments (OGDs) and stakeholders, should develop an evidence-based integrated strategy that supports households holistically, from identification of a learning disability through to related early years support, and also onwards throughout life.
2. Joined-up working is key. Teams from the above-mentioned departments and others in the community, should integrate to improve outcomes through action on specific social determinants of health for people with learning disabilities. For example, to reduce poverty and simultaneously improve the physical and social environment for people living in deprived areas.
3. To ensure no one is left out, early identification rates should be improved and information-sharing rationalised across all agencies and across registers, such as sharing all age General Practice (GP) Learning Disability registers with local authorities and to inform the education, health and care (EHC) plan process.
4. DfE and Health and Social Care Commissioners should lead the change in the 'choice architecture' by removing unhealthy options at influential institutional settings, such as in hospitals and care settings, to support healthier behaviours for people with learning disabilities, and to

support the parents of children with learning disabilities to do the same.

5. DfE and NHSE should adopt the 'equal right to sight' approach and work together with charities to appropriately design eyesight and hearing tests, administered to all children in special and mainstream schools within their first year of joining.
6. The DfE and NHSE should formally require that specific actions are included in the education, health and care plan process from the beginning, to ensure improved take-up of: appropriate-to-age screening tests, improvements in health behaviours, and improved action on the social determinants of health.
7. DWP and DHSC, with the Joint Health and Work Unit (JHWU), should learn from trials and existing programmes, and work with local authorities and employers to ensure that employment offers for people with learning disabilities are available nationally, and provide stakeholders with a timetable that delivers this as rapidly as possible.
8. The Government, specifically DWP and DHSC, should undertake a systematic review of how it supports people with learning disabilities, ensuring that access to work, homes, benefits, health and care services and education are adequate. A review of the sufficiency of the personal budget for EHC plans is advised, to identify whether or not this is being adequately rolled out to those in most need.
9. PHE, local authorities and NHSE should support coordinated campaigns for greater integration of people with learning disabilities into mainstream society, to reduce discrimination and stigma and support representation. This should include a push towards more inclusion of children with learning disabilities within mainstream schooling. To build on progress made by NHSE, public sector employers should be mandated to provide opportunities for those with learning disabilities, and private sector employers should be incentivised to do the same by supporting apprenticeships for people with learning disabilities.
10. A hearts and minds campaign is recommended, led by a collaboration of learning disability campaign groups close to the cause, to improve attitudes towards people with learning disabilities. This should build on successful campaigns for other minority groups. Alongside this, a review of general attitudes and perceived safeguarding requirements and procedures within professional, community and educational settings may be useful to understand detrimental attitudes towards people with learning disabilities. This work should be evaluated given that there is little evidence regarding effective practice in this area. Further, tougher and more visible punishment of crimes against those with learning disabilities should be considered by the Home Office.
11. Friendship support groups should be made available to all people with learning disabilities. As a part of EHC plans, children and young people with learning disabilities should be linked with friendship groups, and to networks that will support their participation in society. A wellbeing plan for

> adults with learning disabilities should consider not just the medical needs arising from their disability, but also their social interaction needs. Professionals should be required to link people with a learning disability with appropriate friendship support groups.

We very much hope that these recommendations will be taken seriously by the government and implemented quickly. We will keep readers updated on any significant developments.

Older people in care homes: Sex, Sexuality and Intimate Relationships

The Royal College of Nursing has updated its guidance on sexual intimacy and care homes. The new guidance includes frameworks for decision-making and case scenarios, as well as a summary of the applicable legal principles. It is likely to be of particular interest to nurses, care assistants, social workers and care home managers, and can be downloaded here.

Participants wanted!

Amber Pugh, a PhD student at the University of Liverpool, is conducting very timely research on how decisions about sex and contraception involving adults with learning disabilities are made. For more details, and to become involved, see here.

We are always willing to advertise research projects like this – contact one of the editors. We do not charge (or ask for a donation to charity) where the research is being conducted by a university or a charity.

GMC consent consultation

The General Medical Council is consulting on their revised consent guidance. The updated guidance focuses on the importance of communication, personalised conversations, and doctors and patients making decisions about treatment and care together.

The consultation is open until Wednesday 23 January 2019 and there are several ways you can take part.

Full questionnaire for medical and lay professionals: aimed at those with a detailed working knowledge of the policy, practice and law around consent. You'll need to read the guidance to answer the questions.

A survey for doctors and other healthcare professionals: aimed at those with a detailed working knowledge of the issues, but who may not have time to respond to the full questionnaire.

A survey for patients, carers and members of the public: aimed at those who may not be familiar with the GMC guidance, but will have views on good consent practice.

Talking about death

The Royal College of Physicians has published a report entitled: *Talking about dying: How to begin honest conversations about what lies ahead*. As the RCP identify, timely, honest conversations about their future that patients want are not happening. The report begins to highlight and challenge professional reluctance to engage in conversations with patients about uncertainty, treatment ceilings, resuscitation status and death. It includes offer some 'mythbusters' to get physicians thinking and offers signposts to tools and educational resources to support physicians and other healthcare professionals.

