

# Chapter 1

## **Setting the Context**

# Chapter 1: Setting the Context – an Overview of New Zealand and English Mental Capacity Law

Chapter 1 is in three sections:

- A. Setting the context and understanding the legal concept of capacity.
- B. An overview of mental capacity law in New Zealand, with a particular focus on the jurisdiction under the Protection of Personal and Property Rights Act 1988.
- C. An overview of the historical origins of the Mental Capacity Act (England and Wales) 2005, the law reform that produced it, and the jurisdiction it creates.

## 1A: THE LEGAL CONCEPT OF CAPACITY

### Understanding capacity

- 1.1 Decision-making capacity (or simply “capacity”) refers to individuals’ ability to make particular decisions or take actions that influence their lives. In a legal context, capacity is concerned with whether a person’s decision-making ability is recognised as valid and, if not, who should make decisions on their behalf and on what basis should such substitute decisions be made.
- 1.2 Capacity or incapacity is the “bright line” determining whether the law permits intervention in people’s lives, and on what basis.<sup>24</sup> Those who lack capacity are deemed unable to make decisions for themselves thereby justifying intervention in their lives. Decisions are then made by others based on an assessment of what is in the best interests of the person lacking capacity. Those with capacity are free to make decisions about their lives, even decisions that may be regarded as unwise, subject to the constraints of the law.<sup>25</sup> Concerns may still arise as to whether an individual is competent to make a particular decision, or is merely acquiescing under pressure from others (referred to in law as “undue influence”), and concerns may exist as to the extent to which such influence affects their capacity for decision-making.
- 1.3 Capacity is decision and time specific. Lack of capacity may arise for a variety of reasons and may be partial or total. When lack of capacity is temporary or fluctuating it may be possible to defer decisions until capacity is restored. But if it is of lasting duration or permanent, or if an urgent decision otherwise needs to be made, there must be some legally recognised procedure whereby necessary decisions can be made by some other person or body.<sup>26</sup>

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<sup>24</sup> M Donnelly “A Legal Overview” in C Foster, J Herring and I Doron (eds) *Law and Ethics of Dementia* (Hart Publishing, Oxford and Portland, 2014) 271 at 278.

<sup>25</sup> I Goold and J Herring “Palgrave Great Debates in Law” in J Herring (ed) *Medical Law and Ethics* (5<sup>th</sup> edition, Oxford University Press, Oxford, 2014).

<sup>26</sup> G Ashton *Mental Capacity Law and Practice* (2<sup>nd</sup> ed, Jordans, Bristol, 2012) at 2.

## Conditions affecting capacity

- 1.4 Decision-making capacity can affect people of all ages and arises in a variety of social environments and healthcare settings. A range of conditions and disabilities can impair capacity; the most common of these, in the context of community care of older people, is dementia.<sup>27</sup> It is difficult to predict from the stage of dementia whether a person retains or has lost the capacity to make a particular decision. Measures of dementia severity correspond only approximately with capacity. It is important to recognise that different types of dementia may impair capacity in different ways. The most common form of dementia, Alzheimer's disease, affects memory in the first instance, whilst dementia secondary to vascular disease of the brain tends to impact on frontal and subcortical systems, causing problems with higher cognitive functions.
- 1.5 Delirium is a disorder that is seen more commonly in residential care and hospital settings and is characterised by a relatively sudden decline in cognitive function, or fluctuations in such function, and impaired attention. It occurs in the context of physical illness or toxic states and may represent the first time a capacity assessment is required. Head injury (or acquired brain injury) and intellectual disability (in England referred to as learning disability) are usually chronic, stable states where it is more likely the person's abilities will be understood and the focus should be on optimising the person's capacity.
- 1.6 Mental incapacity is not the same as mental disability. Mental disability, including mental illnesses such as depression, anxiety and psychosis, can impair capacity in a number of ways, including by causing forgetfulness or reducing the person's ability to think through complex issues, through inattention, or by causing a bias in reasoning to the point of impairing capacity. In psychiatry, there are approaches for making self-binding directives (the Ulysses Contract) by which patients with bipolar affective disorder commit themselves to treatment during episodes of mania, even if unwilling. For certain individuals, this can seem the most rational way to deal with their fluctuating condition.<sup>28</sup>
- 1.7 The prevalence of patients who lack capacity in New Zealand hospitals and care facilities is unknown. A recent review of 58 international studies of capacity found 45% of patients in psychiatric settings and 34% of patients in general medical settings lacked decision-making capacity.<sup>29</sup> Two million people in the UK are estimated to lack capacity through illness.<sup>30</sup> There is nothing to suggest that the proportion of people that lack capacity throughout the healthcare institutions in New Zealand is dissimilar; nearly a third of patients may be regarded as not having legal capacity for decision-making.

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<sup>27</sup> Dr Greg Young, consultant psychiatrist, Capital and Coast District Health Board.

<sup>28</sup> G Owen and T Gergel "Fluctuating Capacity and Advanced Decision Making in Bipolar Affective Disorder – Self-Binding Directives and Self Determination" (2015) 40 Int J Law Psychiatry 92 at 95.

<sup>29</sup> P Lepping, T Stanly and J Turner "Systematic review on the prevalence of lack of capacity in medical and psychiatric settings" (2015) 15 Clin Med (JRCF) 337. The study looked at the average proportion of patients and showed that psychiatric patients with psychosis, dementia and mania are more likely to lack decision-making capacity than those with depression or personality disorder. Likewise, in general medical settings, patients with learning disabilities, delirium and neurological disease were most likely to lack capacity.

<sup>30</sup> T Nicholson, W Cutler and M Hotopf "Assessing mental capacity: the Mental Capacity Act" (2008) 336 BMJ 322 at 322.

## Assessment of capacity

- 1.8 Deciding whether a person has the capacity or competence to make particular decisions is a legal, and in some cases judicial, determination, informed by medical evidence.<sup>31</sup> Capacity can be difficult to assess, may not be clear-cut and involves value judgments about people's preferences and beliefs. To deprive people who are capable of making their own decisions of the right to do so would be an abuse, yet failure to recognise lack of capacity results in continuing vulnerability.
- 1.9 The careful assessment of the individual's capacity to make particular decisions is crucial. This turns on an understanding of the kinds of decisions to be made, the legal thresholds for capacity, and a judgment of the point at which a person is considered incompetent or lacking capacity. Getting the process for these decisions right is essential to the protection of a person's rights and in determining the legal consequences that follow.

## Legal capacity

- 1.10 The term "legal capacity" recognises the legal right to exercise rights and legal status.<sup>32</sup> Legal capacity has a particular meaning in the context of international conventions such as the Convention on the Rights of Persons with Disabilities (CRPD), where it is understood to refer to a person's possession of rights and the ability to act on those rights on an equal basis with others without discrimination on the grounds of disability. The right to legal capacity includes, for example, having the right to choose where and with whom you wish to live, and most importantly, having those choices respected. The concept is relevant to all areas of an individual's life, including the exercise of legal capacity to enter a contract, to marry, to vote, to deal with property and to make personal life, personal care and healthcare decisions.<sup>33</sup>
- 1.11 Under New Zealand law, people who lack capacity and are subject to the adult guardianship legislation (the PPPR Act) may be regarded as having the same legal rights as others except to the extent their rights are expressly limited by the PPPR Act or other legal principles.<sup>34</sup>
- 1.12 "Legal capacity" is distinct from "mental capacity", the latter being the cognitive ability considered necessary to exercise one's legal rights. In discussing mental capacity, the terms "decision-making capacity" or "competence" are often used in the clinical context<sup>35</sup> as a descriptor of the mental or cognitive characteristics considered necessary to exercise legal capacity.<sup>36</sup> Despite the potential to confuse legal capacity (a legal concept) and mental

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<sup>31</sup> In *McFadzean v Moleta* [2013] NZHC 1601, a case involving the assessment of a person's testamentary capacity, Collins J observed at [7]: "Unfortunately, while the law and medicine intersect, the two disciplines are not synchronised".

<sup>32</sup> R Firmston and A Ruck Keene *The International Protection of Adults* (Oxford Press, Oxford, 2015) at 67.

<sup>33</sup> M Bach and L Kerzner "A new paradigm for protecting autonomy" (2014) Ontario Law Commission <http://repositoriocdpd.net:8080/handle/123456789/449> at 16.

<sup>34</sup> Protection of Personal and Property Rights Act 1988. Section 4 provides that the legal capacity of a person who may be subject to the Court's jurisdiction and in respect of whom an order is made may be regarded as having the same legal rights as anyone else unless those rights are expressly limited, varied, or taken away under the Act or some other Act.

<sup>35</sup> These terms also get confused with the legal concept of capacity. C Duncan, psychiatrist Capital and Coast District Health Board, "The Red Flags and Pitfalls of Assessing Capacity", presentation to Bioethics Centre, University of Otago, 7 September 2015. Interview with G Owen, psychiatrist, Kings' College London (A Douglass, London, 22 April 2015). In the United States, "competence" is generally used as the legal term: Buchanan Brock *Deciding for Others, The Ethics of Surrogate Decision Making* (Cambridge University Press, 1990).

<sup>36</sup> The Protection of Personal and Property Rights Act 1988 uses "capacity" and "competence" interchangeably and the Code of Rights refers exclusively to "competence". For ease of reference I use the terms "capacity" or "mental capacity".

capacity (the cognitive abilities required), the term “mental capacity” is the one used in the legislation in the United Kingdom.<sup>37</sup>

## 1B: OVERVIEW OF MENTAL CAPACITY LAW IN NEW ZEALAND

### The Protection of Personal and Property Rights Act 1988 (PPPR Act) – background

- 1.13 In New Zealand, the PPPR Act is the guardianship law for adults who may permanently or temporarily lack capacity. The PPPR Act is the main legislation that applies to people who lack capacity and is a vitally important piece of legislation. It has played a key role over the last 28 years by recognising the vulnerability of adults with impaired capacity and the concern of the State to “protect and promote” the rights of those who cannot manage their own affairs.
- 1.14 The passing of the PPPR Act in 1988 responded to the needs of the community at a time when there was no guardianship law in place for adults who lacked capacity. The PPPR Act mainly grew out of the need to protect adults with intellectual disabilities in the community during deinstitutionalisation of psychiatric institutions in the 1980s, and was intended to remove them from under the control of “the murky stream of mental health law”.<sup>38</sup> Until the introduction of this Act in 1988, it was not possible to provide guardianship of people over 20 and, as a result, people over that age were often committed under the Mental Health Act 1969 (MHA 1969).
- 1.15 The PPPR Act created a new and expanded jurisdiction for the Family Court and in doing so relieved the High Court of a significant part of its first instance jurisdiction for people who lack capacity. The legislation adopted the social philosophy of the United Nations Declaration on the Rights of Mentally Retarded Persons 1971. It reformed aspects of the law governing both personal and property rights, and repealed the prior legislation dealing with administration of the property of people who lacked capacity: that is, the Aged and Infirm Persons Protection Act 1912 and property-related aspects of the MHA 1969.<sup>39</sup>
- 1.16 Early decisions of the Family Court under the PPPR Act, notably decisions by the late Judge Inglis QC, were largely concerned with testing the waters of the new jurisdiction, including the tests for incapacity and the power to authorise treatment decisions,<sup>40</sup> as well as the basis upon which people with intellectual disabilities could live in the community with an appointed substitute decision-maker.<sup>41</sup> With the changes in the social environment and burgeoning older

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<sup>37</sup> Mental Capacity Act 2005 (England and Wales), Mental Capacity Bill (currently before the Northern Ireland Parliament), Adults with Incapacity Act 2000 (Scotland) and the Supported Decision-Making (Capacity) Act 2015 in the Republic of Ireland. Note also the Mental Capacity Act 2010 (Charter 177A) Singapore which almost entirely adopts the English legislation.

