CHAPTER 1

The legal framework: the Mental Capacity Act, the Human Rights Act and common law

Clinical practice involves doing things to, and for, other people. Touching, undressing, examining and medicating another person require some legal authority. Depending on the circumstances, that authority is established in England and Wales within the common law, the Mental Capacity Act 2005 (MCA), the Mental Health Act 1983 (MHA) and, underpinning it all, the European Convention on Human Rights (ECHR) as incorporated into the Human Rights Act 1998.

- **Common law** is judge-made law. It is a body of law made up entirely of principles developed organically from individual court cases on a case-by-case basis. As Lord Donaldson said, 'The common law is common sense under a wig'.[4] Common law cannot be used where there is a statutory alternative, i.e. statute law overrides common law. For those practitioners who worked prior to 2005, this is particularly important. The common law authority to act in the best interests of a person who lacks capacity has been almost entirely replaced by the MCA.
- **Statute laws** are laws passed by Parliament and called Acts.
- **Judicial interpretation of statute law** Judges also interpret the statutes passed by Parliament and make rulings on these.
- **European Law** is a potentially confusing term because there are two distinct types of European law. There is European Law passed by the European Union (EU). These laws tend to make specific requirements of member countries and are binding on those countries. An example is the European Working Time Directive. The other European law, and in relation to clinical decision-making much more relevant, is the European Convention on Human Rights (ECHR). This is incorporated into UK law by the Human Rights Act 1998. The latter makes some specific requirements of UK national laws (which must be compatible with the ECHR) and also sets a framework for the interpretation of national laws and practices both by the UK courts and individual clinicians.
- **State compliance with the ECHR** is determined by the European Court of Human Rights (ECtHR).

- **In relation to consent to medical treatment**, unless a patient is subject to the Mental Health Act, the common law and statutory criminal law determine the rules for clinicians whose patients have decision-making capacity. For patients who lack capacity, the Mental Capacity Act gives the legal framework (the only exception to this is when a person who lacks capacity needs control or restraint in the interests of someone else, e.g. to prevent them hurting another person). That is, the MCA provides a statutory framework for decision-making and the care and treatment of people who lack decision-making capacity. It also introduced substitute decision-making powers in the form of advance refusals of medical treatment, lasting powers of attorney and deputies appointed by the Court of Protection (Court Appointed Deputies). The Act provides safeguards in the form of a new Court of Protection, the Office of the Public Guardian, the Independent Mental Capacity Advocate and a new criminal offence of ill-treating or neglecting a person lacking capacity.

The MCA is underpinned by five key principles:

- **a presumption of capacity** – every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise
- **support in decision-making** – a person must be given all practicable help before anyone treats them as not being able to make their own decisions
- **acceptance of unwise decisions** – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision
- **acting in the best interests** – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests
- **taking the least restrictive option** – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

The main provisions of the MCA are:

- **A definition of incapacity** The Act introduced a test for incapacity. First, there must be evidence of an impairment of, or disturbance in the functioning of, the mind or brain. Second, the person must be unable to make a decision because of that impairment or disturbance. The test is decision- and time-specific.
- **Best interests** The Act requires that all decisions in relation to a person lacking capacity must be in their best interests. Decision makers must work through a checklist to establish best interests.
- **Acts in connection with care and treatment** The Act gives a clear legal authority, and protection, for those who make decisions on behalf of, or care for, people who lack capacity in relation to the matter in question, so long as they act in that person's best interests.