Mental Health (Use of Force) Act

The Mental Health Units (Use of Force) Act 2018 which started life as a private members bill by Labour MP Steve Reed has been granted Royal Assent.

Widely referred to as "Seni's Law" in reference to Olaseni "Seni" Lewis who died in 2010 having been restrained by 11 police officer at Bethlem Royal Hospital, the Act makes provision for the oversight and management of appropriate force in relation to people in mental health units and other similar units. It requires mental health units to appoint a responsible person who must publish a policy regarding the use of force by staff who work there (s.3(1)), which must include steps taken to reduce the use of force by staff in the unit (s.3(7)). The Act also provides that each responsible person must publish information for patients at a mental health unit about their rights in relation to the use of force by staff (s.4(1)). As a means of effecting greater scrutiny, the Act also provides that the responsible person must maintain a record of the use of force (s.6(1)) which must include, inter alia, records of the patient's disabilities and mental disorder and whether they suffer from learning disabilities or autism; further, in circumstances where a police officer is going to a mental health unit on duty that involve assisting staff who work there, the police officer must take a body camera if reasonably practicable (s.12).

We congratulate all those involved in taking this Bill through to enactment as a law – and trust that implementation will lead to real changes, as opposed to the mere completion of more paperwork.

Negligence, human rights, murder and the failure to detain

Griffiths v Chief Constable of Suffolk [2018] EWHC 2538 (QB) (High Court (Ouseley J))

Other proceedings – civil

Summary

Ouseley J has examined whether a claim in negligence following a murder committed by an individual whom a mental health trust failed to detain under the MHA could succeed. He concluded ultimately that it could not on the basis that the relevant NHS Trust had not acted negligently in performing its s.2 assessment and that it had had no duty to warn the relevant victim or the police.

The case concerned a claim for damages brought by the three children of Mary Griffiths. Ms Griffiths was murdered by a man John McFarlane after she had made clear to him that she did not wish to have a romantic relationship with him. In the days prior to the murder, Mr McFarlane had attempted suicide. Having been saved by the intervention of friends, he was taken to North Suffolk NHS Foundation Trust where a panel was convened to determine whether he was eligible for admission pursuant to s.2 Mental Health Act 1983. It concluded that he did not meet the criteria for admission on the basis that he was not suffering from mental disorder of a nature or degree which warranted detention and released him. Two days later, Ms Griffiths called Suffolk police complaining that Mr McFarlane was harassing her and she was frightened. The Police offered to send someone round the next morning. A few hours later at 2.40am, Mr McFarlane broke into Ms Griffiths house and murdered her in the street in front of her children.

Ms Griffiths' young daughters pursued a claim under the Fatal Accidents Act 1976 on the basis that her death was caused by the wrongful act, neglect or default of either Suffolk Police or the North Suffolk NHS trust. The daughters also claimed damages under s.8 of the Human Rights Act 1998 alleging breaches of Articles 2,3 and 8 ECHR.

The claim was argued on the basis that the NHS Trust ought to have admitted Mr McFarlance under section and/or to have warned Ms Griffiths and/or Suffolk police that he posed a danger to her; further that having received a worried call from Ms Griffiths, the police should have graded the risk to her as more severe and taken swifter action.

Ouseley J noted that counsel for the claimants "*denied that the allegation was that detention ought to have taken place unlawfully; yet his questions at times came perilously close to such a suggestion, and at least suggested that the issues which the criteria require to be resolved could and should be fudged, where other difficulties were present, such as accommodation or risk*." (paragraph 265)

Having concluded that the s.2 MHA assessment was properly carried out, Ouseley J concluded that there was no expert support for the claim that the NHS Trust breached its duty of care towards Mr McFarlane.

With regard to the duty of the various statutory bodies towards Ms Griffiths, Ouseley J engaged in an analysis of the notoriously difficult area of proximity in tort law – though interestingly it appears that this case was not pleaded and therefore did not address the possibility of Ms Griffiths children as being secondary victims to her murder (ie as suffering from what was formerly referred to as "nervous shock").

Ouseley J identified the key issues as control over the malefactor with proximity to the victim, and the existence of a positive duty to safeguard someone and noted at paragraph 446 that "a duty to warn does not exist without some relationship between both the person being warned, and the person about whom the warning is given. The special relationship between defendant and wrongdoer [is] not the only relationship which mattered because there also had to [be] a relationship of proximity between the defendant and the person injured."

On whether there was sufficient proximity between Ms Griffiths and the NHS Trust for a duty of care to arise, Ouseley J held that there was not. He noted that once Mr McFarlane was discharged from hospital, having been deemed not to meet the statutory criteria for admission – an assessment which Ouseley J had already concluded was not negligent – the issue of whether or not Mr McFarlane was in the "control" of the NHS Trust became more complicated.

