

# Hope and Stigma

Catherine Harper



# Silent Justice

## Dr Margaret du Feu



# Capacity Assessment of a Deaf Man charged with criminal damage

- Previous long history of petty offending
- Fitness to plead never considered.





## Communication Receptive / Expressive

- Residual hearing/aids/implants
- Literacy
- Sign language /interpretation



## Cause of Deafness

- Cognitive assessment
- Education and General Knowledge








# Scenario – General Adult

- 35 year old male
- Paranoid Schizophrenia
- Disengaged from services
- Non-concordant with medication
- Misusing cannabis
- Family call to say he is very paranoid and threatening to kill his father
- Refusing admission to hospital on a voluntary basis

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- Who does the initial assessments in the community to decide if he meets criteria for involuntary treatment under Mental Capacity Act?
  - What are the options open to the initial assessors?
  - Assuming he's detained in hospital - what are the next steps?

# Community Detention

- Short term detention authorisation – detention to hospital for examination and / or treatment
- Up to 14 days initially
- Can be extended for a further 14 days
- Done by “appropriate healthcare professional”
  - social worker
  - medical practitioner (not necessarily psychiatrist)
  - nurse / midwife
  - psychologist

# Community Detention

- Criteria for authorisation
  - P has / suspected to have an illness
  - Prevention of serious harm condition is met
  - P lacks capacity in relation to the detention
  - It would be in P's best interests to be detained
- Illness - a disorder, disability or injury that requires treatment or nursing if it, or any of its symptoms or manifestations, could be alleviated or prevented from worsening by treatment or nursing

# Community Detention

- In an Emergency, if the risk of harm outweighs the time needed for the safeguard, then can leave the safeguard until later
- So CPN can fill out the short-term authorisation at home in this example
- In emergency, do not have to speak to Nominated Person re best interests
- So no requirement to consult ASW
- Safeguards are on arriving at hospital, rather than at home as now
- The Act does not regulate who does it
- There has to be an assessment of capacity, but not a formal one


# Initial Hospital Detention

- Short-term detention authorisation form
- Statement of incapacity
- Best interests determination statement
- Prevention of serious harm condition statement
- Consultation with nominated person
- Independent mental capacity advocate report
- Approved social worker information
- Medical report
- Statement re capacity to apply to Review Tribunal
- Admission Report - RMO or someone of same level

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- He refuses all meds as an inpatient and requires restraint and rapid tranquillisation after an episode of aggression in the ward

# Restraint

- Restraint and administration of medication can happen without safeguards
- Restraint in the Act allows reactive restraints
- No form required
- Document a risk assessment to determine the need and appropriateness of any restraint

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- After a further period of aggression, he requires to be moved from an open ward to a PICU- where he requires a period of seclusion

# Transfer to PICU

- No additional forms / safeguards required – unless being transferred to different hospital


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- After 2 weeks, it's decided to put him on a depot, which he refuses

# Depot Treatment

- Short term detention is for assessment and treatment
- Depot is a treatment of serious consequences
- If Nominated Person does not object - no authority is required
- If Nominated Person does object - need Trust Panel authorisation
- Capacity is informally assessed at all times, formally assessed every 14 days
- After 4 weeks, if he still needs detained - Trust Panel authorisation required

# Depot Treatment

- Trust panel authorisation – additional safeguard for the most serious of interventions
- Trust panel make decision to grant or refuse application within 7 working days
- Required for
  - Treatment with serious consequences and nominated person reasonably objects
  - Detention amounting to deprivation of liberty
  - Attendance requirement
  - Community residence requirement

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- 6 weeks later, he's a lot better, but the team want him to go to a supported living unit and continue on depot - he is reluctant to do either.