<sup>38</sup> AC Hughes-Johnson “The Protection of Personal and Property Rights Act 1988: An analysis, commentary and answers to likely questions”. (A seminar by the New Zealand Law Society, October 1988) at 11.

<sup>39</sup> Australian legislation, the Victorian Adult Guardianship Act 1987, provided the adult guardianship law model for the Protection of Personal and Property Rights Act 1988.

<sup>40</sup> In *Re S (Shock Treatment)* [1992] NZFLR 208 Judge Twaddle declined to order shock treatment therapy for a person with intellectual disability and instead ordered that they live in a community trust home and receive supported rehabilitative therapy.

<sup>41</sup> In *Re E* [1992] 9 FRNZ 393, the Court declined jurisdiction to make a residential care order for a 28-year-old with severe physical disability, as she did not “wholly” lack the capacity to communicate, and she clearly had the capacity to understand the nature of her decision. In *Re “Tony”* [1990] 5 NZFLR 609 Judge Inglis declined jurisdiction to make welfare guardian and property orders in respect of a man with schizophrenia who lived in a home described as a “protected environment”, where it was only a

population, many of the more recent cases before the Family Court are concerned with older adults who lack capacity.<sup>42</sup>

- 1.17 As a matter of social policy, a consistent theme emerges: the most significant decision for people who lack capacity, young or old, is where they are to live. All other decisions, healthcare, welfare, financial and property are important, but tend to be secondary to their living arrangements – whether supported in the community or in more institutionalised models of care and support.

### The PPPR Act – an overview

- 1.18 The PPPR Act and its Regulations provide the mechanisms for the making and use of an enduring power of attorney (EPOA), which a person can execute in advance to authorise another person to make decisions about their care, welfare or property if they later become mentally incapable of making those decisions.<sup>43</sup> It authorises the Family Court to appoint substitute decision-makers, known as welfare guardians and property managers, and make personal orders that can be tailored for specific interventions, such as treatment decisions, therapeutic services or living arrangements.<sup>44</sup>
- 1.19 The primary objectives of the PPPR Act are to make the least restrictive intervention and to maximise a person’s decision-making capacity where possible.<sup>45</sup> Another principle that underpins the Act is the presumption of competence: a person must be assumed to have capacity unless proved otherwise.<sup>46</sup> A limitation on any intervention by the court is the principle that people are entitled to make imprudent or unwise decisions so long as they are considered to have the capacity to do so.<sup>47</sup> As such, the Act has good bones: it is intended to be enabling and supportive of people who lack capacity, not unnecessarily restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or participate in decision-making, as far as they are able to do so.
- 1.20 The Family Court is assigned this protective jurisdiction but it is a creature of statute and its jurisdiction in matters involving mental capacity is limited in scope by the legislation. There is a right of appeal and the ability to transfer Family Court proceedings to the High Court in certain circumstances.<sup>48</sup>
- 1.21 The High Court’s inherent *parens patriae* jurisdiction in relation to vulnerable adults operates as a safety net to provide a remedy beyond the scope of the statutory scheme.<sup>49</sup> This

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hypothetical possibility he might leave. *Re A and Others* [1993] 10 FRNZ 537, Judge Inglis made an order allowing for the joint appointment of the care centre and a parent for each of five long-term institutionalised individuals with intellectual disability.

<sup>42</sup> See for example, *Wilson v Wilson* [2015] NZFLR 104, where a personal order was necessary to mitigate perceived undue influence for an elderly man with partial incapacity. In *Hutt Valley District Health Board v MJP* [2012] NZFLR 458 the Court held that it had jurisdiction to order an elderly woman with dementia to reside in a care facility despite her vehement objections.

<sup>43</sup> Changes to Part 9 of the PPPR Act are discussed below. An EPOA is a grant by a donor when they are mentally capable to another person (the donee) which allows that person to make welfare and/or property decisions when they become mentally incapable or lack capacity for decision-making.

<sup>44</sup> There are statutory limitations on substitute decision-makers’ powers; Protection of Personal and Property Rights Act 1988, ss 18 and 98.

<sup>45</sup> Protection of Personal and Property Rights Act 1988, ss 8(a) and 8(b).

<sup>46</sup> Protection of Personal and Property Rights Act 1988, s 5.

<sup>47</sup> Protection of Personal and Property Rights Act 1988, s 8(3).

<sup>48</sup> Protection of Personal and Property Rights Act 1988, s 83; Family Courts Act 1980 s 14.

<sup>49</sup> *Carrington v Carrington* (2014) NZHC 869 Katz J at [103]. The *parens patriae* jurisdiction is expressly contemplated by s 114 of the PPPR Act. Section 17 Judicature Act 1908 applies to “Persons and

jurisdiction is rarely used but has some application, where, for example, there are limitations on the powers of an appointed welfare guardian,<sup>50</sup> or where disputes arise about end of life decision-making for fully incapacitated persons.<sup>51</sup>

- 1.22 The PPPR Act contemplates a two-stage procedure in which the Court must first determine whether there is jurisdiction and then determine the degree of intervention, if any, that is necessary.<sup>52</sup> In *KR v MR*, Miller J held:<sup>53</sup>

The question of capacity to make the decision that is the subject of an application (under the Act) is a threshold question and must be considered in every case; because jurisdiction to make an order ... depends on it.

- 1.23 The Act provides no single test for incapacity, which makes it complex legislation to follow and apply.<sup>54</sup> In general terms, however, the Act says a person lacks capacity if they do not understand the nature or cannot foresee the consequences of decisions, or are unable to communicate them.<sup>55</sup> As the Family Court can only intervene where a person lacks capacity, this concept of capacity and how it is assessed and considered by the court is central to the workings of the Act.

- 1.24 Although often assumed to be relevant, the further principle of the person's "best interests" is neither a primary objective of the PPPR Act nor defined in it. Substitute decision-makers appointed by a court order or by an EPOA are charged with making decisions in the person's "best interests and welfare", but there is no clear direction for the court to do so. The legislative intent in this area was discussed in an early decision by a full Court which warned against adopting:<sup>56</sup>

... a narrow, legalistic approach to the Act where the welfare and best interests of the person the subject of the application are part of a hidden rather than stated objective.

- 1.25 The absence of a best interests standard and lack of clarity as to its significance (a "hidden objective") has led to a confused understanding of best interest's role within the legislation and risks conflating matters of best interests with the legal tests for capacity.<sup>57</sup>

- 1.26 The Act provides a number of safeguards for the person who is subject to the Act (referred to as the "subject person"), including ensuring their right to be heard and the appointment of a

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estates of mentally disordered persons and persons of unsound mind". See also *Dawson v Keesing* [2004] 23 FRNZ 493.

<sup>50</sup> Protection of Personal and Property Rights Act 1988, s 18, Limitation on the powers of welfare guardians. In *Re W* [1994] 3 NZLR 600 the High Court held that it had inherent jurisdiction to declare W's marriage void on the basis of absence of consent through lack of intellectual capacity.

<sup>51</sup> The High Court's jurisdiction is used where there is withdrawal of life support from incapacitated patients in coma or persistent vegetative state (PVS). The continued existence in New Zealand of the Court's *parens patriae* jurisdiction in this context was accepted in *Auckland Area Health Board v A-G* [1993] 1 NZLR 235, and reaffirmed by the High Court in *Re W* [1994] 3 NZLR 600 and *Re G* [1997] 2 NZLR 201. *KR v MR* [2004] 2 NZLR 847 at [72]. Also reported as *X v Y (Mental Health: Sterilisation)* [2004] 23 FRNZ 475.

<sup>53</sup> *KR v MR*, above n 52 at [25].

<sup>54</sup> Protection of Personal and Property Rights Act 1988, ss 12(5)(b), 18(3), 97A(2) and 98A(2). See Chapter 4 Defining Capacity.

<sup>55</sup> The factors relevant to deciding capacity are the ability to: communicate choice; understand the relevant information; manipulate the information and appreciate the situation and its consequences (*KR v MR* at [51]).

<sup>56</sup> *In the Matter of A* [1996] 2 NZLR 354 at 356.

<sup>57</sup> See Chapter 5 Best Interests.

lawyer to represent them in court proceedings.<sup>58</sup> Where there is a conflict between the views of the subject person and others' views about their welfare and best interests, the lawyer is required to discuss the issues with them as far as possible, and attempt to resolve the conflict with that person, but also required to put before the court all relevant information from a "best interests point of view".<sup>59</sup> The court can make an interim personal order under urgency without the person being served but can only do so after a lawyer for the subject person is appointed and is in a position to be heard.<sup>60</sup> People subject to personal orders (including the appointment of a welfare guardian) have the right of review of the order and/or decisions by the welfare guardian at any time during the currency of the order. Other than appointing the lawyer at the time the order is made, these safeguards are not often used.<sup>61</sup>

- 1.27 Enforcing court orders against third parties to protect the person with diminished capacity, who may be vulnerable to undue influence from others, is a vexed issue.<sup>62</sup> There have been cases involving incapacitated persons where (unsuccessful) habeas corpus arguments have been considered, based on allegations that a person subject to care and welfare orders has been unlawfully deprived of their liberty by their appointed welfare guardian.<sup>63</sup> There are a number of decisions where the court has creatively used supplementary orders under s10(4) as a means of enforcing the main order but the extent to which this provision can be used as a method of enforcement is unclear and unsatisfactory.<sup>64</sup>
- 1.28 The court has limited ability to take contempt action against third parties who unduly influence the subject person and interfere with court orders designed to meet their needs. In *JMG (by her Litigation Guardian AMB) v CCS Disability Action Inc*,<sup>65</sup> JMG and her mother interfered with the provision of disability services to JCE and a tenancy order was made in the Family Court to facilitate access to these services. The Family Court Judge expressed concern that JCE was being manipulated and controlled by his partner JMG and her mother, contrary to his rights under the CRPD.<sup>66</sup> A report from the court-appointed psychologist "compellingly" confirmed JCE's need for supported decision-making from both the disability service and his

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<sup>58</sup> Protection of Personal and Property Rights Act 1988, s 65. An application to the Court activates the appointment of a lawyer to represent the "subject person" under s 65 and to report to the Court, among other things, whether the medical evidence supports the Court having jurisdiction to intervene.

<sup>59</sup> Ministry of Justice "Guidelines for subject person appointed under PPPR Act, Principal Family Court Judge" (24 March 2011) at [www.justice.govt.nz](http://www.justice.govt.nz). Where there is a conflict between the wishes of the subject person and what might be considered in a person's best interests the Court may appoint a lawyer to assist the Court under s 65A.

<sup>60</sup> *Public Trust v MJD* [2013] NZFC 2706.

<sup>61</sup> Protection of Personal and Property Rights Act 1988, ss 86-89. The maximum term of personal orders is three and sometimes five years.

<sup>62</sup> See for example, *JMG (by her Litigation Guardian AMB) v CCS Disability Action Inc* [2012] NZFLR 369, Miller J.

<sup>63</sup> *E v E*, Wellington HC, CIV-2009-485-2335, 20 November 2009. Simon France J. See also *JDEB & ors v JAB & RHB and MAB* [2013] NZFC 4234, Judge O'Dwyer, following an unsuccessful writ of habeas corpus in the High Court.