Ouseley J held that:

> *if the panel foresaw or should reasonably have foreseen the risk of Mr McFarlane murdering her or assaulting her in a way which breached Article 3, serious physical assault, the law would in my judgment impose an obligation to safeguard her by taking steps such as warning her or alerting the police. I consider that that duty would have arisen whether or not he had been sectioned or*

> *admitted voluntarily. The gravity of the risk would be sufficient to impose such a duty; a good measure of that point is that it would be at the point at which the duty of confidentiality to the patient was overridden by the public interest in the avoidance of risk to others* (para 459)

However, Ouseley J concluded on the facts of the case that there was no basis upon which the panel could have foreseen that Mr McFarlane might murder Ms Griffiths, holding at paragraph 462 that:

> *The facts are not such as to impose responsibility for protecting Ms Griffiths on the NHS Trust. When it comes to the legal imposition of responsibility, the fact that the potential victim is aware of all the relevant behaviour tells against it with some force, especially, as here, if the NHS Trust has nothing of significance to add to what she knows. Nor did Ms Griffiths, in my judgment, come into the category of a victim vulnerable through disability or mental capacity or state, in respect of whom a warning should be given to the police, rather than to the potential victim."*

With regard to the Human Rights Act claims Ouseley J noted (at 472) the *Osman v UK* (1998) 29 EHRR 245 basis for the state's protective duty towards a potential victim and its conclusion that "*the positive obligation* [arising under Article 2 ECHR] *should not be applied in such a way as to impose impossible or disproportionate burdens on the authorities. Not every claimed risk to life could entail an obligation to take operational measures to prevent it. To prove a violation of that positive obligation to prevent and suppress offences against the person, in the context of Article 2*, [116] : "*… it must be established…that the authorities knew or ought to have known at the time of the existence of a real and immediate threat to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk….*"

Ouseley J at paragraph 504 further concluded that no Article 8 claim could arise given the failure of any claim pursuant to Articles 2 and 3.

> *even if the operational duty in these circumstances could impose an obligation to take reasonable steps to protect Ms Griffiths against stalking, harassment or sexual assault, and could lead to a breach of the duties under Articles 2 and 3, because such steps might have in fact prevented the murder, albeit unintentionally and unforeseeably, there was no breach. That risk was not foreseen nor ought it to have been. There were no steps which the assessors ought to have taken which they failed to take. It is at the very least debatable what nature and degree of the risk would permit patient confidentiality to be breached, and how the knowledge of the potential victim of the relevant facts would affect that duty. In my judgment, nothing short of knowledge of the position as at the time the police were phoned on 5 May, and of how Ms Griffiths then saw matters, could have produced any obligation, and the likeliest would have been to alert the police. But that situation did not arise.*

Ouseley J noted the severity of the level of failure in operation or in a system necessary to constitute a breach of the protective duties in either Articles 2 or 3 (paragraph 619), none of which arose in the case. Even though there was clearly a risk of harassment and stalking to Ms Griffiths of which Suffolk Police were aware,

> *there was nothing to suggest that it was an imminent risk, against which measures were required that night. So if there were a protective duty in relation to such a risk, which could arise under Article 8, the Suffolk Police did not breach it in their response, by grading the call as 3, and ringing back at 21.43 and acting in reliance upon what Ms Griffiths said. I do not accept that a breach of Article 8 can be raised where Articles 2 and 3 were not breached, nor that Strasbourg jurisprudence permits a breach of Articles 2 or 3 to be based on a failure to take steps which an Article 8 duty would have required, where no breach of Articles 2 or 3 was or should have been foreseen* (parah 620).

Comment

This is a tragic case and it is in the context of its extreme facts that Ouseley J dedicates over 600 paragraphs to analysis of the rights and duties at play. Given the conclusions as to the appropriateness of the s.2 Mental Health Act assessment however, the ultimate conclusion that there was no breach of duty is, in the context of existing tort law and Strasbourg jurisprudence, unsurprising. It is an important case, however, in terms of confirming that it is always necessary to consider what the relevant individuals knew or ought to have known at the time, and not to superimpose hindsight through the operation of the 'retrospectoscope' that can all too often be deployed.

OVERSEAS DEVELOPMENTS OF RELEVANCE

Capacity, ECT and comparative law

PBU and NJE v Mental Health Tribunal [2018] VSC 564 (Supreme Court of Victoria (Bell J))

Mental capacity – assessing capacity – medical treatment – other proceedings – other

Summary

This significant judgment of the Supreme Court of Victoria, Australia, concerned two patients for whom electro-convulsive therapy ('ECT') was proposed. PBU did not agree that he had schizophrenia but accepted that he had mental health problems, namely depression, anxiety and post-traumatic stress disorder. He was willing to receive psychiatric and psychological treatment for those conditions but not ECT or anti-psychotic medication or treatment. He wished to be discharged from hospital to a prevention and recovery facility and then return home. The detaining hospital considered him to be too unwell for discharge and instead sought the authority of the tribunal to provide ECT on the basis that he lacked capacity to make the relevant decision. NJE suffered from treatment resistant schizophrenia. She wanted to remain in hospital and continue to receive depot and other prescribed medication but the tribunal found that ECT provided the best chance of addressing her symptoms.