## Attendance / Community Residence Requirements

- If he lacks capacity - consider an Attendance Requirement with depot a treatment condition
- Requires an individual to attend a certain place at certain times or intervals for certain types of treatment
- Requires receipt of treatment condition – that failure to impose the requirement would more likely than not result in P not receiving the treatment
- Trust panel authorisation valid for max 6 months, then extended for 6 months, then 1 year at a time – can be challenged at Review Tribunal

# Attendance / Community Residence Requirements

- Community Residence Requirement – imposes on a person the requirement to live and reside in a particular place
- May also include a requirement to allow a healthcare professional access to the person
- Can never amount to a Deprivation of Liberty
- P allowed to leave, but not allowed to reside anywhere else

# Intoxication and risk: Capacity Legislation – to use or not to use

Dr Helen Toal



# Senario

- ▶ Referral to the Addictions service for assessment and management of a patient misusing a combination of drugs and alcohol
- ▶ Referred from the crisis response team where the patient had presented 2 days ago feeling agitated and with suicidal thoughts
- ▶ Alcohol and drugs were thought to contribute greatly to the presentation of this gentleman and a safety plan was agreed and a referral to the addictions service made

# Assessment

- ▶ On presentation with the addictions service it is clear the patient is under the influence of substances
- ▶ He is reluctant to take part in the full assessment and continually requests that the help he needs is to be prescribed diazepam and pregabalin

- ▶ The key worker makes all efforts to deescalate the situation and to complete a full substance misuse and mental health assessment
- ▶ The patient becomes more agitated, becomes somewhat demanding, raising his voice and continually asking for help in the form of a prescription
- ▶ He eventually states 'if I am not given the help I need, I am going to lose it and take an overdose'

- ▶ He is highly aroused, disinhibited and intoxicated
- ▶ He is potentially putting staff and himself at risk
- ▶ His family are worried about his behaviour and are asking for help

# Do we use capacity legislation in this scenario??

- ▶ For detention under the MCA (NI), 3 criteria must be met;
  1. *The patient lacks capacity in relation to detention*
  2. *Detention is in the best interest of the patient*
  3. *Prevention of serious harm condition is met*

# *1. The patient lacks capacity in relation to detention*

- ▶ Are drugs and alcohol causing a disturbance in his brain or mind such that this patient lacks capacity?

## *2. Detention is in the best interest of the patient*

- ▶ Best interests must be considered including consideration of whether he is likely to regain capacity in a timeframe to make decisions regarding his safety
- ▶ Consider the likelihood of harm if you fail to act
- ▶ Consult with others

### *3. Prevention of serious harm condition is met*

- ▶ Will failure to detain this patient result in a serious risk of harm to the patient or others?
- ▶ How serious are these threats?

# What do we need to do?

- ▶ Explanation of what is the best, most appropriate treatment plan in the medium and short term
- ▶ Consult with family
- ▶ Consideration of the threats to harm himself and others in the context of his perceived needs not been met
- ▶ Assess the actual risk at this time - looking at past history

# Challenges of the Act for Forensic Psychiatry

Dr Adrian East



# Liaison Psychiatry

## Dr Catherine Taggart



# Scenario

- 40 year old man admitted following RTA
- Multiple serious injuries
- Requires emergency treatment
- Moved to ICU
- On ventilator, getting ongoing treatment

# Questions

- What constitutes an emergency?
- What is process once emergency has ended?
- Is this a DOL?
- Who does capacity assessment?

# Emergencies

- MCA allows for treatment without safeguards
- “Delay would result in unacceptable risk of harm”
- Put in place “as soon as practicable”
- Trust panel may take up to 7 days
- Still considered emergency during this time
- But don’t wait to put other safeguards in place

# Process

- Tx with serious consequences
  - Formal capacity assessment
  - Statement of incapacity, inc. support given
  - Nominated person
- NP has reasonable objection
  - IMCA
  - POSH condition
  - Trust Panel

# DOL ?

- Short answer – not a DOL
- Cases
  - *Surrey County Council v P* [2014] UKSC 19 (*Cheshire West*)
  - *R(Ferreira) v HM Senior Coroner for Inner South London* [2015] EWHC 2990 (Admin)

# Who does capacity assessment ?

- An appropriately trained professional
- Preferably from team looking after P
  
- Training requirement
- 'Ownership' of legislation

# Friction, Fractures and Finding somewhere to live

Dr Dearbhail Lewis



# MRS P

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- 83 year old lady
- Known diagnosis of dementia
- Previously cared for by daughter
- Son now NOK