- **Restraint** The Act defines restraint as the use of force or the threat of use of force. Restraint is only authorised for the prevention of harm to the person themselves and must be proportionate to the likelihood and seriousness of the harm.
- **Deprivation of liberty** The Act includes a schedule to provide authorisation for depriving a person who lacks capacity of their liberty, so long as it is in the best interests of that person and there are no less restrictive alternatives.
- **Lasting powers of attorney (LPAs)** The person can decide whether to have one or several attorneys (also called donees); if several, how they should act together; and whether they can make decisions regarding property and affairs, or health and welfare, or both.
- **Court Appointed Deputies** The Act gives the Court of Protection the authority to appoint deputies to take decisions on health, welfare and/or financial matters as authorised by the Court.
- **Advance decisions to refuse treatment** The Act allows people to make anticipatory decisions – decisions in advance of losing capacity – to refuse medical treatment should they lack capacity in the future. The Act sets safeguards in relation to advance decisions. Decisions must be both applicable and valid. If the decision relates to the withholding or withdrawing of life-sustaining treatment there are additional requirements.
- **Independent Mental Capacity Advocates (IMCAs)** The Act requires the involvement of an Independent Mental Capacity Advocate in specified circumstances. When the decision relates to serious medical treatment or a change in the accommodation of a person who lacks capacity, and the person has no family member or friend to speak for them, an Independent Mental Capacity Advocate must be appointed.
- **Research** The Act sets out the conditions and requirements governing research involving people who lack capacity.
- **A criminal offence** A person found guilty of ill treatment or neglect of a person who lacks capacity may be liable to imprisonment for a term of up to 5 years.

A number of matters fall outside the scope of the MCA:

- marriage/civil partnerships
- divorce
- sexual relationships
- placing a child for adoption
- taking over parental responsibility for a child
- consent to fertility treatment
- voting
- detention/treatment of people under the authority of the Mental Health Act.

Age and the Mental Capacity Act

The MCA applies to people aged 16 and over, with the following exceptions:

- Under the age of 16:
  - if the child is unable to make decisions about property or finances and is unlikely to acquire capacity when they reach 18, then the Court of Protection can make the decision or appoint a deputy to do so (section 18(3))
  - offences of ill-treatment or wilful neglect of a person who lacks capacity (section 2(1)) includes child victims (section 44).
- Under the age of 18 a person cannot:
  - make a lasting power of attorney
  - make an advance decision to refuse medical treatment
  - apply to the Court of Protection.

Note

There are some overlaps in legislation. The Code of Practice refers to 'children' as people under the age of 16 and 'young people' as people aged 16–17, whereas in the Children Act 1989 and the law more generally the term 'child' refers to people under 18.

Note

The term 'learning disability' is used throughout this book. We recognise that many clinicians, and others, are more familiar with or prefer the term 'intellectual disability'. We are using learning disability because it is the term used and defined in the MHA ('a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning') and used throughout the secondary legislation and Codes of Practice.

An individual carrying out care or treatment of a young person aged 16–17 who lacks capacity to consent will generally have protection from liability provided that they follow the principles of the Act. When assessing best interests, the individual providing care or treatment must consult others involved in the person's care or welfare if it is practical and appropriate to do so, and this may include parents. It is important that in such circumstances, care is taken not to unlawfully breach the young person's rights to confidentiality.

If there is disagreement about the care, treatment or welfare of a young person who lacks capacity to make relevant decisions, then, depending on

the circumstances, the case may be heard in the family courts or the Court of Protection. Cases may be transferred between the Court of Protection and the family courts, depending on what is appropriate for the particular circumstances. For example, if there is a parental dispute about the best place of residence for a 17-year-old with severe learning (i.e. intellectual) disability, it may be appropriate for the Court of Protection to deal with the disputed issues, because orders made under the Children Act 1989 will expire when the young person becomes 18.

European law and the Human Rights Act

Understanding European institutions isn't easy or, thankfully, necessary here. Our concern is with the European Convention on Human Rights. This was adopted by the Council of Europe (a group of 42 States) in 1951. The UK was one of the first signatories to the Convention. Although before 2000, when the Human Rights Act 1998 came into force, 'public authorities' (the term used to describe 'the State') and private institutions providing public functions were supposedly obliged to comply with the Convention, it was difficult in practice for an aggrieved person to obtain a judgment because they needed to exhaust all domestic legal remedies before they could appeal to the European Court of Human Rights. The Human Rights Act changed this. Parliament is required to ensure that its laws are compliant with the European Convention on Human Rights, and courts and other public authorities are required to interpret Acts in line with the Convention as far as possible. European Court of Human Rights judgments are applicable (although not binding) in UK courts.