At first instance, the tribunal decided that each patient could understand and remember relevant information and communicate a decision in relation to ECT but could not use or weigh that information. It found that each patient lack capacity to give informed consent and that, in the absence of any less restrictive alternative, ordered a course of ECT to be given. On appeal, Justice Bell found that the tribunal had erred in law. It was wrong to conclude that a supposed lack of insight was determinative of PBU's lack of capacity. And requiring NJE to give "careful consideration" to the advantages and disadvantages of ECT set too high a threshold of capacity which was discriminatory. Accordingly, the tribunal decisions were quashed.

The judgment is of particular relevance to the law in England and Wales as the Australian statutory provisions being considered are similar to those in the Mental Health Act 1983 and the Mental Capacity Act 2005. That is, a detained patient with the relevant capacity cannot be compelled to have ECT. Before analysing particular areas of legal interest, it may be helpful to tailor to our domestic law some of Justice Bell's summary of relevant principles (para 206):

1. Providing treatment for mental illness is to be done in a manner that affords equal respect for patients' human rights and particularly their right to self-determination, to be free of non-consensual medical treatment and to personal inviolability.

2. There is a (rebuttable) presumption that people with mental illness (as for people without that illness) have the capacity to give informed consent which is issue-specific, can fluctuate, and may be enhanced with support, all of which may have significant implications for the capacity-assessing process and the ultimate determination.

3. The test of capacity is a functional one in which the question is whether the person has the ability to understand, retain, use and weigh relevant information and communicate a decision; not whether the person has actually done so. The purpose of the functional test (as distinct from a status or outcome-based test) is to ensure that, in relation to capacity to give informed consent, people with mental illness are afforded the same respect for their inherent dignity and autonomy-space as people not having that illness.

4. The capacity test must be applied in a non-discriminatory manner so as to ensure that people with mental illness are not deprived of their equal right to exercise legal capacity upon the basis of contestable value-judgments relating to their illness, decisions or behaviour, rather than upon the basis of the neutral application of the statutory criteria. In short, the test is not to be applied so as to produce social conformity at the expense of personal autonomy.

5. The right to make unwise decisions recognises that self-determination is important for both dignity and health and that people with mental illness should have the same dignity of risk in relation to personal healthcare decision-making as other people. This reflects the two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and personal health and wellbeing on the other.

6. Those assessing capacity must vigilantly ensure that the assessment is evidence-based, patient-centred, criteria-focussed and non-judgmental, and not made to

depend, implicitly or explicitly, upon identification of a so-called objectively reasonable outcome.

7. The threshold of capacity is relatively low and the person need only possess the functional abilities in respect of the salient features of the decision.
8. Acceptance of, belief in and insight into the diagnosis of illness and need for treatment varies significantly depending upon the person and the situation. It is not a normative criterion. Depending upon the facts of the case, a person with mental illness may lack that insight or otherwise not accept or believe that the person has a mental illness or needs treatment yet may have the capacity to give informed consent when assessed under the statutory test. The opposite may be so.

With that overview, we focus on two specific issues that arose in the case before him, but are of equal difficulty and importance in consideration and application of functional tests of capacity like the MCA 2005.

Capacity and insight

Analysing the Mental Capacity Act 2005, Justice Bell noted the absence of a belief requirement which had appeared previously at common law in *Re C* [1994] 1 WLR 290, 292 (the gangrenous leg case). He went on to consider the relevance of belief and emphasised that in *Re C,* Thorpe J had referred to how the patient "*in his own way* [C] *believes it*":

> *190. … Thus Thorpe J appears to have approached the matter by considering the extent to which the person could weigh or use the information. In other words, his Honour has taken belief and insight in respect of the diagnosis and treatment into account not as a criterion (a normative consideration) but as a factual consideration.*

It followed that a lack of insight was not necessarily indicative of a lack of capacity: "*A person who lacks insight may, not must, be lacking in capacity*" (para 193) and Justice Bell went on to observe:

> *194. Insight into one's diagnosis and need for treatment varies significantly between different persons and between the same persons in different situations. Insight is potentially affected in nature and degree by various non-capacity influences, including educational background, language proficiency, familiarity with medical issues and family and social relationships (negative and positive) and (often critically) the availability of appropriate support. For these reasons, it is but one of the factual considerations that may be relevant when assessing capacity to give informed consent. As disability law scholars have written:*
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>> *A lack of insight may impact a person's ability to understand [or use or weigh] relevant information, but the presence or absence of insight is not a proxy for the presence or absence of decision-making capacity. Insight is an extremely complicated phenomenon that is rarely either simply present or absent. Various aspects of insight — such as insight into diagnosis, insight into the presence or veracity of phenomenology and insight into the need for treatment — may all*

