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Mental Health and Capacity Law Newsletter

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Editorial

Welcome to this Mental Health and Capacity Law Newsletter from Arnot Manderson Advocates.

Commencement of the Mental Health (Scotland) Act 2015 has begun, and is summarised here. Cross-border problems are becoming increasingly common in this area. In the last issue, we featured transfers out of Scotland from the perspective of the 2003 Act, and in this issue Alan Inglis considers ordinary residence for the purposes of the incapacity regimes in Scotland and England. Deprivation of Liberty Safeguards have featured here previously, and their operation continues to be the subject of dialogue between the Court of Protection and the Court of Appeal in England (see *Re X (Court of Protection Practice)* [2015] EWCA Civ 599. We revisit the subject with David Cobb's commentary on proposals for reform in in each of the UK jurisdictions. Finally we mention a number of documents produced recently by the Mental Welfare Commission which will be of interest to practitioners.

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First commencement order for Mental Health (Scotland) Act 2015

The first commencement order made under the Mental Health (Scotland) Act 2015 brought a number of provisions into force on 16th November 2015. These are sections 14, 15, 16 and 18 all of which relate to the extension of excessive security appeals to patients detained in the medium secure hospitals at Rowanbank, the Orchard Clinic, and Rohallion, though the scope of some provisions goes beyond those patients.

Section 14 introduces a requirement that an excessive security appeal is accompanied by a medical practitioner which states that the practitioner is of the view that the patient does not need to be detained in the level of security in question. This provision applies both to State Hospital patients proceeding under section 264, and to medium secure patients proceeding under section 268, and consequently the formal requirements of the opinions are slightly different because of the test imposed under each of those sections.

Sections 15 and 16 make a series of consequential amendments to the enforcement process once the Tribunal has made an order determining that the patient is detained in conditions of excessive security.

Section 18 meets a practical concern raised in the Scottish Government consultation which preceded these particular provisions, and provide that in relation to the 2003 Act provisions about excessive security, 'hospital' includes 'hospital unit', which is any part of a hospital treated as a separate unit. It is understood that may be of particular assistance at Rohallion, which has a number of different services on the same campus.

It is understood that the Tribunal has already received a number of excessive security appeals from medium secure clinics, and the results are awaited with interest.

Kenneth Campbell QC

Cross-Border Placements of Incapacitated Adults

In both Scots law and the law of England and Wales, jurisdiction in relation to mentally incapacitated adults primarily lies where the individual is habitually resident. In Scotland, this is set forth in the Adults with Incapacity (Scotland) Act 2000, Schedule 3 paragraph 1. In England and Wales the corresponding provision is contained in the Mental Capacity Act 2005, Schedule 3 Paragraph 7. Particular problems arise in determining habitual residence where a cross border placement is effected by a local authority.

There is no authoritative decision of a Scottish court on how habitual residence is acquired and lost in the context of the 2000 Act. The issue has been addressed in three first instance decisions in England although their ratios are not without problems. The starting point is the Hague Convention on the International Protection of Adults 2000. It is from that treaty the requirement of habitual residence is drawn. The Explanatory Note to the Convention records that the intention was to follow the model established by the Hague Convention on Child Protection 1996 which, in turn, reflects the Convention on the Civil Aspects of International Child Abduction 1980. The meaning of habitual residence in the latter convention is, of course, the subject of numerous judicial determinations.

The first case in which an English court considered the habitual residence of an incapacitated adult is the decision of Hedley J in *Re MN* [2010] EWHC 1926. MN had been taken from California to the UK. Orders had been made by the Californian court in relation to her welfare. In determining habitual residence, the court was concerned with whether those orders authorised her niece to arrange her removal to England. If she had, habitual residence would have moved from California to England and Wales. If the move exceeded the niece's authority, habitual residence remained in California. That case-specific issue was resolved by a determination that she should be returned to California and decisions about her best interests made there. Within the judgement there is obiter dicta that the passage of time might have led to a different conclusion.

In the Matter Of PO [2013] EWCOP 3932; [2014] 1 Fam 197, Sir James Munby P considered a case where Greenock Sherriff Court was already exercising jurisdiction on the ground that PO was resident in its jurisdiction and that the matter was urgent. PO had been moved from England to Scotland by one of her

children, initially to live in his home but later to a residential unit. By the time the case reached the President, PO had been in Scotland for fifteen months. He accepted the submission on behalf of the son that (a) there had been no kidnapping; (b) "some time" had elapsed since the move; (c) PO was settled in her care home; (d) she was no longer expressing a wish to return to England. He concluded on that basis that she was habitually resident in Scotland and declined jurisdiction.