<sup>64</sup> Examples include: setting in place a procedure on notice to a landlord to make the subject person a party to a tenancy agreement so that support services could be provided to him, *JMG v CCS Disability Action*, above n 62; facilitating attendance at a hospital so that the mental health patient who lacked capacity to consent to treatment could receive cancer treatment (*CD v JMT* [2012] NZFC 10147), and transporting a person with severe alcohol dependence to a residential facility to avoid "absconding" *Loli v MWY* FAM-2009-004-001877, 13 Jan 2011 NZFC Auckland 2011.

<sup>65</sup> Above n 62.

<sup>66</sup> Above n 62 at [8]. Counsel to assist was appointed by the High Court to consider its *parens patriae* jurisdiction with regard to JMG who lacked capacity to litigate, but was not subject to any orders under the PPPR Act and who was considered vulnerable.



parents.<sup>67</sup> In an unsuccessful appeal to the High Court, Ronald Young J warned JMG's mother, DH, of the risk of contempt action and that:<sup>68</sup>

... only for so long can a Court tolerate the flouting of its orders. Given that JMG admittedly is not able to play a full part in the litigation, and so is unlikely to be sanctioned for breach, attention must turn for enforcement purposes to those who act on her behalf and by their own admission possess the ability to influence her decisions. I find that DH is in that position.

## The PPPR Act – law reform

- 1.29 The PPPR Act may be regarded as progressive legislation and in some respects ahead of its time. It was enacted in 1988, the year of the report of the Cartwright Inquiry, and pre-dates significant developments of the law relating to patients' rights following the Cartwright Inquiry and leading passage of the Health and Disability Commissioner Act 1994 and the HDC Code. Despite these developments, there has been surprisingly little attention or review of the operation of the PPPR Act or the principles that underpin it.
- 1.30 In 2001, the Law Commission published a report following a discussion paper entitled, *Misuse of Enduring Powers of Attorney*.<sup>69</sup> The discussion paper was triggered by concerns expressed by Age Concern about the lack of protection and adequate safeguards for those whom the statute was designed to assist, and by increasing awareness of elder abuse in the community. The subsequent report of the Law Commission identified problems with the way in which the initial grants of enduring powers of attorney (EPOA) were made, such as the donor feeling under duress, failure to explain the implications of the powers given to the attorney, or a donor lacking the capacity to understand what they were signing.
- 1.31 Part 9 of the PPPR Act was subsequently amended by the PPPR Amendment Act 2007. Prior to this amendment, the issue of a donor's capacity was not addressed in the legislation; one of the most significant changes was the introduction of a presumption of donor competence.<sup>70</sup>
- 1.32 In the response to a 2013 request for "feedback" on the 2007 amendments from the Office for Senior Citizens of the Ministry of Social Development, the New Zealand Law Society reported that these changes have been problematic and difficult to implement. But the Law Society recommended that the changes to EPOAs made in 2007 should be considered in the context of a review of the PPPR Act as a whole.<sup>71</sup>
- 1.33 The Law Society advised that the increase in cost to meet the new legal requirements has had the effect of dissuading some clients from appointing attorneys; the new legal threshold for determining whether a person lacks capacity for the purpose of activating an EPOA is different from the threshold for the appointment of a welfare guardian by the court, adding to

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<sup>67</sup> *JMG (by her Litigation Guardian AMB) v CCS Disability Action Inc* (stay application) Wellington HC, (27 May 2011) Ronald Young J at [20].

<sup>68</sup> Above n 67 at [52].

<sup>69</sup> Law Commission *Misuse of Enduring Powers of Attorney* (NZLCR, Wellington, 2001).

<sup>70</sup> Protection of Personal and Property Rights Act 1988, s 93B. See also B Atkin "Schizophrenia and Protection Orders" (1990) NZLJ 204 and discussion on the Part 9 Amendments in S Bell *Protection of Personal and Property Rights Act & Analysis* (Thomson Reuters, Auckland, 2012) at 36.

<sup>71</sup> Letter from Chris Moore (President, New Zealand Law Society) to Claire Kibblewhite (Ministry of Social Development Office for Senior Citizens) regarding the 2007 Amendments to Enduring Powers of Attorney Provisions (5 July 2013) [https://www.lawsociety.org.nz/data/assets/pdf\\_file/0011/69194/MSD-EPAs-5-7-13.pdf](https://www.lawsociety.org.nz/data/assets/pdf_file/0011/69194/MSD-EPAs-5-7-13.pdf).

the complexity of using the Act; the different processes create confusion for people using them and complexities for health professionals making capacity assessments; and there is no independent oversight of the medical certification process required to certify a donor's mental incapacity when the power is activated, such as an appointed lawyer to represent a person where court orders are proposed.<sup>72</sup>

- 1.34 The Law Society also highlighted the lack of guidance for health practitioners concerning EPOAs. A similar gap exists regarding court proceedings under the Act, particularly about what the courts require of medical, psychiatric and psychological reports from clinicians and healthcare providers, to ensure there are consistent procedures for capacity assessment and a common approach to the essential question of whether the court has jurisdiction.
- 1.35 In June 2014, the Minister for Senior Citizens reported to Parliament on a review of the effectiveness of the 2007 amendments.<sup>73</sup> That report recommended an information campaign to improve legal and health professionals' knowledge about their responsibilities and sources of information and support, but rejected the Law Society's submission for a national register of EPOAs.
- 1.36 In 2015, an amendment to the PPPR Act was introduced to make minor and technical changes to the EPOA provisions and the witnessing requirements.<sup>74</sup> The 2015 amendments reflect the ongoing concern expressed by the New Zealand Law Society that the witnessing requirements in the 2007 amendments more than doubled the legal costs of making EPOAs and resulted in fewer EPOAs being made.<sup>75</sup> These changes will provide neither system-wide mechanisms to protect those vulnerable to abuse through incapacity, nor take account of New Zealand's human rights obligations under international treaties.<sup>76</sup>

### Family Court statistics

- 1.37 There is no comprehensive data published on Family Court proceedings concerning the PPPR Act. The Ministry of Justice published a general review of the Family Court in 2009. This showed a generally upward trend in numbers of applications for welfare guardians and property management orders and a relatively stable number of applications for personal orders. In 2011 the Family Court Public Consultation Paper looked at the total number of PPPR applications between 2004 and 2010. While there was some fluctuation, on average there were approximately 2500 applications annually.<sup>77</sup> During the 2006–2007 period, 40

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<sup>72</sup> Ibid.

<sup>73</sup> The report was required by s 108AAB of the PPPR Act 1988. *Report of the Minister for Senior Citizens on the Review of the Amendments to the Protection of Personal and Property Rights Act 1988 made by the Protection of Personal and Property Rights Amendment Act 2007*, Ministry of Social Development, June 2014.

<sup>74</sup> Statutes Amendment Bill 2015, Part 21, introduced into Parliament in November 2015.

<sup>75</sup> Submission by the New Zealand Law Society on the Statutes Amendment Bill: Part 21 (29/01/2016), [http://www.lawsociety.org.nz/\\_data/assets/pdf\\_file/0008/98207/Statutes-Amendment-Bill,-Part-21-29-1-16.pdf](http://www.lawsociety.org.nz/_data/assets/pdf_file/0008/98207/Statutes-Amendment-Bill,-Part-21-29-1-16.pdf) at [2.7]. The Law Society submitted that the effect of the 2007 changes to the PPPR Act was "an increasing number of people who, for reasons of cost, have not made their own decision about who should be their substituted decision-maker if they lose their mental capacity".

<sup>76</sup> See Chapter 3 Supported Decision-making, and the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

<sup>77</sup> Ministry of Justice *Reviewing the Family Court: a public consultation paper* (Ministry of Justice, Wellington, 2011) at 81.

percent of cases involved people over the age of 60, showing the weighting of proceedings toward older people, as this group only represents 17 percent of the general population.<sup>78</sup>

- 1.38 Appendix A is a review of reported Family Court cases under the PPPR Act from 1988, and unreported cases from 2010 to 2015, where the decision expressly refers to the subject person's capacity in ascertaining whether the court had jurisdiction (that is, that the person lacks capacity and there is a basis for the court to intervene).<sup>79</sup> The review is not a comprehensive evaluation of the PPPR Act but a snapshot of how decisions on jurisdiction are made.<sup>80</sup> Nor do these judgments tell the full, or even partial, story behind the many applications before the court that may have been resolved – not by way of judicial hearing and formal decision – but either “on the papers”, by way of unreported interim decision, court minutes, or judicial or settlement conferences.<sup>81</sup>
- 1.39 There have been few cases where a person's capacity (and the jurisdiction of the court) have been contested by way of a defended hearing and even fewer where the person has given sworn or oral evidence. When judges are concerned that there is insufficient evidence to determine jurisdiction, they sometimes order further medical reports, and the outcome of these cases is often not known. The review identified 41 cases (30% of the total) where the subject person participated in a defended hearing, and another two cases where the decision records that the judge talked to the person on an unsworn basis. Of these, there were 19 cases where the person gave evidence contesting incapacity.<sup>82</sup> The requirement that the person subject to an application should be present, unless formally excused under s76, does not appear to be rigorously followed.

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<sup>78</sup> Ministry of Justice *Family Court Statistics in New Zealand in 2006 and 2007* (Ministry of Justice, Wellington, 2009) at 57.

<sup>79</sup> Unreported Family Court judgments were accessed from the Ministry of Justice but many of these judgments are not on any electronic database. While the process for deciding which judgments will be published aims to become more transparent, there is no “hard data” that can be statistically validated. Furthermore, even where capacity may have been contested, the case may have been resolved through the court-appointed lawyer's involvement or for reasons unknown.

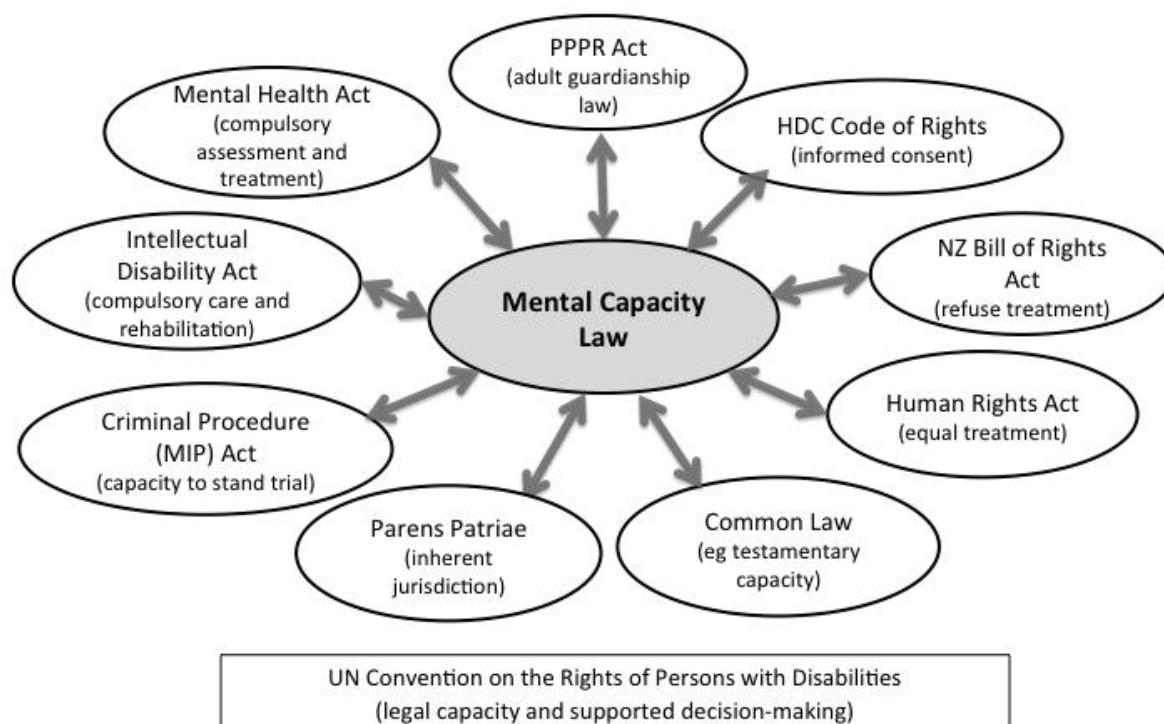
<sup>80</sup> The review was limited by the small sample size and what information can be ascertained from the combined reported (41) and unreported (94) cases.