> *vary independently.*[1] *This, in combination with the requirement that a person only needs to understand information that is relevant to the decision being made, means that while a lack of insight may suggest a lack of decision-making capacity, this deficit alone will rarely be determinative.*[2]

195. The way in which lack of belief or insight in respect of the illness and the need for treatment is considered when assessing capacity is a matter of importance to people with mental disability. This is because it is not uncommon, for various personal, social and medical reasons, for a person with mental disability to deny or diminish the illness and the need for treatment, or to choose non-advised treatment.[3] *Nor is it uncommon, for various personal, social and medical reasons, for persons not having mental disability to deny or diminish illness or the need for treatment, or to choose non-advised treatment. In neither case does this mean of itself that the person lacks capacity. …*

198. In conclusion, it may be accepted that the presence of delusional thinking and irrational fears is '<u>*capabl*</u>*e of depriving a person of capacity. The question is whether it does'.*[4] *So may it be accepted that lack of belief or insight in respect of a mental illness or need for treatment may be capable of supporting a finding of incapacity. The question is whether it does. This means giving due consideration to a relevant fact, not (in effect) applying a determinative normative criterion…*

227… [T]*o rebut the presumption of capacity, it is not sufficient to find that a person does not accept or believe the diagnosis that the person has a mental illness or that the person has no insight into the need for treatment. According to the statutory criteria, a person may not have that acceptance, belief or insight yet may have capacity to give an informed consent, although these matters may be factually relevant in the overall consideration. This is important if the capacity criteria and are to be applied in a manner that is non-discriminatory towards and respects the autonomy space of people with mental illness…*

231. It is of the first importance that the test of capacity … is applied in a way that does not discriminate against people with mental disability upon that ground, implicitly or explicitly. For anybody, mentally disabled or not, non-belief or

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[1] Kate Diesfeld, 'Insight: Unpacking the Concept in Mental Health law' (2003) 10 *Psychiatry, Psychology and Law* 63; Yuval Melamed et al, 'Insight and Competence to Consent to Psychiatric Hospitalization' (1997) 16 *Medicine and Law* 721; TE Smith et al, 'Insight and recovery from psychosis in chronic schizophrenia and schizoaffective disorder patients' (2004) 38 *Journal of Psychiatric Research* 169.

[2] Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The capacity to refuse psychiatric treatment: A guide to the law for clinicians and tribunal members' (2015) 49 *Australian and New Zealand Journal of Psychiatry* 324, 328.

[3] See, eg, *Re SB v (A patient: Capacity to consent to termination)* [2013] EWHC 1417 (COP) (21 May 2013) [15] (Holman J); *Heart of England NHS Foundation Trust* [2014] EWHC 342 (COP) (17 February 2014) [9] (Peter Jackson J).

[4] *Cooper* [2009] 1 WLR 786, 1794 [28] (Baroness Hale, Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing); this conclusion was reached after an analysis that included consideration of *Re C* [1994] 1 WLR 290, *Re MB* (1997) 2 FLR 426 and *NHS Trust* [2005] 1 All ER 387: at 1793 [24].

> *non-acceptance of a diagnosis and lack of insight into the need for treatment would not be a sufficient basis for rebutting the presumption of capacity at common law (see above), and it is not under these provisions. As discussed, for a variety of reasons, people have deficiencies of belief, acceptance or insight in relation to the need for medical treatment that to others defy reality. Out of respect for the diversity of humanity and the dignity of risk, the capacity of people not having mental disability is not denied for that reason alone, and it would be discriminatory to deny people with mental disability the same respect. Giving that respect is consistent with ensuring the equal right of people with people with mental disability to self-determination, to freedom from non-consensual medical treatment and to personal inviolability.*

Objectivity when assessing capacity

Developing the need to avoid the protection imperative so as to maintain objectivity when determining someone's ability to decide, Justice Bell noted:

> *167. It has been said that capacity assessments are inherently risky, uncertain and 'epistemologically fallible',[5] driving many capacity assessors to the apparent safe ground of the 'reasonable' outcome as an implicit default criterion. One can understand the natural human tendency of health professionals and judicial officers, among others, to make decisions in the best interests of vulnerable persons, especially where treatment for grievous ill-health, or even the person's life, is at stake.[6] It has been described as the 'protection imperative'.[7]…*
>
> *169. Moreover, in relation to something as personal as whether a person should consent to or refuse medical treatment, it is problematic to suggest that one person can necessarily determine that another person's decision is objectively unreasonable: a decision to consent to or refuse such treatment may be so subjectively anchored in the individual values, relationships and life's experience of the person as to make it difficult for another even to comprehend the decision; or even if properly comprehended, it may be so subjectively anchored in those respects as simply to defy objective characterisation at all. This is so whether the person has capacity to consent or refuse or not.[8]…*
>
> *172.… The judgment of MacDonald J, and those of Peter Jackson J in Heart of England NHS Foundation Trust[9] and Wye Valley NHS Trust v B[10] and the plurality in Starson v Swayze,[11] all concerned with highly eccentric individuals, are notable for applying the capacity test in a way*

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[5] Mary Donnelly, *Healthcare Decision-Making and the Law* (Cambridge University Press, 2010) 116.