The Human Rights Act 1998

The Human Rights Act incorporated the European Convention on Human Rights into UK law. In clinical practice, references to the Human Rights Act and to the European Convention on Human Rights are interchangeable. The purpose of the Convention is to ensure that governments behave with a proper regard for human rights (it followed the atrocities of the Second World War). It does not apply directly to private companies or citizens unless they are carrying out public functions in the place of the government. It is for governments to legislate to make private bodies and citizens behave properly. It is unlawful for a public authority (the government or its agents) to act incompatibly with the European Convention on Human Rights. If they do, the Convention allows for a case to be brought in a UK court. Clinicians, when treating a National Health Service (NHS) patient or a private patient on behalf of the State, act as public authorities. They do not do so when treating paying private patients. Private hospitals are public authorities when providing services to NHS-funded patients. Professionals must keep the European Convention on Human Rights in mind when

conducting their clinical practice. The Articles of major relevance are the following (that's not to say the others are irrelevant):

- Article 2, the right to life
- Article 3, the prohibition of torture and inhuman and degrading treatment
- Article 5, the right to liberty and security
- Article 6, the right to a fair trial
- Article 8, the right to respect for private and family life.

The European Convention on Human Rights requires all UK legislation to be interpreted, as far as possible, in accordance with Convention rights. If a UK court decides that it cannot interpret an Act in a way that is compatible with the Convention, it has to make a 'declaration of incompatibility' (between UK law and the European Convention on Human Rights) so that the government can ask Parliament to change the law. This does not override Parliament. The Act remains unaltered until amended by Parliament. Parliament has a fast-track method for amending Acts under such circumstances.

The European Convention on Human Rights is said to be a 'living' document. It is expected that the way courts interpret its Articles will change over time, developing in line with the current mores of society. There are three categories of rights under the Convention:

- 'absolute' – no excuses (e.g. Article 3)
- 'limited' – there are specific, explicit circumstances, defined in the Article, when it doesn't apply (e.g. Article 5)
- 'qualified' – interference is permitted in a range of circumstances (e.g. Article 8).

One potential difficulty is that one person's rights may compete with another person's. For example, should there be an absolute right to practise one's religion? Clearly not, if to do so involves sacrificing the lives or freedoms of others. Furthermore, some Articles appear to clash and a balance must be struck. For example, Article 2, which puts a positive duty on the State to preserve life, may conflict with Article 8, which requires the State not to interfere in people's lives. Indeed, there may be a problem even within a single Article. Should, for example, a person with a learning disability who cannot make these decisions for themselves be left with their family (assuming that is the family's wish), or be moved to encourage living an independent life (against the family's wish)? Article 8 is respect for both family and private life and has been used by both sides in support of their argument.

One of the most useful concepts introduced by the European Convention on Human Rights is that of 'proportionality'. This says that any interference with a Convention right must be proportionate to the intended aims and

the aims themselves must be legitimate. How much force can be used in a particular circumstance, for example an interference with a person's physical integrity, depends on the severity of the threat to the person or to others.

Finally, it is perhaps worth noting that only a public authority, including private bodies when exercising public functions, can be sued under the Human Rights Act and only victims can sue. Identifying the victim may not always be obvious. A patient's daughter successfully sued a hospital when her mother, while detained under the MHA, died by suicide (the hospital had breached Article 2, the patient's right to life, by providing care that was not of the required standard).[5]

The following section looks at specific human rights legislation. In an attempt to limit confusion, only the most relevant Articles are reproduced and discussed.

Convention Articles

Article 2: Right to life

1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
   a. in defence of any person from unlawful violence;
   b. in order to effect a lawful arrest or to prevent escape of a person lawfully detained;
   c. in action lawfully taken for the purpose of quelling a riot or insurrection.