<sup>81</sup> Even where capacity may have been contested, the case may have been resolved through the involvement of the court-appointed lawyer.

<sup>82</sup> There are few reports of judges visiting the person in their care setting or on a hospital ward, an approach used for reviews and hearings under the MH(CAT) Act. It is common and appropriate for judges to engage in informal discussion with the subject person and to encourage them to participate, where possible.

## Mental capacity law in New Zealand

Figure 1: Mental Capacity Law in New Zealand



1.40 In addition to the adult guardianship law under the PPPR Act, there is also common law (case law), and other legislation that is relevant to people who lack capacity. The common law provides legal tests of capacity in respect to a range of situations and transactions, including: capacity to make a will (testamentary capacity); capacity to make a gift; capacity to enter into a contract; capacity to vote; and capacity to consent in the context of the criminal law, and particularly of sexual offences. The legal system recognises capacity to litigate and the role of a litigation guardian to represent those who lack capacity to instruct a lawyer.<sup>83</sup>

1.41 There is a wide range of legislation in New Zealand where a person's capacity for decision-making has an important bearing on the operation of the law and people's access to it. The Accident Compensation Act 2001, for example, provides cover for claimants who may have suffered a traumatic brain injury and who may be either incapable or in need of support to access and manage their entitlements to rehabilitation and compensation.<sup>84</sup> There is a clear gap in the law for young persons between the ages of 17 and 18 who lack capacity and who are in need of care and protection, as custody orders under the Children, Young Persons and

<sup>83</sup> Judicature Act 1908, Schedule 2 High Court Rules, Part 4 subpart 7; and District Court Rules 2014, Part 4 subpart 7.

<sup>84</sup> A recent report on claimants' experiences with the ACC appeal process does not address for example, problems ACC encounters in case management for claimants with diminished capacity for decision-making during the claims process: *Acclaim Otago Understanding the Problem: An analysis of ACC appeals process to identify barriers to access to justice for injured New Zealanders* (Acclaim Otago and University of Otago Legal Issues Centre, Dunedin, 2015).

their Families Act 1989 expire when the person attains the age of 17, and the PPPR Act generally does not apply until a person turns 18.<sup>85</sup> There are criminal offences that recognise sexual exploitation<sup>86</sup> or neglect or abuse of vulnerable adults who may lack capacity.<sup>87</sup> Protection orders have been made where there has been domestic violence towards people who lack capacity.<sup>88</sup> Some legislation that governs what can and cannot be done for people lacking capacity may be viewed as paternalistic and out-dated.<sup>89</sup>

- 1.42 There is legislation with compulsory powers under mental health law and the law for people with intellectual disabilities who commit criminal offences that affects people who lack capacity.<sup>90</sup>

### **Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT) Act)**

- 1.43 The MH(CAT) Act provides a civil commitment process under which people who are considered to be “mentally disordered” may be placed under compulsory assessment and treatment. The MH(CAT) Act’s criteria for compulsion are not based on capacity but on a special legal test of “mental disorder” (based on the presence of discrete mental phenomena) and a serious threat of harm to self or others, or seriously diminished capacity to care for self.
- 1.44 Mental health legislation and mental capacity legislation have very different aims. The MH(CAT) Act provides powers for the detention and treatment of a person with a mental disorder, if necessary without that person’s consent. It is primarily concerned with the reduction of risk, both to the patient and to others, using compulsion where necessary. By contrast, mental capacity legislation, such as the PPPR Act, is concerned with enabling and supporting people to make their own decisions where possible. Whilst there is a need to protect people, the legislation is not intended to provide coercive powers (which can also be a problem, as discussed above).
- 1.45 The interface between the compulsory powers under the MH(CAT) Act and the PPPR Act is not entirely clear and sometimes the court has a choice over which Act to use. In *Canterbury District Health Board v MH*,<sup>91</sup> the Family Court confirmed that the MH(CAT) Act cannot be used to keep a patient with dementia in hospital against her wishes for the purpose of providing for the patient’s physical, not mental, healthcare, despite such care not being available at her home.

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<sup>85</sup> Children, Young Person and Their Families (CPYF) Act 1989, s 108; Protection of Personal and Property Rights Act 1988, s 6(2). See AJ Cooke “State Responsibility for Children in Care” (PhD Thesis, University of Otago, 2014) <http://hdl.handle.net/10523/4796>; Personal communication from L Harrison, (former Barrister) (Dunedin, 2015).

<sup>86</sup> Crimes Act 1961, s 138.

<sup>87</sup> Crimes Amendment Act (No 3) 2011, ss 151, 195 and 195A create criminal liability for failure to provide necessities of life, or protect from ill treatment or injury to a child or a vulnerable adult. Section 2 of the Crimes Act 1961 defines a “vulnerable adult” as a person who is unable, by reason of detention, age, sickness, mental impairment, or any other cause to withdraw himself or herself from the care and charge of another. The definition of “vulnerable adult” does not specify an age threshold, but it is presumed to refer to persons over 18.

<sup>88</sup> Domestic Violence Act 1995, s 11. See for example, *AR and Anor v RDH FC* Christchurch FAM-2008-009-002784.

<sup>89</sup> Contraception Sterilisation and Abortion Act 1977 and the Alcohol and Drug Addiction Act 1966. This latter legislation is due to be repealed: Substance Addiction (Compulsory Assessment and Treatment) Bill 2015.

<sup>90</sup> Mental Capacity (Compulsory Care and Treatment) Act 1992; Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; Criminal Procedure (Mentally Impaired Persons) Act 2003.

<sup>91</sup> [2012] NZFC 4432, Judge C P Somerville.

- 1.46 Under the MH(CAT) Act, mental capacity is largely irrelevant, as the Act does not specifically require a compulsory patient's capacity to consent to their psychiatric treatment to be formally assessed at intervals, or to be taken into account in deciding on their detention. A study has shown that of those patients under compulsory treatment in New Zealand, many of whom are under community treatment orders, a significant proportion – perhaps as many as two-thirds of involuntary patients – might retain the capacity to agree with, or refuse, their proposed course of psychiatric treatment. Therefore, potentially only one-third of involuntary patients do not have capacity for decision-making affecting their care.<sup>92</sup>
- 1.47 The New Zealand mental health system has an emphasis on informal care. The safeguards available to patients subject to compulsory powers, such as the watchdog role of the District Inspector, do not apply to informal patients who are not subject to the MH(CAT) Act. To date, there has been no consideration by the New Zealand Government of the English law reforms concerning the position of compliant people who lack capacity and do not object to their detention in care facilities, who are effectively deprived of their liberty but are not under the MH(CAT) Act.<sup>93</sup>
- 1.48 There is a complex interface between these two legislative regimes, particularly where an individual lacks capacity to consent to or refuse treatment. Problems include: the extent to which the proper treatment is for a “mental disorder” and would therefore be authorised under the MH(CAT) Act, or treatment is for a general medical condition that is being provided on a “voluntary” basis; how the presumption of competence operates in these circumstances; and whether the provisions of the PPPR Act – rather than the MH(ACT) Act – should apply, since it is likely to be less restrictive of a person's human rights and freedom of action.

### **Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act)**

- 1.49 The IDCCR Act is unique to New Zealand.<sup>94</sup> It provides for compulsory care and rehabilitation within the health system of persons with an intellectual disability who commit criminal offences and who are no longer subject to the criminal justice system (referred to as “care recipients” or “special care recipients”). There are two principal pathways into the care regime under this Act. The most common route is a court order upon being found unfit to stand trial, found not guilty on the basis of insanity, or convicted of an imprisonable offence.<sup>95</sup> Rarely, a prison manager will activate the second route, by applying for the making of a care order under s 29 of the IDCCR Act.<sup>96</sup>
- 1.50 Eligibility is determined by application of a test based on assessed IQ and social functioning. The Act defines an intellectual disability as a permanent impairment that has manifested during the developmental period of the person and results in significantly sub-average general

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<sup>92</sup> J Skipworth “Should Involuntary Patients with Capacity Have the Right to Refuse Treatment” in J Dawson and K Gledhill *New Zealand's Mental Health Act in Practice* (VUP, Wellington, 2013) at 218. See also Lepping, Stanly and Turner, above n 29 and discussed in Chapter 1A of this report.

<sup>93</sup> See Chapter 3 – Liberty Safeguards, for discussion of the interface between MH(CAT) Act and the PPPR Act.

<sup>94</sup> See W Brookbanks “Further Reform of Unfitness to Stand Trial” in Dawson and Gledhill, above n 92 at 321.

<sup>95</sup> Criminal Procedure (Mentally Impaired Persons) Act 2003, s 24(2)(b) (detention in a secure facility of a defendant found unfit to stand trial or insane as a special care recipient) and s 25(1)(b) (orders declaring a defendant found unfit to stand trial or insane as a care recipient to receive care under a care programme).

<sup>96</sup> Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 29 allows a manager of a prison (in the case of a serving prisoner) or the Director of Area Mental Health Services (DAHMS) (in the case of a former special patient) to apply for an assessment if there are reasonable grounds for believing that the person has an intellectual disability.

intelligence (IQ less than 70) and significant deficits in adaptive functioning.<sup>97</sup> When a compulsory care order is made, the judge must specify the term of that order, with a maximum of three years.<sup>98</sup> The court reviews the care and rehabilitation plan at six months but only has the power to recommend changes. Care recipients are legally represented at some stages of the proceedings and there are six-monthly clinical reviews. However, there is no ongoing independent scrutiny of whether the care recipient continues to meet the criteria of intellectual disability.<sup>99</sup> Specialist assessors are designated by the Director-General of Health and are qualified health and disability professionals. Their role is to assess the level of risk posed by the individual and to try and predict the likelihood of future behaviour.<sup>100</sup>

- 1.51 Exiting the compulsory care regime can be difficult, particularly for care recipients who are not likely to rehabilitate. As intellectual disability is defined in the Act as a permanent status, the ongoing detention of people under the regime presents a conundrum: as there is no guarantee that rehabilitation will necessarily reduce risk factors, there is potential for an indefinite sentencing regime with disproportionately severe infringements on an individual's liberty. In *RIDCA Central v VM*,<sup>101</sup> the Court of Appeal held the principle of proportionality required there to be a balance between the need to protect the community and the liberty interests of the care recipient in extending a compulsory care order. The Court concluded that any "order must be the least coercive and restrictive option available".
- 1.52 While the expressed aim of the IDCCR Act is to limit the detention period to a maximum of three years, in reality the failure of the legislature to define criteria limiting the courts' ability to extend such orders has repeatedly resulted in a de facto position whereby compulsory care risks becoming indefinite preventive detention.<sup>102</sup> In a dissenting opinion in the application for leave to appeal in *VM*, Baragwanath J highlighted the "difficult balance" between protecting the community from low level offending by individuals, who because of intellectual disability are not legally responsible, and the human rights of such people.<sup>103</sup>

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<sup>97</sup> Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 7(1); s 7(5) states that the developmental period of a person "generally finishes when the person turns 18 years". Evidence now shows that cognitive development takes place at least until the mid-20s, and is dependent on a person's developmental environment. Often care recipients who been raised in a developmentally deprived circumstances will show significant improvement in cognitive functioning. This has already resulted in some care recipients no longer meeting the criteria of intellectual disability and under s 8(2), the IDCCR Act does not apply. Email from Anthony Duncan (National Advisor to the IDCCR Act, Ministry of Health) to A Douglass regarding the IDCCR Act (7 October 2015).