[6] *PH v A Local Authority* [2011] EWCOP 1704 (30 June 2011) [16(iii)] (Baker J) ('*PH*').

[7] *A University Hospital NHS Trust v CA* [2016] EWCOP 51 (8 December 2016) [19(8)] (Baker J); see also *PH* [2011] EWCOP 1704 (30 June 2011) [16(iii)] (Baker J).

[8] See further Emily Jackson, 'From "Doctor Knows Best" to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions about Their Medical Treatment' (2018) 81(2) *Modern Law Review* 247, 263–4.

[9] [2014] EWHC 342 (COP) (17 February 2014).

[10] [2015] EWCOP 60 (28 September 2015).

[11] [2003] 1 SCR 722 (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ) ('*Starson*').

> *that is criteria-focused, evidence-based, patient-centred and non-judgmental.*

In NJE's case, the tribunal was concerned that she was spending several nights per week without sleep because she was working with psychic healing powers. But it did not relate this to the statutory criteria regarding capacity. Justice Bell held:

> *242. A person may be frequently active and awake at night due to a desire to work with psychic healing powers. This may or may not help to support a finding that the person does not have the ability to use or weigh relevant information. It is important to determine capacity by reference to the statutory criteria, which are based on domains of cognitive functioning, not by reference to decisions or behaviours, which give rise to contestable value judgments. Variation in human behaviour is normal and not necessarily a sign of lacking the capacity to give informed consent. Normal people often believe what to others is extraordinary. Being frequently active and awake during the night is not unheard of in the general population. Many people believe in the power of prayer to heal either individuals or humanity, and actively stay awake at night (sometimes all night) praying with that belief. Some people believe they can heal others by touching or be healed themselves by bathing in or drinking sacred water, and touch others or bath in or drink those waters with that belief. Psychiatric evidence may establish that the belief or behaviour is delusional. Even then, the person may be able to use or weigh relevant information in relation to ECT (and the subjective value of the belief or behaviour to the patient must count in determining whether there is no less restrictive way to treat the patient, having regard to the patient's views and preferences, where this is reasonable…). The capacity assessment needs to go into the relationship (if any) between the delusion and the ability to use or weigh the relevant information, for that is what the statutory criteria and respect for human rights requires.*

Comment

This judgment is catnip for capacity geeks like the editors (and we also note with pleasure that it specifically cites from research conducted by our Scottish contributor, Jill Stavert). It provides a fascinating, detailed summary of relevant academic opinion and case-law from around the globe, including extensive consideration of Court of Protection judgments. Extracts will – spoiler alert – undoubtedly be festooning forthcoming editions of the Court of Protection Practice and the Court of Protection Handbook (and have already made their way into a skeleton argument at appellate level here). In addition to the extracts that we have concentrated on here, the judgment also contains an important summary of the state of the current art as regards the place of mental capacity in the context of the CRPD, which will be equally useful in informing these debates as they continue to roll around the globe.

Mental health and human rights – international developments

An extremely helpful systematic review has been published by the University of Melbourne of global practices that aim to reduce, prevent and end coercive practices in mental health settings. It was commissioned by the United Nations to inform a report of the United Nations Special

Rapporteur on the Rights of Persons with Disabilities. In similar vein, a report by the United Nations High Commissioner for Human Rights on mental health on human rights has recently also been published (on 24 July 2018, but only made available more recently), reporting on a consultation on human rights and mental health held in Geneva on 14 and 15 May 2018. It contains a summary of the discussions, as well as conclusions and recommendations from the consultation.

International Journal of Mental Health and Capacity Law

The most recent edition of this has now been published, and (abusing editor's privilege, Alex being one of the editorial team), we reproduce the editorial:

> *There is an Antipodean theme to this, the fifth issue of the Journal in its new guise. As editors, we were delighted that a paper published in the fourth issue provoked a reaction from the President of the Tribunal whose work was under scrutiny. Christopher Maylea and Christopher James Ryan's article 'Decision-Making Capacity and the Victorian Mental Health Tribunal' ([2017] International Journal of Mental Health and Capacity Law 87) had proposed an interpretation of how the Mental Health Act 2014 in Victoria, Australia, should work, before turning to two empirical studies which analysed the decisions of the Statements of Reasons of the Victoria Mental Health Tribunal to gain some appreciation of how the Act was working. Maylea and Ryan argued that the Tribunal had an obligation to consider the assessment of a compulsory patient's decision-making capacity when determining whether or not to make a compulsory Treatment Order, and that the Tribunal was falling into error by not meeting this positive obligation to take this matter into consideration.*
>
> *The President of the Tribunal, Matthew Carroll, in a rejoinder published in this issue, suggests that this criticism was based on: a fundamental misinterpretation of relevant law, a misunderstanding of the processes of the Tribunal, and a lack of sufficient recognition of the distinctive features of the legislation that establishes the Tribunal and its processes. Carroll further suggests that Maylea and Ryan generated a misconception that by not focusing on their decision-making capacity, the perspectives of mental health consumers are not being considered as part of Tribunal hearings in Victoria.*
>
> *So as not to leave readers in suspense, this issue also contains a response by Maylea and Ryan, to the effect, broadly, that the President's understanding of the way that the Tribunal should operate is understandable, but does not, in their view, reflect the best reading of the legislation. Many may wish to follow their suggestion of returning to the analysis presented in their original paper and review it in light of Carroll's criticism. Should the President wish to continue the debate, the pages of the Journal are firmly open, and the editors would be delighted to facilitate further debate on what is undeniably a very important, yet perhaps, penumbrous topic within the Tribunal jurisdiction.*
>
> *Next is a stimulating article by Bennetts, Maylea, McKenna and Makregiorgos on the 'tricky dance' of advocacy, a study of non-legal mental health advocacy in*

> *Victoria, Australia. The article serves the useful purpose both of reviewing some of the underpinning drivers and models of advocacy in the context of the Convention on the Rights of Persons with Disabilities ('CRPD'), and describing the application of the model of non-legal representational advocacy within the Victorian context, drawing on indepth qualitative interviews with advocates and other key stakeholders. The authors state that this is not an evaluation of this model or its impact, but rather a descriptive illustration of its intent and approach. This is exactly the sort of illustration which is required to flesh out what can otherwise become sterile exchanges of slogans.*
>
> *We then have a review paper by Piers Gooding on recent United Nations activity concerning Article 19 CRPD. As Gooding highlights, Article 19 produces an unusual consensus: " commentators across the spectrum – from those who see a role for coercion and substituted decision - making, to those who think they should be eliminated – appear to agree on the need for more resources for people with intellectual, cognitive and psychosocial disabilities to exercise their right to live independently and participate in the community ." In the personal experience of one of the editors (Ruck Keene) on the independent review of the Mental Health Act 1983 in England and Wales under way at the time of writing, this consensus is not merely shared by commentators, but also by those seeking to take forward law reforms in this area. Gooding's article, therefore, serves the invaluable purpose of placing the recent 'General Comment' No. 5 (August 2017) on Article 19 in its context, summarising its content, and critically analysing its key provisions. Remaining focused on the CRPD, the final paper relates to an entirely different part of the world and is a valuable spotlight on a jurisdiction based on a mixture of civil law and Shari'a law. Patricia Cuenca Gómez, María del Carmen Barranco Avilés and Pablo Rodríguez del Pozo review the provisions of Qatari law relating to deprivation of liberty in the context of psychosocial disability in the light of the CRPD. They find the provisions substantially lacking, and propose reforms to ensure that persons with psychosocial disabilities enjoy the right to liberty on equal terms with others.*

Submissions to the journal are always welcome: details can be found here.

A Standing Inquiry Into Abuse and Neglect of Vulnerable Adults: Learning from New South Wales

"Atrocious" neglect and abuse

In Australia an important report from a recent standing inquiry ('the inquiry') went to the New South Wales ('NSW') Parliament calling for more action to protect adults with disability from abuse and neglect in community settings, including within family homes. *Abuse and neglect of vulnerable adults in NSW – the need for action*, published on 2 November 2018, was presented by the NSW Ombudsman including a finding that

> *…the inquiry has identified highly vulnerable adults who are living in atrocious circumstances, and experiencing serious and ongoing abuse and neglect.*

These are just three examples of what was reported to the NSW Ombudsman during their recent inquiry:

> *A young woman with intellectual and physical disability who is unable to verbally communicate and relies on a feeding tube for nutrition lives at home with her mother and her mother's partner. The mother uses cable ties, a dog leash and sheets to tie the young woman to her wheelchair and bed. The mother terminated the services of a previous disability in-home support provider who made a report to police about her restraining the young woman and leaving her alone in the house for the evening while she went out.*
>
> *A young man with intellectual disability lives at home with his parent. He shows signs of neglect, including poor hygiene, weight loss, and limited access to food. He has unexplained bruising, does not have access to medical treatment for his health issues, his parent has stopped him from seeing his psychiatrist, and he turns up to his day program in a sedated state. The young man does not have any access to his own money, and it is suspected he is exposed to domestic violence and drug use in the home.*
>
> *[A] young man lived in a converted garage at the back of his family's house, and the neighbour reported that the young man was left at home unsupervised and extremely distressed for most of the day. The young man was observed to wander the backyard for hours, slapping his face, biting himself, crying out, and banging on the door to the main house. The man's family was seen by the neighbour to hit him with a broom to move him away if he approached visitors to the home.*

Background and mandatory reporting

In 2014 legislation in NSW introduced the *Disability Reportable Incidents* scheme requiring the Department of Family and Community Services (FACS) and funded disability providers to notify the *NSW Ombudsman* "of serious incidents of abuse, neglect and ill-treatment of people with disability living in supported group accommodation". NSW has led the way in the mandatory reporting and independent oversight of the abuse and neglect of people with disability in disability accommodation settings.