# MEDICAL ADMISSION SUMMER 2016

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- Concern from MDT
- Son not meeting all care needs
- Not administering all medications
- Not bringing her to OP appointments
- Son named NOK (previously daughter)



# PLACEMENT

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- MDT considered placement for Mrs P
- Asked for an opinion by Consultant Psychiatrist
- Found to lack capacity to decide upon place of residence
- Best Interests meeting
  - Daughter in support of same
  - Son opposed
- Declaratory Order





# READMISSION (AUTUMN 2016)

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- Readmitted with fractured neck of femur
- Needs surgery
- Joint assessment (Surgery/Psychiatry)
- Lacked capacity (though assenting)
  
- Court hearing
- Son entitled to representation
- Cross examination





# REHABILITATION

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- Moved to Rehabilitation ward
- Progressing well
- Discharge planning
- To return to EMI Residential Unit



- Assessed as lacking capacity to decide upon discharge destination
- Was for further Court Hearing

# BEST LAID PLANS...

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- Further fall in ward
- Fractured zygomatic arch
- Fracture base of thumb
- Further period of rehabilitation
- Discharge planning



- Again recommendation is to return to EMI Residential Home

# BACK TO COURT

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- Further assessment of capacity
- Again lacked capacity
  
- Court hearing
- Son again entitled to representation



# MCA 2016

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- Place of residence - serious intervention
  - Formal assessment
  - Nominated person
  - Second opinion
  - **Authorisation – Trust panel**
  - **Independent Advocate**



# CONCLUSION

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- Ongoing process in the Community
- Again assessed as lacking capacity by Community Consultant
- Final ruling re place of residence April 2017



'TRUE GENIUS RESIDES IN THE CAPACITY  
FOR EVALUATION OF UNCERTAIN,  
HAZARDOUS AND CONFLICTING  
INFORMATION.'

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Winston Churchill



# Teenagers and the MCA – an hour before midnight

Dr Richard Wilson



# Teenagers and the Mental Capacity Act

## An hour before midnight



# Scenario

**Hope, aged 16,**

Diagnosis – pervasive refusal syndrome.

- Treated in paediatric ward under court direction (Declaratory Order at age 15).
- Refuses transfer to specialist inpatient unit at age 16.

# The Tipping Point

## 15 Years 364 Days

- ▶ UNCRC Article 12
- ▶ UNCRPD Article 7
- ▶ Children (NI) Order 1995
  - ▶ Gillick Competence
- ▶ Mental Health Order 1986

# Post Tipping Point 16 Years and 1 Second

- ▶ UNCRC Article 12
- ▶ UNCRPD Article 7
- ▶ Children (NI) Order 1995
  - ▶ Gillick Competence
- ▶ The Age of Majority Act (NI) 1969
  - ▶ Mental Capacity Act 2016



# Scenario

- A 40 year old woman attends a cardiology clinic because of congenital heart disease. ( structural abnormality of the heart from birth)
- The cardiologist and cardiac surgeon together consult with her. They recommend an operation to replace one of her heart valves. It is open heart surgery and will take some time. There are risks associated with the anaesthetic and the procedure. She will need some time to recover and there will be some pain. It is not urgent and she will not die in the immediate future if she does not have the surgery. It is good practice, it will prolong the function of her heart and most people with this condition would be offered it.

# Scenario

- The cardiologist and cardiac surgeon are aware that the woman does have some mental health problems but they don't know much about these things.
- They explain the surgery to her in much the same way they would to anyone as they feel it is important not to discriminate or stigmatise.
- She agrees to have the surgery and signs the consent form

# Questions?

- Has the surgeon gone far enough?
- What should trigger a more detailed assessment of capacity?
- Who should do the assessment?
- Is it ok to accept an apparently 'wise' decision even if made passively?
- Does the situation change if she says no?