<sup>98</sup> Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 46.

<sup>99</sup> For example, in a case where the writer represented the care recipient, the initial assessment undertaken in the criminal court was based on reports 12 years prior and there had not been a reassessment of the care recipient's adaptive functioning for the purpose of bringing the person under the IDCCR Act regime.

<sup>100</sup> Ministry of Health *Guidelines for the Role and Function of Specialist Assessors under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (Ministry of Health, Wellington, 2004) at 5–6. These guidelines have not been reviewed since originally published and the measures for predictive risk have not been translated into the New Zealand context.

<sup>101</sup> *Regional Intellectual Disability Care Agency Central v VM* [2012] BCL 398; [2011] NZCA 659 at [92(a)]. The appeal upheld a High Court decision, *VM v RIDCA Central (Regional Intellectual Disability Care Agency)* HC Wellington CIV-2009-485-541 (Simon France J). In both *VM* and another High Court appeal, *L v Regional Intellectual Disability Care Agency Central* HC Wellington CIV-2010-485-1279 (Mallon J), the care recipients were women in their mid-forties who had assaulted and threatened violence against their caregivers. Prior to being under compulsory care orders they had largely lived in the community with supported care.

<sup>102</sup> W Brookbanks "Managing the challenges and protecting the rights of intellectually disabled offenders" in B McSherry and I Freckleton (eds) *Coercive Care: Rights, Law and Policy* (Routledge, Abington Oxon, 2013) at 219.

<sup>103</sup> *RIDCA Central (Regional Intellectual Disability Care Agency) v VM* [2010] NZCA 213 at [16].

- 1.53 The IDCCR Act has not been reviewed since it was passed. When it was first introduced, a significant funding pool was allocated from disability resources and there is more potential in disability services for the provision of individualised care packages than under the MH(CAT) Act.<sup>104</sup> In a recent study of people with intellectual disability, lawyers, among others, voiced concern that some of the procedural aspects of the IDCCR Act impacted on access to justice by care recipients.<sup>105</sup> The Act also does not cover the unknown number of prisoners who may lack capacity through intellectual disabilities or those who have suffered brain injuries and were convicted prior to the Act coming into force.<sup>106</sup>

### **The Code of Health and Disability Services Consumers' Rights (the HDC Code)**

- 1.54 The HDC Code is now a central part of New Zealand's health and disability regulatory framework. The interface between the PPPR Act and the HDC Code for people who lack capacity is not well understood. The PPPR Act is essentially about incapacity and the formal procedures for the appointment of substitute decision-makers for adults who lack capacity in a wide range of situations, some of which cross over into healthcare delivery. In contrast, the aim of the HDC Code is to place patients at the heart of healthcare decision-making and, where possible, without a substitute decision-maker. It is concerned with informal procedures for ensuring that a patient is capable of giving consent or refusal to a healthcare procedure and the standards to be adhered to by health professionals and providers of healthcare. Decisions are made every day by, or for, people in the health system who may have diminished capacity to give informed consent to healthcare procedures.
- 1.55 Capacity to make an informed choice and give informed consent to healthcare procedures is a key component to ensuring that the rights of patients are protected under Rights 5, 6 and 7 of the HDC Code.<sup>107</sup> Decision-making capacity may become an issue in the healthcare setting where a person's ability to give informed consent is in question because of their refusal, for example, to consent to a treatment decision or to undergo a needs assessment for the purpose of assessing the level of ongoing care they require.<sup>108</sup>
- 1.56 Unlike the PPPR Act, the HDC Code does not define the concept of capacity but it does recognise the common law presumption of competence (Right 7(2)) and that those with impaired capacity should participate as much as possible in decisions regarding their healthcare (Right 7(3)).<sup>109</sup> The presumption of competence may often be entirely appropriate in the context of legal proceedings but it does not provide an adequate framework for clinical

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<sup>104</sup> Email from Anthony Duncan, National Advisor in the IDCCR Act 2003 regarding the IDCCR Act (7 October 2015).

<sup>105</sup> Mirfin-Veitch, Gates, Diesfeld and others, above n 21 at viii. This study recommended that there needed to be mandatory training for individuals representing clients under the IDCCR Act.

<sup>106</sup> Justice S Glazebrook "Foreword" in Dawson and Gledhill, above n 92 at 9. It is estimated that some 64 percent of prisoners have experienced a head injury. The extent of prisoners having impaired decision-making capacity is unknown. For example, the writer represented a prisoner before the Parole Board with dual disabilities (mental health and intellectual disabilities) who was subject to an indefinite sentence of periodic detention but whose disabilities only became apparent when in prison.

<sup>107</sup> The HDC Code is set out in Appendix C. Right 5 is the right to effective communication; Right 6 is the right to be fully informed; and Right 7 is the right to make an informed choice and give informed consent. Section 11 of the New Zealand Bill of Rights Act 1990 provides that everyone has the right to refuse to undergo medical treatment. The word "everyone" has been interpreted to mean every person who has capacity to consent: *Re S* [1992] 1 NZLR 363, although this interpretation would now be called in question with the modern notion of legal capacity under the CRPD.

<sup>108</sup> In *Bedford* [2013] NZCorC Decision No. 43/2013, the Coroner commented that no capacity assessment was undertaken when the patient (under the MH(CAT) Act) with Korsakoff's dementia refused insertion of a nasogastric tube for a hernia repair operation and subsequently died.

<sup>109</sup> The terms "capacity" (PPPR Act) and "competence" (HDC Code) are used interchangeably in the relevant legislation.



practice. The discussion on the presumption has tended to proceed without consideration of a clinician's duty of care towards a patient, particularly the circumstances in which there is a duty to assess the patient's competence.<sup>110</sup>

- 1.57 There is no formal requirement or procedure for assessing a person's competence under the HDC Code for the purposes of giving or refusing informed consent under Right 7. Nevertheless, the Health and Disability Commissioner has found a GP to be in breach of the HDC Code for failing to assess the capacity of a woman with Huntington's disease who was living in isolation and squalor in her own home over a 10-year period. The doctor was found to be in breach of Right 4 in that she failed to provide adequate care and support for her patient.<sup>111</sup>
- 1.58 If a person is assessed as lacking capacity and there is no substitute decision-maker, Right 7(4) of the Code of Rights provides legal justification for providing health and disability services without consent. The right is based on the common law principle or doctrine of necessity and justifies healthcare providers acting in what they consider to be the person's best interests. It largely provides a defence for the health professional, rather than a safeguard for the patient, and does not provide a good basis for making important decisions with ongoing consequences for people who lack capacity.<sup>112</sup>
- 1.59 Providers of services for the elderly, including District Health Boards (DHBs) and rest home proprietors, often seem confused about the requirements under the PPPR Act. They often require prospective residents to appoint an attorney for personal care and welfare decisions (a HealthCERT audit requirement), whether or not the resident wishes to do so, resulting in a facility insisting on the appointment of an EPOA as a requirement for admission. There is also inconsistency on how Right 7(4) of the HDC Code is applied.<sup>113</sup>
- 1.60 Unlike in England, the prominence of capacity issues in health and disability law has not led to a comprehensive review of adult guardianship law in New Zealand. One of the consequences of the "no-fault" accident compensation scheme and its statutory bar against suing health professionals for medical negligence causing "personal injuries" is the absence in New Zealand of litigation, and associated case law, contesting and clarifying capacity to consent. Yet capacity to consent is increasingly recognised in the more informal "case law" of the Health and Disability Commissioner's opinions.<sup>114</sup>
- 1.61 Appendix B is a review of the Health and Disability Commissioner's opinions and of decisions of the Human Rights Review Tribunal. This review shows that over time, the issue whether a consumer/patient lacks capacity or has impaired capacity for decision-making is becoming more prevalent in complaints investigated. Even where there is a substitute decision-maker appointed (a welfare guardian or attorney under an EPOA) there have been breaches of Rights 6 and 7 of the HDC Code in circumstances where the person is unable to make an

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<sup>110</sup> PDG Skegg "Presuming Competence to Consent: could anything be sillier?" (2011) 30 U Queensland Law J 165.

<sup>111</sup> Health and Disability Commissioner: *General Practitioner Dr C*, 11 HDC00647.

<sup>112</sup> The doctrine of necessity and Right 7(4) is discussed below in Chapter 3 Liberty Safeguards and Chapter 6 Research on People who Lack Capacity.

<sup>113</sup> Letter from Chris Moore (President, New Zealand Law Society) to Claire Kibblewhite (Ministry of Social Development Office for Senior Citizens) regarding the 2007 Amendments to Enduring Powers of Attorney Provisions (5 July 2013) [https://www.lawsociety.org.nz/\\_data/assets/pdf\\_file/0011/69194/l-MSD-EPAs-5-7-13.pdf](https://www.lawsociety.org.nz/_data/assets/pdf_file/0011/69194/l-MSD-EPAs-5-7-13.pdf).

<sup>114</sup> Negligent failure to obtain informed consent was previously a ground for medical misadventure but is no longer since the introduction of treatment injury provisions in the Accident Compensation Act 2001, as amended in 2005.

informed choice or give informed consent. These breaches have occurred when there has been a failure to properly activate an EPOA or to consult with the legally appointed substitute decision-maker. There is a greater emphasis on ensuring that providers adequately assess capacity, and are clear on the legal basis on which substitute decisions are made when a person cannot give informed consent.

- 1.62 The Commissioner is charged with investigating complaints under the HDC Code.<sup>115</sup> It is a reactive, not a proactive, process, and does not provide adequate protective mechanisms for those who lack capacity and are especially vulnerable in the health system. The Commissioner's opinions are limited to breaches of the HDC Code, and the requirement for the Commissioner to investigate a complaint initially has a gatekeeper effect, as few complaints are investigated in fact and even fewer result in further action through the tribunal or disciplinary processes.<sup>116</sup> There is a health and disability advocacy service under the Commissioner, but the role of the advocates is centred on providing assistance when a complaint is made, rather than at the front-end of the informed consent process.<sup>117</sup>

### New Zealand summary

- 1.63 The PPPR Act is in need of review.<sup>118</sup> The legal landscape of mental capacity law in New Zealand is fragmented. There is neither an overarching legal framework nor a cohesive social policy in New Zealand for dealing with issues arising for people who lack capacity. Mental capacity affects all aspects of people's lives and access to the legal system. There is a danger of a silo effect isolating different aspects of the legal system, compartmentalising the issues in elder, family, property, medical, mental health or disability law, and so on. Increasingly, there is greater recognition that regulatory frameworks in the health and social policy spheres need to avoid these gaps. As Professor Laurie says:<sup>119</sup>

These regulatory gaps are described as "liminal" (the spaces in between). They often exist outside existing formal legal and social structures, and are often in a state of flux. Citizens who also experience flux in their capacity can find themselves in liminal regulatory spaces where at times laws might, or might not, apply to them.

- 1.64 A review of the law therefore requires a coordinated government approach.