In ***Re SW*** [2014] EWCOP 43, Moylan J took the issue of the effect of the passage of time further. SW suffered a hypoxic brain injury in 2006. She remained in hospital for three years until she was discharged to a rehabilitation facility in England in early 2009. The following year SW moved to her own flat in a development offering 24-hour support. She wished to remain there. This placement was funded and supported by the Scottish local authority in whose area she had lived when the injury occurred. Moylan J considered in detail the analysis of 'habitual residence' given by the Supreme Court in ***A v A (Children: Habitual Residence)*** [2014] 1 FLR 111, the principles of which he held should be the same under the Mental Capacity Act. He concluded that, "As SW has been living in England since 2009 and has been living in her own flat since December 2010, in my view there would need to be compelling countervailing factors in order for me to determine that she is not habitually resident in England". He found that no such factors existed and therefore that she was so habitually resident.

Some conclusions may be drawn from these authorities despite their factual dissimilarities. Firstly, a move between jurisdictions without lawful authority is unlikely to cause a change in habitual residence unless there is a sustained interregnum between the move and the court proceedings. Secondly, a lengthy stay in a placement which is envisaged as enduring and not temporary is likely to result in a change of habitual residence to the jurisdiction in which the individual is now placed. Thirdly, the desire of the individual to remain in the jurisdiction is an important factor in determining habitual residence.

Re SW is the only case involving placement by a local authority. It is a useful one for local authorities who wish to argue that jurisdiction has been transferred by an enduring cross border placement. However it can also be argued that it is *per incuriam*. It appears that the Scottish local authority accepted that she remained ordinarily resident in their area. That is the only basis upon which they could have been continuing to finance and support her placement. It is a factor which does not arise in child abduction proceedings and is therefore a reason why direct application of *A v A* may not always be appropriate in incapacity cases. It seems not to have been argued that the effect of deciding that she was habitual residence in England and Wales was that she was ordinarily resident in one jurisdiction whilst habitually resident in another. Whether such a conclusion is tenable remains open for determination.

Alan Inglis

Reform of Deprivation of Liberty Safeguards in 3 jurisdictions:
different roads to the same end?

One underlying purpose of legislative devolution is facilitation of responses by each of the devolved Parliaments to issues falling within their competence. In the field of mental health and mental capacity, the differences emerging recently are becoming striking. Much of the impetus for change within the law stems from the decision of the Strasbourg Court in *HL v United Kingdom* [2005] 40 EHRR 32 (otherwise, the "*Bournewood"* decision), which called into question the adequacy of the law in England specifically governing the deprivation of liberty of incapable individuals. Such matters require to be carried out in a manner compliant with Article 5 of the Convention.

In England, these issues were addressed by the Deprivation of Liberty Safeguards ("DOLS"); see Mental Capacity Act 2005, Schedule 1A, as amended. These have proved to be complex and difficult to operate in practice, to the extent that evidence suggests that they are simply ignored in many instances. Moreover, the decision of the Supreme Court in *P v Cheshire West and Chester Council* [2014] AC 896 considerably extended the range of situations where Article 5 potentially could be engaged, albeit the DOLS apply only to residents in care homes and hospitals. Nevertheless, the number of DOLS Applications made to the Court of Protection increased tenfold during 2015, with attempts being made to streamline the Court's procedures in response to the increased volume of work.

In turn, the English Law Commission has begun to consult on a number of proposals for authorising the Deprivation of Liberty in a Convention compliant manner in substitution of the DOLS. In *Mental Capacity and Deprivation of Liberty* (Consultation Paper No.222), the Commission considers both the objective indicators in which a deprivation of liberty may occur, as well as taking account of Article 8 rights – such as prohibition of communication – which may arise where an incapable experiences a regime of "restrictive care and treatment" outwith a family situation. In the present context, it is worth noting that, as proposed, Regulations defining such circumstances can be issued separately by Welsh Ministers.

As mentioned in a previous article, the Scottish Law Commission has issued its own proposals in this field in the *Report on Adults with Incapacity* (Scot Law Com No.240). Throughout development of these proposals, the SLC has appeared careful to avoid the shortcomings of the DOLS, preferring to adopt a more restrictive approach where only a "significant restriction of liberty", for example, inability to leave accommodation unaccompanied, would require authorisation by the Sheriff Court. While some have expressed reservations as to the extent of regulation contemplated – the SLC scheme would only apply to individuals residing in hospitals and care homes - it is notable that the States of Jersey appear to have adopted the gist of the SLC's proposals in its draft *Capacity and Self Determination (Jersey) Law*.

Perhaps the most interesting initiative currently is before the Northern Ireland Assembly in the shape of the Mental Capacity (NI) Bill. Overall, this measure – running to 295 clauses as introduced - intends to provide a unified system for dealing with individuals who have a mental disorder or mental incapacity, a regime recommended to Scottish Ministers by the Millan Commission, but not yet adopted here. The Northern Ireland Bill places the concept of a "deprivation of liberty" within the meaning assigned by Article 5 of the Convention at the centre of the relevant part. Such actions, which require authorisation and regular renewal and must also satisfy a test of being imposed proportionately for the "prevention of serious harm" to the individual or others, and would apply in any place "where care or treatment" is being provided.