# MCA ( code of practice) 2016

- *Principle 1. A person is not to be treated as lacking capacity unless it is established that the person lacks capacity in relation to the matter in question.*
- *However, it is important that a person who is thinking of carrying out an act in reliance on the persons consent does not misinterpret the first principle as requiring them to assume that the person has capacity .....proceeding on a mere assumption that the person has capacity to consent could end in liability if in fact the person lacks capacity*

# Developments

- Simple answer is no. It is not ok to accept passive agreement
- *'It is down to professional judgment. It is the Surgeon's call, but it might be good practice to engage specialist help'*
- *'Equally, remember that just because someone says the apparently wise Yes in this case, does not mean that they should be assumed to have capacity.'*
- *(I am going to add in a "Who does What" Chapter in terms of capacity assessment. I will be saying that anyone who doubts capacity, needs to be checking it.)*

# Development- Capacity

- In fact the woman has very complex mental health problems and multi-morbidities.
- Through a combination of schizophrenia, acquired brain injury and other problems she has significant difficulty with many decisions.
- These are not obvious to the heart doctors and they have not identified that she has not fully understood and cannot retain the information about the operation. Symptoms of psychosis such as persecutory delusions also having an effect.
- Understand
- Retain
- **Weigh up and use– hardest to establish may need specialist help.**
- Communicate

# Development- Best Interests

- *The person D ( often in conjunction with an MDT) who carries out the act in relation to P has responsibility to ensure that the act is in Ps best interests*
- *Relevant factors are anything that P would consider important and pertinent to the intervention in question.*
- *Communication with family members and friends of P will be of fundamental importance in ascertaining what relevant factors should be taken into account and how much weight to ascribe to them.*

# What happens next?

- While not wishing to make stereotyping assumptions about mental health the surgeon and cardiologist in this case have failed to investigate the situation adequately
- They need to seek further information and possibly a specialist opinion in relation to the matter of P's capacity to consent to surgery.
- This may be where a rehabilitation psychiatrist comes in.
- Rehabilitation psychiatrists have experience in treating patients with very long term and disabling illnesses over many years.
- The nature of rehabilitation psychiatry means that these types of scenarios will occur more frequently.

# So far so familiar – what happens next?

## Currently

- Assessment of capacity ostensibly by surgeon, usually by psychiatrist ideally by both.
- MDT meeting regarding best interests
- Application to court to make a ruling with reports provided by Surgeon, Psychiatrist and probably Social Worker addressing both capacity and best interests.
- Patients views represented by own legal representative.

# What happens next?

## MCA 2016

- Is this a Treatment with Serious Consequences?– Major Surgery so yes.
- Is it in Ps best interests? – finely balanced question. Would we still ask a court to make this decision?
- *If the act is a treatment with serious consequences the additional safeguards required for serious interventions must be put in place. If the nominated person objects the act must be authorised by a trust panel*

# Safeguards for Treatment with serious consequences.

- 1. A formal assessment of capacity and statement of incapacity
- 2. A nominated person must be consulted
  
- This seems to read that if the nominated person does not object then the surgery could go ahead without any external authorisation.
- BUT begs the question : Does the admission to hospital for the surgery amount to a deprivation of liberty which would then need an authorisation and have to meet a higher threshold ? – Prevention of harm.

# Safeguards for TSC

- If nominated person objects then application made to trust panel requiring :
  - Details of intervention
  - Statement of incapacity
  - Consultation with nominated person
  - IMCA report
  - Medical report
  - Care plan +

# Thought experiment

- What if she says no she does not want the surgery?
- Is the threshold different to consent or to refuse consent?
- *In considering a person's capacity to make a certain decision, it is important to understand that just because a person makes what others might see as an unwise decision, this does not mean that the person lacks capacity. Everyone has the right to make unwise decisions if they have capacity to do so.*
- Therefore in principle the matter of Ps capacity to make the decision should be independent of the choice she makes

( although of course her wishes may strongly influence the best interests determination)

# Thought experiment on Refusal of consent

- In this case it was established that P lacked capacity to make a decision regarding the surgery either way? But both decisions are complex, finely balanced and have consequences which need to be weighed up.
- Are there any scenarios where the threshold capacity required would be different depending on whether P agrees or refuses the intervention?
- Instinctive sense of justice says no but what if the intervention has minimal or no consequences but refusing it has serious ones?
- E.g a pinprick blood test for blood sugar? A minor procedure to investigate suspected cancer?

# Panel Discussion