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<sup>115</sup> Health and Disability Commissioner Act 1994, s 14(e). The Commissioner can investigate potential breaches of the HDC Code on a complaint or on his own initiative.

<sup>116</sup> Email from Chris Moore (President, New Zealand Law Society) to the Health and Disability Commissioner regarding Review of the HDC Act and Code (17 February 2014) [https://www.lawsociety.org.nz/\\_data/assets/pdf\\_file/0012/75999/I-HDC-Act-and-Code-Review-17-02-14.pdf](https://www.lawsociety.org.nz/_data/assets/pdf_file/0012/75999/I-HDC-Act-and-Code-Review-17-02-14.pdf).

<sup>117</sup> Health and Disability Commissioner Act 1994 s 30 sets out the functions of advocates, which includes ensuring that consumers are aware of their rights under the HDC Code and to provide assistance to ensure that healthcare procedures are performed with informed consent of the consumer: s 30(d). Health advocates can also receive complaints and assist persons who wish to pursue a complaint.

<sup>118</sup> B Atkin "The Protection of Personal and Property Rights Act 1988 – Update and Reflections" (2013) 44 VUWLR 439.

<sup>119</sup> These regulatory gaps are described as "liminal" (the spaces in between) in socio-political literature. Liminal spaces are realms of possibility and transition. Interview with Professor Graeme Laurie, Chair of Medical Jurisprudence and Director of the JK Mason Institute for Medicine, Life Sciences and Law, Edinburgh University (A Douglass, Edinburgh, 29 May 2015).

## 1C: OVERVIEW OF MENTAL CAPACITY LAW IN ENGLAND AND WALES

### Historical origins – Magna Carta 1215

- 1.65 The origins of the adult guardianship system in England and Wales are a poignant reminder of the enduring significance of the Magna Carta just after it marked the 800th anniversary in 2015. In about 1270, shortly after the end of the Second Barons' War, King Henry III, as head of the feudal system, assumed control over the estates of "lunatics" and "idiots". The powers and obligations held by the Crown became part of "the royal prerogative" and were reserved to the king in his role as *parens patriae* or father of the nation.<sup>120</sup> Subsequently the king delegated the exercise of these powers to the judges.
- 1.66 The area of law now known as mental capacity law was historically referred to as lunacy law and from 1846 to 1947 the judges were called the "Masters in Lunacy". Senior Judge Lush of the modern day Court of Protection describes this jurisdiction as "optimistic", because it was based on the premise that lunatics (sometimes of good and sound memory and understanding and sometimes not) might regain capacity and would expect their assets to be restored to them intact, whereas idiots (fools from birth) would not.<sup>121</sup>
- 1.67 Since the Reform Act 1832, generally regarded as the beginning of modern parliamentary democracy in Britain, there have been changes to mental health and mental capacity legislation about once in a generation to reflect current trends and best practice. The next revision of the English legislation will probably take into account recent developments including the United Nations Convention on the Rights of Persons with Disabilities (CRPD).<sup>122</sup>

### Law reform – United Kingdom and Ireland

- 1.68 In England and Wales, the Mental Capacity Act dates from 2005; it has, however, been described as a "1995 law", reflecting the policies, philosophy and practice of the 1990s.<sup>123</sup> The Mental Capacity Bill was already 10 years old when it was put before Parliament, having originally appeared in a Law Commission report published in 1995.<sup>124</sup> The 1995 report was the culmination of a series of four Law Commission consultation papers on decision-making and incapacity, which identified a number of deficiencies in the law, including there being no legislation authorising any other person or court to take a medical decision on behalf of an adult patient without capacity to make a decision. This meant heavy reliance had to be placed on the common law justification of necessity, under which clinicians made the decision to proceed.<sup>125</sup>
- 1.69 The Law Commission recommended there be a single coherent statutory scheme to which recourse could be had when any decision (whether personal, medical or financial) needed to

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<sup>120</sup> Ashton, above n 26 at 11.

<sup>121</sup> D Lush "The Evolution of the Statutory Will Jurisdiction" (2014) Eld LJ 173.

<sup>122</sup> D Lush, Paper presented to The Academy of European Law's Conference on the Rights of Persons with Disabilities (12 Dec 2014). Relevant statutes were passed in 1833, 1863, 1890, 1913, 1934, 1959, 1983 and 2005, some of which were more radical than others.

<sup>123</sup> Lush, above n 121.

<sup>124</sup> Ashton, above n 26 at 68–9. The Law Society provided the stimulus for the review by publishing a discussion document in 1989, "Decision-making and mental incapacity".

<sup>125</sup> *Re F (Mental patient: Sterilisation)* [1990] 2 AC 1. See also Law Commission *Mental Incapacity* (UKLC No 231, 1995) at 2.

be made for a person aged 16 or over who lacked capacity.<sup>126</sup> The Mental Capacity Act 2005 (England and Wales) eventually came into force on 1 October 2007.

- 1.70 Scotland achieved mental capacity legislation first. The Adults with Incapacity (Scotland) Act 2000 followed recommendations of the Scottish Law Commission<sup>127</sup> and was one of the earliest pieces of legislation to be passed by the newly formed Scottish Parliament.<sup>128</sup> The Scottish legislation was implemented in stages. There are three main agencies involved: the Public Guardian has a supervisory role and keeps registers of attorneys, people who can access funds, guardians and intervention orders; local authorities look after the welfare of adults who lack capacity; and the Mental Welfare Commission protects the interests of adults who lack capacity as a result of a mental disorder, under both the mental health and the mental capacity legislation.<sup>129</sup> The Commission's functions include: undertaking visits in a variety of settings; carrying out investigations relating to improper detention, abuse, neglect or deficiency of care and treatment; giving advice; promoting best practice; and challenging legislation and social policy where appropriate.<sup>130</sup> It has similar investigatory powers to the Health and Disability Commissioner in New Zealand but is not operating under a code of patients' rights.<sup>131</sup>
- 1.71 It is interesting to note that the Scottish legislation establishes a special procedure for approving medical treatment in certain cases for a person who lacks capacity. A second opinion can be obtained from a doctor through the Mental Welfare Commission, to review specified treatments given under that Act, and to adjudicate in cases where there is disagreement between a treating physician and a welfare guardian or attorney, although it is rare for a doctor to carry out treatment in the face of a refusal by a welfare guardian or attorney.<sup>132</sup>
- 1.72 In Northern Ireland, the Mental Capacity Bill recently passed by the Parliament is the newest and most ambitious piece of legislation.<sup>133</sup> It will put Northern Ireland ahead of any other jurisdiction in the world in terms of trying to combine mental health and mental capacity legislation that is strongly (if not exclusively) capacity based. It is a brave attempt to be compatible with the CRPD and to avoid discrimination on the grounds of disability as the sole basis for compulsory treatment. It retains the functional test and the "diagnostic threshold"

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<sup>126</sup> In the early 1990s there were four Law Commission reports that formed the basis of the Mental Capacity Act 2005 <http://www.bailii.org/ew/other/EWLC/1991/c119.html>.

<sup>127</sup> Law Commission *Report on Incapable Adults* (Scot LC No 151, July 1995).

<sup>128</sup> A Ward *The Power to Act: The Development of Scots Law for Mentally Handicapped People* (Scottish Society for the Mentally Handicapped, Glasgow, 1990) at 121. Much of the impetus for the Scottish law reform and gaining the attention of the Scottish Law Commission was (and still is) driven by Adrian Ward, a solicitor based in Glasgow, who wrote several books in the 1990s on law reform that was occurring internationally, including the New Zealand model in the then newly passed PPPR Act 1988.

<sup>129</sup> Mental Health (Care and Treatment) (Scotland) Act 2003 and Adults with Incapacity Act 2000. See [www.mwscot.org.uk](http://www.mwscot.org.uk).

<sup>130</sup> Interview with Colin McKay, Chief Executive, Mental Welfare Commission for Scotland (A Douglass, Edinburgh, 21 May 2015). There has been a steep rise in welfare guardianship applications to the Commission – 58% in four years.

<sup>131</sup> A Ruck Keene and E Horne "Why a Mental Capacity Act Commission (and What Should It Look Like)?" (2014) 4 *Eld LJ* 217.

<sup>132</sup> Adults with Incapacity Act 2000, ss 48, 50. The Commission has a responsibility to nominate an independent medical practitioner. Interview with Colin McKay, Chief Executive, Mental Welfare Commission for Scotland (A Douglass, Edinburgh, 21 May 2015). Section 51 of this Act provides legislative safeguards where research is undertaken on people who lack capacity similar to ss 30–34 of the MCA. See Chapter 7 Research on People who Lack Capacity.

<sup>133</sup> Introduced into the Northern Ireland Parliament on 8 June 2015. The bill was completed on 15 March 2016 and was awaiting Royal Assent at the time of writing this report. [www.niassembly.gov.uk/assembly-business/legislation/primary-legislation-current-bills/mental-capacity-bill](http://www.niassembly.gov.uk/assembly-business/legislation/primary-legislation-current-bills/mental-capacity-bill).

(impairment of, or disturbance in the functioning of, the brain or mind)<sup>134</sup> of the English and Welsh MCA. However, the MCA test is qualified so that it “does not matter whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disability”.<sup>135</sup>

- 1.73 In the Republic of Ireland, the Assisted Decision-Making (Capacity) Bill was introduced in 2013. Following substantive amendments during 2015 it was passed into law at the end of the year.<sup>136</sup> Law reform is well overdue in Ireland: the new law will replace the Lunacy Regulations Act Ireland 1871, draconian legislation administered through the Wards of Court system in the High Court.
- 1.74 The new legislation in Ireland embraces supported decision-making under the CRPD with a three-stage approach to the assessment of capacity.<sup>137</sup> At the least formal end of the spectrum, people can appoint a decision-making assistant when they are concerned that they have or will shortly have difficulty in making decisions without assistance.<sup>138</sup> The next step is appointment of a co-decision-maker, which is a contractual arrangement that must be witnessed by two people (one completely independent of either party), but does not require court approval.<sup>139</sup> Finally, there is an application process for a decision-making representative appointed by the court, who is an individual with a “bona fide” interest in the welfare of the relevant person, when the person lacks capacity to make decisions.<sup>140</sup> The Irish law is progressive and aligns with human rights obligations by recognising legal capacity as a continuum and the role of supported decision-making. Co-decision-making represents an intermediate phase where a person falls somewhere between needing help to make decisions and being completely unable to make decisions for themselves.<sup>141</sup>

### **Mental Capacity Act 2005 (England and Wales) – an overview**

- 1.75 The Mental Capacity Act 2005 (MCA) is a comprehensive overhaul of this area of law in England and Wales. The legislation made significant changes to the legal rights afforded to those who lack capacity in England. The MCA establishes a single statutory framework for the making of personal welfare decisions, healthcare decisions and financial decisions on behalf of adults who may lack capacity to make specific decisions for themselves.<sup>142</sup> The framework provides a hierarchy of processes, extending from informal day-to-day care and treatment decisions, to decision-making requiring the exercise of formal powers, and ultimately to court decisions and judgments. It also clarifies the actions that can be taken by others involved with the care or medical treatment of people lacking capacity to consent.
- 1.76 The key provisions of the MCA, relating to the guiding legal principles (s 1), the definition of capacity and the legal test for intervention (ss 2 and 3), and the concept of the person’s best interests (s 4), are set out in Appendix C.

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<sup>134</sup> Mental Capacity Bill (NI), s 3(1).

<sup>135</sup> Mental Capacity Bill (NI), s 3(3).

<sup>136</sup> The Assisted Decision-making (Capacity) Act 2015 was passed into law on 30 December 2015. <http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/pdf>.