Article 2 puts a positive duty on the State. An institution will not have breached Article 2 if it has done everything correctly but there is poor practice or negligence by an individual member of staff. Article 2 also covers the clinician's duty to pass on sensitive information about serious risks to others when transferring the care of a mentally disordered patient, including the need to consider the risks to other in-patients (e.g. ensuring an appropriate environment if admitting a very disturbed patient). Other examples include: 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, withdrawal of life-sustaining/prolonging treatments, and arguments about when the State will not fund particular treatments. An interesting example arose in a case concerning conjoined twins. Separating the twins would result in the immediate death of one twin, but not separating them would lead to the death of both. It was argued that one of the twins was interfering in the right to life of the other.[6]

The State's responsibilities are greater in relation to those who are in its custody, such as prisoners. Patients detained under the MHA or the

Deprivation of Liberty Safeguards of the MCA come under this category. Additionally, the right to life and the obligations it puts on clinicians apply at an enhanced level to psychiatric patients, even those admitted informally (voluntarily). As Lady Hale, one of the judges in the case of Rabone[7] explained, voluntary psychiatric patients who have consented to admission to hospital (such as Ms Rabone) may not be in the same position as physically ill patients who have consented, because the former (a) may have impaired capacity, (b) may be consenting because they fear detention and (c) can be detained under section 5 of the MHA.

Article 3: Prohibition of torture and inhuman and degrading treatment

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 3 is an absolute right. A person can argue that their care and/or treatment is incompatible with Article 3 and its protection of fundamental human dignity without having to point to (or be capable of pointing to) any specific ill-effects arising from it. For example, tying an elderly patient to a bed may breach Article 3 even though the patient isn't physically harmed. Equally, neglect of a person that leads to death may be a breach of Article 3 rather than Article 2. The threshold for Article 3 is high. In the case of *Herczegfalvy v Austria*,[8] a patient complained that he had been forcibly administered food and antipsychotics, isolated and attached to a security bed with handcuffs. The European Court of Human Rights held that 'as a general rule a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading'. The medical intervention must, of course, be 'a necessity'. As was pointed out by Lady Hale, the judge in a case from Broadmoor hospital, 'Forcible measures inflicted upon an incapacitated patient which are not a medical necessity may indeed be inhuman or degrading'.[9]

Furthermore, the UK has breached Article 3, for example in the case of a man taken to a police station under section 136 of the MHA. He was kept in a cell for four days although he was clearly seriously mentally ill: shouting, taking off all his clothes, banging his head on the wall, drinking from the toilet and smearing himself with food and faeces. The European Court of Human Rights said 'Even though there was no intention to humiliate or debase him, the Court finds that the conditions which the applicant was required to endure were an affront to human dignity and reached the threshold of degrading treatment for the purposes of Article 3'.[10]

Article 5: Right to liberty and security of person

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
   a. the lawful detention of a person after conviction by a competent court;
   b. the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
   c. the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
   d. the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
   e. the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants;
   f. the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.
2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.
3. Everyone arrested or detained in accordance with the provisions of paragraph 1c. of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.
4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.
5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

Article 5 is central to issues relating to the Deprivation of Liberty Safeguards (DoLS) of the MCA (discussed in Chapter 7) and the MHA. Paragraph 1(e) of Article 5 allows for 'the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants'. What is meant by unsound mind and who decides that a person is so suffering? In a pivotal case, *Winterwerp v The Netherlands*,[11] the European Court of Human Rights said:

> 'A person cannot be detained as being of unsound mind unless he or she is reliably shown to be so as demonstrated by objective medical expertise and the nature or degree of his or her mental disorder is such as to justify the deprivation of liberty. The detention ceases to be valid when the relevant mental disorder disappears or ceases to be such as justifies the deprivation of liberty.'

This is important because it means that a detained patient's mental state must be kept under constant review by the clinician responsible for their care and the patient must be discharged from detention under the MHA, or MCA Deprivation of Liberty Safeguards, if they are deemed no longer to be suffering from any mental disorder.

Article 6: Right to a fair trial

1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.
2. Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.
3. Everyone charged with a criminal offence has the following minimum rights:
   a. to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;
   b. to have adequate time and facilities for the preparation of his defence;
   c. to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;
   d. to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;
   e. to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

Article 6 is important not only in relation to civil and criminal cases but also, for example, in tribunals (e.g. disability, employment, mental health), General Medical Council and other professional body hearings, and employment and disciplinary procedures.

Article 8: Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.