From 2015, as the numbers of contacts with the NSW Ombudsman about these matters increased, "*coinciding with the progressive withdrawal of FACS from the provision of specialist disability services*" the decision was taken to commence a standing inquiry; it reflected "the seriousness of the matters that were being reported" to the NSW Ombudsman, and the fact that no other agency has "*the powers to adequately investigate these types of allegations.*"

Reports to the inquiry

Between August 2015 and October 2018, the NSW Ombudsman received 358 contacts relating to the alleged abuse and neglect of adults with disability living in community settings. 206 reports did not relate to the conduct of service providers but were about "*the conduct of the person's family and other informal supports, and members of the community.*" Of the 206, just under a third were referred to the inquiry via the National Disability Abuse and Neglect Hotline and the rest via reported external agencies or individuals. Most of the allegations were of abuse and/or neglect by family members including partner/ spouse, parent or sibling.

Two of the limits of the inquiry

The scope of the NSW Ombudsman's inquiry was limited to "*adults with disability who receive, or are eligible to receive, community services*" and therefore could not include all vulnerable adults; for example many incidents of elder abuse did not fall within these limits. The report notes that there is a NSW Elder Abuse Helpline and Resource Unit funded by FACS but its function is to support rather than investigate or coordinate cases management. Another key limit of the inquiry was that the NSW Ombudsman had no power to enter private residences to gain direct access to the alleged victim and the information they obtain is not necessarily admissible in legal proceedings.

A new body and new legislation?

The inquiry found that there was *"horrendous abuse occurring in family homes and other community settings*." The report provides powerful evidence in support of the recommendation of the NSW Law Reform Commission for a Public Advocate to *"(among other things) investigate – of its own motion or in response to a complaint – cases of potential abuse and neglect of people who need decision- making assistance*." It also calls for new law to enable inter-agency information sharing and supported decision making and further review to find ways to strengthen the NSW system for protecting vulnerable adults.

The inquiry concluded that there needs to be "*swift action to establish a comprehensive adult safeguarding approach that will both fill the looming gap in relation to adults with disability, and address the longstanding gap in relation to vulnerable older persons*."

New guidance for people who interview vulnerable adults

In 2016 I spent two months in New South Wales to help set up a witness intermediary scheme based on the English model. NSW went one step further than any other jurisdiction has so far and introduced witness intermediaries at the same time as pre-recording of cross-examination (Cooper, 2016) and the scheme has been very positively, independently evaluated (Cashmore et al., 2017). NSW legislation does not, as yet, extend intermediaries to vulnerable adults, however the importance of research-informed questioning techniques (see for example my latest research publication and The Advocate's Gateway) is already being realised in NSW.

I have been working for some time with the NSW Ombudsman to create an evidence-based guide to interviewing people with cognitive disability and communication support needs. It forms part of the NSW Ombudsman's Rights Project for people with disability which was funded by FACS.

> *It is critical that concerted and ongoing efforts are made to maximise the ability of more vulnerable members of the community, including people with cognitive impairment, to be able to speak up about abuse and other unacceptable situations.. it does a disservice to vulnerable adults to provide information about how to exercise their rights without ensuring that appropriate supports are in place to help them to do so, and that services are adequately prepared and equipped to respond.*

The Guide is intended to give disability workers and investigators tasked with responding to allegations and complaints, advice about how to obtain the best evidence from people with cognitive impairment, particularly those who are the subject of, or witnesses to, alleged abuse. The Guide covers:

- how to remove barriers to effective participation in an interview by making reasonable adjustments
- conducting a pre-interview assessment – gathering key information about the interviewee and assessing issues such as ‘capacity’ and ‘competence’
- the impact of trauma on communication and how to manage this
- critical steps in interview planning and preparation
- assistance with communication and support for the interviewee – the role of support people; communication assistants, such as intermediaries; interpreters and using communication aids
- strategies for rapport building
- factors to consider in choosing the right time and location for the interview, and the right interviewer, and
- obtaining an account – questioning techniques and things to avoid

I hope that that this guide will be put to practical use in the United Kingdom. We share New South Wales’ desire to improve the ways in which we enable vulnerable adults to be heard and to exercise their rights. The Guide is due for release within months and an update for readers will follow.

Penny Cooper, PhD
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[*Penny’s academic research projects at Birkbeck, University of London, include studies funded by the Nuffield Foundation and the AHRC about the participation of witnesses and parties, including P in the Court of Protection. Penny’s forthcoming book, Access to Justice for Vulnerable People, edited with Linda Hunting will be available in December from Wildy & Sons Ltd.*]

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Conferences

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 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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