<sup>137</sup> GR Ashton, “Has our Mental Capacity Jurisdiction Reached the Turning Point?” [2014] Eld LJ, 214.

<sup>138</sup> Assisted Decision-Making (Capacity) Act 2015 (Republic of Ireland), Part 3, s10.

<sup>139</sup> Assisted Decision-Making (Capacity) Act 2015 (Republic of Ireland), Part 4, s 17.

<sup>140</sup> Assisted Decision-Making (Capacity) Act 2015 (Republic of Ireland), Part 5, s 36.

<sup>141</sup> Interview with Dr Frances Matthews, GP/lawyer who has worked as a doctor in Ireland (A Douglass, Dunedin, 25 November 2015).

<sup>142</sup> In England and Wales, many people lacking capacity due to mental disorder (including learning disability and dementia) come under the Mental Health Act 1983, although the concept of capacity is not mentioned in the legislation.

- 1.77 The MCA's starting point is to confirm in legislation the presumption at common law that an adult (aged 16 or over) has full legal capacity, unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. It includes provisions to ensure that in any decision-making process people are given all appropriate help and support to enable them to make their own decisions and to maximise their participation in any decision-making process.
- 1.78 The statutory framework is based on two fundamental concepts: lack of capacity and best interests.<sup>143</sup> For those who lack capacity to make particular decisions, the MCA provides a range of processes extending from informal arrangements to court-based powers, to govern the circumstances in which necessary decisions can be made on their behalf and in their best interests.
- 1.79 The essential provisions of the MCA (and corresponding provisions of the PPPR Act, where they exist) include:<sup>144</sup>
- *Principles*: Five guiding statutory principles – the values that underpin the legal requirements of the Act (MCA s 1; PPPR Act s 8).
  - *Capacity definition*: A definition of people who lack capacity (MCA s 2; no equivalent in PPPR Act).
  - *Capacity test*: A single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time (MCA s 3; PPPR Act ss 6, 12, 25(1)(b), 94(1) and 94(2)).
  - *Best interests standard*: A single criterion (best interests) for carrying out acts or taking decisions on behalf of people who lack capacity to consent to such acts or take those specific decisions for themselves (MCA s 4; no express criterion in PPPR Act).
  - *Codified defence of necessity*: Clarifying the law when acts in connection with the care or treatment of people lacking capacity to consent are carried out in their best interests without formal procedures or judicial intervention, with clear restrictions placed on the use of restraint, in particular, on acts resulting in deprivation of liberty (MCA ss 5 and 6; no equivalent PPPR Act, common law defence of necessity).<sup>145</sup>
  - *Lasting powers of attorney*: Extending the provisions for making powers of attorney which outlast capacity (referred to as “lasting powers of attorney” (LPA) – equivalent to an enduring power of attorney (EPOA) in New Zealand), covering health and welfare decisions as well as financial affairs, with safeguards against abuse and exploitation (MCA ss 22 and 23; PPPR Act Part 9 EPOAs).<sup>146</sup>

<sup>143</sup> These are discussed in Chapter 4 Defining Capacity and Chapter 5 Best Interests.

<sup>144</sup> Sections 1–4 of the Mental Capacity Act 2005 are set out in full in Appendix C.

<sup>145</sup> The provisions of s 5 are based on the common law “doctrine of necessity” as set out in *Re F*, above n 125. The MCA 2005 was subsequently amended by the Mental Health Act 2007 to provide procedural safeguards in cases where someone lacking capacity may be deprived of their liberty and their best interests – discussed below.

<sup>146</sup> Ashton, above n 26 at 165. The existing enduring powers of attorney regime under the Enduring Powers of Attorney Act 1985 continues concurrently with the same legal principles as existed when they were made, although within the framework of the MCA 2005. The EPA jurisdiction had several drawbacks, including that EPA relates only to property and affairs of the donor and as they operated with little official

- *Deputies*: Providing for decisions to be made by a “deputy”, to be appointed by a specialist Court of Protection; (MCA ss 16; PPPR Act s 18 (welfare guardian) or s 25 (property manager)).
- *Advance decisions*: Provides statutory rules, with clear safeguards, for the making of advance decisions as to refusal of medical treatment (MCA ss 23–25; Code of Rights, Right 7(5) (advance directives)).
- *Research on people who lack capacity*: Sets out specific parameters for research involving, or in relation to, people lacking capacity to consent to their involvement (MCA ss 30–34; no provisions in New Zealand legislation, HDC Code Right 7(4) applies).
- *Independent advocates*: Providing for the appointment of independent mental capacity advocates (IMCAs) to support people with no-one to speak for them who lack capacity to make important decisions about serious medical treatment and changes of accommodation, deprivation of liberty safeguarding procedures and research; (MCA, ss35–41; no equivalent in the PPPR Act, health and disability advocates with focus on complaints under the HDC Code).<sup>147</sup>
- *Code of Practice*: Authorising statutory guidance to be issued, in the form of a code (or codes) of practice, setting good practice standards for people using the Act’s provisions (MCA ss 42 and 43; no equivalent in the PPPR Act).<sup>148</sup>

1.80 The Mental Capacity Act also created two public bodies: the new Court of Protection (COP) and the Office of the Public Guardian (OPG). Both of these bodies play a key role in supporting and implementing the statutory framework.

## Court of Protection

1.81 Central to the MCA 2005 is the expanded Court of Protection (COP), which enjoys a wide-ranging jurisdiction to oversee the care of adults lacking mental capacity.<sup>149</sup> It is a superior court of record with jurisdiction relating to the whole of the MCA 2005 and with its own procedures and nominated judges.<sup>150</sup> As a specialist court it can deal with decision-making for adults (and children in a few cases) who may lack capacity to make specific decisions for themselves. The court is able to establish precedent (set examples for future cases) and it can build up expertise in all issues related to incapacity.<sup>151</sup> The court has wide powers including making interim orders and directions and calling for expert reports from a public guardian or a Court of Protection visitor.<sup>152</sup> Appeals go directly from the COP to the Court of Appeal.

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intervention were not viewed as protecting the incapable person who is vulnerable and at risk from abuse.

<sup>147</sup> Currently referred to as the “Deprivation of Liberty Safeguards” (DoLS).

<sup>148</sup> Mental Capacity Act 2005, ss 35–41, Code of Practice 2007.

<sup>149</sup> The MCA extended the jurisdiction of the old Court of Protection from property alone to personal care and welfare.

<sup>150</sup> Mental Capacity Act 2005, s 45.

<sup>151</sup> R Jones *Mental Capacity Act Manual* (6<sup>th</sup> ed, Sweet & Maxwell, London, 2014) at 383. There are extensive Court of Protection Rules that can be made under s 51, currently revised in 2014 and again in 2015.

<sup>152</sup> Mental Capacity Act 2005, s 49.

- 1.82 The emphasis in the MCA is on case-specific decisions and, where possible, the participation of the person who lacks capacity (referred to as “P”). A judge can visit a person in their own home in reaching a decision about whether a person lacks capacity and the court will not shy away from reaching its own decision on that matter, even if it is contrary to the expert evidence before the court.<sup>153</sup>
- 1.83 The Official Solicitor is the “litigation friend of last resort” for P, especially in serious medical treatment cases.<sup>154</sup> To ensure legal representation where the official solicitor is not funded, the Court has issued directions for the person, P, to be a party to proceedings and is in the process of establishing a panel of “accredited legal representatives”.<sup>155</sup> In common with the Family Court, there is a move towards greater transparency of court hearings and decisions.<sup>156</sup>
- 1.84 The Court has power to appoint substitute decision-makers, known as deputies,<sup>157</sup> to make decisions for people who lack capacity, or to remove deputies or attorneys who act inappropriately. The thrust of the MCA is that decisions about complex and serious issues are taken by a court rather than any individual, subject to commonsense practicalities such as where a series of decisions need to be made (for example, medical procedures) or the management of substantial assets.
- 1.85 A deputy’s powers must be as limited in scope and duration as is reasonably practicable in the circumstances.<sup>158</sup> By far the majority of the appointments of deputies, and of contested cases, relate to property and similar affairs, not personal welfare. In 2014, there was an increase of cases to 26,000, of which 90 per cent concern property and affairs, and of these, 90 per cent are uncontested.<sup>159</sup>
- 1.86 The living arrangements for people who lack capacity, and how healthcare packages are funded, are often central to the issues before the court under the MCA. In *In the matter of MN (Adult)*,<sup>160</sup> for instance, the Court of Appeal considered the scope of the COP’s jurisdiction where a care provider was unwilling to provide or fund the care sought by the patient or, as here, by the patient’s family. The case concerned where a young man should live (and receive education and care), and supervision of his contact with his parents and other family members where the relevant funding body had made it clear that it was not prepared to fund contact between him and his family at the parents’ home. Sir James Munby P, giving the lead judgment, held that the COP was bound to choose between the options that were actually available.<sup>161</sup> It had no more power, just because it was acting on behalf of an adult who lacked

<sup>153</sup> Interview with Judge Elizabeth Batten, Court of Protection (A Douglass, London, 16 April 2015).

<sup>154</sup> Interview with Janet Illett, Deputy Official Solicitor, (A Douglass, London, 7 May 2015).

<sup>155</sup> The Court of Protection (Amendment) Rules 2015, r 3A.

<sup>156</sup> Sir J Munby “Practice Guidance (Transparency in the Court of Protection): Publication of Judgments” (16 January 2014) <https://www.judiciary.gov.uk/wpcontent/uploads/JCO/Documents/Guidance/transparency-in-the-cop.pdf>.

<sup>157</sup> Mental Capacity Act 2005, s 19(9)(a). There is a panel of professional deputies who are often solicitors. The court can request from a property and affairs deputy some form of security (such as a guarantee bond).

<sup>158</sup> Mental Capacity Act 2005, s 16(4) as discussed in *G v E* [2010] EWHC 2512 (COP) Baker J at [59].

<sup>159</sup> Sir William Charles, Vice-President of the Court of Protection of England and Wales (to the House of Lords MCA Committee, 26 November 2013) <http://www.parliamentlive.tv/Event/Index/0fe8cea8-89db-453c-afb2-7a97d8b20db1>.

<sup>160</sup> [2015] EWCA Civ 411, Sir James Munby P, upholding the decision of Eleanor King J in the Court of Protection.

<sup>161</sup> *In the matter of MN*, above n 160 at [34]. Leave has been granted to one of MN’s parents to appeal the decision of the Court of Appeal on whether the COP is constrained solely to consider available options presented to it.



capacity, to obtain resources or facilities from a third party, whether a private individual or a public authority, than would the adult if they had capacity to obtain the resources personally.

- 1.87 While the MCA is considered sensible legislation, the statutory jurisdiction is limited to matters that fall under the MCA. This limitation can be problematic. For example, cases involving vulnerable adults (who have capacity) require separate proceedings under the inherent jurisdiction of the High Court, as do public law cases involving judicial review applications to the High Court's Administrative Division. Mr Justice Charles, Vice President of the COP, considers a better solution would be to create a "one-stop shop" designed to cover not only the law under the statute but those issues that can only be decided under the inherent jurisdiction or public law jurisdiction.<sup>162</sup>

### *Serious healthcare and treatment decisions*

- 1.88 As well as property and affairs, the COP now also deals with serious decisions affecting healthcare and personal welfare matters. These matters were previously dealt with by the High Court under its inherent jurisdiction, if they came before the courts at all. The COP can make a declaration as to the lawfulness of a specific act relating to a person's care or treatment (where somebody has either carried out the action or is proposing to).<sup>163</sup>

- 1.89 This power to decide on the lawfulness of an act is particularly relevant for major medical treatment cases where there is doubt or disagreement over whether the treatment would be in the person's best interests.<sup>164</sup> In addition, the Code of Practice refers to the kind of cases that should be brought before the Court. These include:

- decisions about proposed withholding or withdrawal of artificial nutrition and hydration from patients in a permanent vegetative state;<sup>165</sup>
- cases involving organ or bone marrow donation by a person who lacks capacity to consent;<sup>166</sup>
- cases involving the proposed non-therapeutic sterilisation (e.g. for contraceptive purposes) of a person who lacks capacity to consent.<sup>167</sup>

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<sup>162</sup> Interview with Mr Justice Charles, Vice-President, The Court of Protection (A Douglass, Royal Courts of Justice London, 9 June 2015).