It seems arguable that the Northern Ireland proposals can also be read as having a broader reach than those of the SLC. While these equally avoid the prescriptive approach manifested in the DOLS, there is evident scope for debate as to where the protections offered end, particularly in the light of the Supreme Court's approach in *Cheshire West*.

Clearly, practitioners in Scotland will have changes in the law here at the forefront of their minds. It is worth recalling that the law in England prompted the *Bournewood* decision, and any of the reforms considered here themselves may well raise issues of compatibility with the Convention in time, and a cautious eye on their progress will be warranted. In that connection, it is perhaps surprising that similar challenges have thus far not made great progress in Scotland. This article can do little more than indicate briefly that the direction of travel of the devolved administrations on this sensitive issue is diverse.

Aside from the Convention, issues may arise whether the various proposals comply with the United Nations Convention on the Rights of Disabled People (UNCRPD). Recently, the Essex Autonomy Project was established by Essex University chaired by Professor Wayne Martin with two co-investigators: Professor Sabine Michalowski of the School of Law, University of Essex, and Professor Jill Stavert of Edinburgh Napier University and support from a number of legal practitioners, hose remit is to examine the compatibility of the law relating to Mental Capacity with the UNCRPD in Scotland, England and Wales and Northern Ireland. This body has indicated that it will welcome contributions to its work, and the diverse approaches considered here will doubtless be a significant feature of its work.

David W Cobb

Recent documents produced by the Mental Welfare Commission

Over the last few months the Mental Welfare Commission for Scotland has produced or updated a number of its advice and guidance publications. While these are not binding, as practitioners will be aware, they can be helpful in advising clients, whether the recipients of care, care providers, or other professionals.

Powers of Attorney have received the Commission's attention from a number of directions over the past several years. In November, the Commission issued guidance notes for care homes and for general practitioners about this subject. These contain helpfully clear and straightforward explanations of Powers of Attorney, and also of guardians. In the care homes notes, there is checklist of points for consideration where someone is considering signing a Power of Attorney, and also a separate one for situations where there is one in place. There is a helpful list of issues to be considered by GPs asked to certify capacity to grant a Power of Attorney, and legal practitioners might also find these of assistance when liaising with the GP.

On 2 December, the Commission published an advice note about hidden surveillance. This is a hugely controversial issue, and there have been well-publicised media investigations of abuses alleged and real in care homes over the last decade, which is the context for the Commission's observation "We are aware that small discreet video recording devices are sometimes being used to monitor the actions of care staff in care homes, other care settings and when people are receiving care at home." Taken together with the ease of acquisition and use of such devices, it is perhaps understandable why the issue is more real than would once have been the case. While the Commission is prepared to support the use of such devices in limited circumstances, it is understandably cautious and advises resort to alternative resolution if at all possible. As the Commission rightly comments, the law, and indeed the ethical context, is complex. Practitioners asked to advise in such a case will find material to reflect on here.

In September, the Commission published a challenging and potentially important report on progress towards meeting commitment 5 of the Mental Health Strategy for Scotland *Human rights in mental health care in Scotland*. Challenging because of the range of ideas considered and the new approach to rights; potentially important because of the likelihood of a wide-ranging review of the Adults with Incapacity legislation, as well, perhaps, as the Mental Health (Care and Treatment)(Scotland) Act 2003 may place these at the centre of the policy agenda.

The principal recommendations are:

1. The next mental health strategy should be explicitly build around a rights-based approach, meaning human rights should be and be seen to be at the heart of decisions.

2. The next mental health strategy should include measures to address stigma, discrimination and problems around access to services.

3. Human rights and equality impact assessments should be integrated, and should be routinely deployed in development of mental health policies, practices and procedures.

4. Consolidation of training initiatives in relation to human rights, including consideration of UNCRPD.

5. The 2003 Act Code of Practice should be revised to make explicit connections with human rights principles.

6. The Scottish Government should issue a Chief Executive letter to Health Boards setting out clearly the expectations on Boards to promote the wider use of advance statements, and should consider what national guidance and support should be made available to support this. This should reflect the new duties in section 26 of the Mental Health (Scotland) Act 2015.

7. The Scottish Government should promote interagency discussion exploring issues of capacity and supported decision-making, identifying how further models can be developed which reflect the Scottish context, and also respond to the UNCRPD.

8. Efforts should be made to improve provision of consistent, reliable and accessible information about rights to user groups.

9. An online portal should be created bringing together and making accessible rights-based materials, evidence and best practice. The content of this portal should be quality-controlled and curated to ensure that it remains focussed on content which is explicitly rights-based.

These are plainly challenging ideas, and it remains to be seen how they shape the development of policy and service-provision in the period of the next Mental Health Strategy.

Kenneth Campbell QC

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