<sup>163</sup> Mental Capacity Act 2005, s 15.

<sup>164</sup> Department of Constitutional Affairs *Mental Capacity Act 2005, Code of Practice* "Serious Healthcare and Treatment Decisions" (TSO, Norwich, 2007) at 143–145. Although this power is based on the declaration of lawfulness (which doctors might want), the decision of the Court as recorded in the order under s 16(2)(a), which in effect represents the giving of the necessary consent on the person's behalf. Email from A Ruck Keene (barrister) to A Douglass (17 January 2016). See for example, *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 and *In the Matter of MN*, above n 160.

<sup>165</sup> *Airedale NHS Trust v Bland* [1993] AC 789. The COP recently expanded the declaratory jurisdiction to withdrawing life-sustaining treatment from someone who was only in a minimally conscious state, not just a permanent vegetative state: *M v Mrs N* (by her litigation friend, the Official Solicitor) [2015] EWCOP 76(Fam).

<sup>166</sup> *Re Y (Mental Incapacity: Bone Marrow Transplant)* [1996] 2 FLR 787. It was in Y's best interest for her to donate bone marrow to her sister. The Court decided that it was in Y's best interest to continue to receive strong emotional support from her mother, which might be diminished if her sister's health were to deteriorate further, or she were to die.

<sup>167</sup> *Re A (Medical Treatment: Male Sterilisation)* (1999) 53 BMLR 66. A mother applied for a declaration that a vasectomy was in the best interests of A, her son (who had Down Syndrome and was borderline between significant and severe impairment of intelligence) in the absence of his consent. After balancing

- 1.90 There is a specific process for dealing with “serious medical treatment” cases which must be referred to the Court,<sup>168</sup> including cases involving a “novel ethical dilemma”. Practice directions define “serious medical treatment” as treatment that involves providing, withdrawing or withholding treatment in circumstances where there may be a fine balance between the benefits and burdens to the patient, or situations in which there is a choice of treatment and what is proposed would likely involve serious consequences for the patient.<sup>169</sup>
- 1.91 There are many reported cases where life-saving treatment has been ordered in the face of trenchant opposition from the person who lacks capacity. For example, in *Re E (Medical Treatment: Anorexia)*<sup>170</sup> all of the parties supported with different degrees of strength the view that it would not be in the best interests of a 32-year-old woman with severe anorexia nervosa to be force-fed. Nonetheless Jackson J held that, as the woman did not have capacity to make the decision about treatment by forcible feeding, the court must take the decision that was in her best interests.
- 1.92 By comparison, in a more recent case, *Wye Valley NHS Trust v Mr B*,<sup>171</sup> the COP affirmed the right of an individual, deemed to lack capacity as a result of mental illness marked by religious delusions, to refuse life-saving medical treatment. Even though Mr B was found to lack capacity to refuse amputation of his gangrenous leg, Jackson J came to the clear conclusion that enforced amputation would not be in his best interests.<sup>172</sup>
- 1.93 While these serious medical treatment cases are considered in a different medico-legal context than New Zealand, they demonstrate the ability of the Court to be an independent decision-maker and take the burden of decision-making from clinicians and healthcare providers in circumstances that are complex and ethically challenging for all of the parties involved.

## The Public Guardian and the Register of Powers of Attorney

- 1.94 The MCA established a new statutory office, known as the Public Guardian. The Office of the Public Guardian (OPG) is an executive agency of the Ministry of Justice, set up to support the Public Guardian. These agencies exist to help make sure that adults who lack capacity to make decisions for themselves are protected from abuse. The functions of the Public Guardian fall into three categories: establishing and maintaining a register of LPAs; supervising deputies (welfare guardian or property manager) appointed by the court; and investigations – referred to as “safeguarding referrals”.<sup>173</sup>

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the burdens and benefits of the proposed vasectomy to A, the Court of Appeal held that the vasectomy would not be in A’s best interests.

<sup>168</sup> *Airedale NHS v Bland*, above n 165. The case law requirement to seek a declaration in cases involving the withholding or withdrawing of artificial nutrition and hydration to people in a permanent vegetative state is unaffected by the Act.

<sup>169</sup> Court of Protection: Practice Direction 2015, r 9E, authorised under Mental Capacity Act 2005, s 52. See for example, *NHS Trust v FG* [2014] EWCOP 30, where Mr Justice Keehan annexed guidance to the judgment in cases where a pregnant woman who lacks, or may lack, the capacity to make decisions about her obstetric care resulting from a diagnosed psychiatric illness.

<sup>170</sup> [2012] EWHC 1639 (COP).

<sup>171</sup> [2015] EWCOP 60 Peter Jackson J.

<sup>172</sup> *Wye Valley NHS Trust v Mr B*, above n 171 at [38]: “A conclusion that a person lacks decision-making capacity is not an ‘off-switch’ for his rights and freedoms” per Jackson J. See discussion of this case in Chapter 2E Supported Decision-making.

<sup>173</sup> Mental Capacity Act 2005 s 59; Office of the Public Guardian *Annual Report and Accounts 2013–14*, (William Lea Group, London, 2014).

- 1.95 Since the commencement of the MCA in October 2007, the OPG has registered a total of 1,436,731 LPAs.<sup>174</sup>
- 1.96 The key objective of the OPG is to develop an approach to resolving issues with deputies and attorneys that does not require recourse to the COP, by building an in-house capacity to use mediation to resolve cases where parties are in dispute.<sup>175</sup>
- 1.97 Safeguarding referrals are received from a number of sources, including relatives, local authorities, care homes and financial institutions.<sup>176</sup> The Code of Practice widely defines the types of abuse that the MCA protections are designed to prevent, including financial, physical, sexual, psychological abuse, and neglect and acts of omission.<sup>177</sup>
- 1.98 Court of Protection visitors have an important part to play in investigating possible abuse.<sup>178</sup> They advise on how anyone given power under the Act should be, and is, carrying out their duties and responsibilities. There are two types of visitor: general visitors and special visitors. Special visitors are registered medical practitioners with relevant expertise. The COP or Public Guardian can send whichever type of visitor is most appropriate to visit and interview a person who may lack capacity, or an attorney or deputy, and to inspect any relevant healthcare or social care records.
- 1.99 The Public Guardian investigation process can ultimately result in an application to the court to remove a deputy or an attorney. Denzil Lush, Senior Judge of the COP, credits the OPG's supervisory role over deputies, and its effectiveness in identifying wayward deputies, for the increasing incidence of applications to the court – an increase from 185 in 2013 to 345 in 2014.<sup>179</sup>
- 1.100 In Judge Lush's experience, financial abuse in England is almost exclusively perpetrated by close relatives.<sup>180</sup> Of a sample of 250 cases in which the power of attorney was revoked by the court because of financial abuse of the donor of the power, the victims of abuse were generally four or five years older than the average donor. Of the abused donors, 174 (70 percent) were women and 76 (30 percent) were men, compared with 61.25 percent and 38.75 percent respectively in the overall sample of 3,958 donors as a whole.<sup>181</sup> Further conclusions can be drawn from the relationship of the abusive attorney to the donor. In 68 percent of cases, the abuser was the donor's child; 35 percent of the donors were abused by their son, 22 percent by their daughter, and 11% by more than one child.
- 1.101 The typical scenario is not of an unscrupulous individual downloading a power of attorney form from the internet and getting a vulnerable elderly person to sign it, but quite the opposite.

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<sup>174</sup> This includes cases that are no longer on the Register, due to withdrawal or cancellation. Interview with Marion Bowgen, Supervision Project, Office of the Public Guardian (A Douglass, London, 4 June 2015).  
<sup>175</sup> P Hartley-Jones "The Role of the Office of the Public Guardian Investigations of Abuse" (2011) 13 J Adult Protect 160 at 161.

<sup>176</sup> Office of the Public Guardian, *Annual Report and Accounts 2014-2015* (William Lea Group, London, 2015) at 15. [www.gov.uk/government/publications](http://www.gov.uk/government/publications). The OPG investigated 743 cases of the 1970 safeguarding referrals during the 2014/15 business year, and 695 investigations were concluded.

<sup>177</sup> Mental Capacity Act 2005, Code of Practice, above n 164 at 245.

<sup>178</sup> Mental Capacity Act 2005, Code of Practice, above n 164 at 248.

<sup>179</sup> D Lush "Financial Crime Committed Against the Elderly and Infirm: A Review of its Increasing Prevalence and how Effective Practitioners, Public Bodies and the Courts are Tackling It" (paper presented at joint seminar STEP London Central Branch and ACTAPS, London, 10 December 2014).

<sup>180</sup> For example, the following three cases all involve members of the person's family: *Re Harcourt* [2013] COPLR 69, Mrs Harcourt's daughter; *Re Buckley* [2013] COPLR 39, Miss Buckley's niece; and *Re GM* [2013] COPLR 290, GM's late husband's niece and great niece.

<sup>181</sup> Lush, above n 179 at 10.

In three-quarters of these abuse cases there was input from the legal or medical professions at the time of the creation of the power; there are individuals who are required to assess the donor's capacity to create an enduring power of attorney.<sup>182</sup>

- 1.102 The granting of a power of attorney is an important expression of autonomy: it allows a prior exercise of the individual's autonomy, when the person has capacity, to direct or make provision for when they may subsequently lack capacity.<sup>183</sup> The combination of having a register of powers of attorney plus a public agency to oversee its use has been a cornerstone of the new COP's ability to tackle financial crimes and abuse of mainly older adults who lack capacity.
- 1.103 In New Zealand, the 2007 amendments to the PPPR Act have not resolved the ongoing problems of misuse and abuse of EPOAs, first raised by the Law Commission in 2000 and 2001,<sup>184</sup> and still apparent in the minor changes currently being made to Part 9 of the PPPR Act.<sup>185</sup> A key factor promoting the success of the English model is the fact that the national register of LPAs is supported by a public agency, to ensure effective supervision of such powers of attorneys.. This would therefore be an essential reform to be adopted in New Zealand.<sup>186</sup>

### **Mental Health Act 1983 (MHA)**

- 1.104 In addition to the MCA, England and Wales have the Mental Health Act 1983 (MHA) and its accompanying Code of Practice<sup>187</sup> which allow for the detention, hospitalisation, and/or treatment of people with a "mental disorder". Mental disorder is broadly defined as "any disorder or disability of the mind",<sup>188</sup> and can include learning disability and personality disorder. English mental health law provides for a system of guardianship for some patients under the MHA, although "capacity" is not a concept referred to in the legislation.<sup>189</sup> Guardians appointed under the MHA have the exclusive right to decide where a patient should live, taking precedence over an attorney or deputy appointed under the MCA.<sup>190</sup>
- 1.105 The dividing line between the need to use the compulsory powers of the MHA and the need - to respect a person's prior exercise of autonomy in an advance decision is not always clear cut. The powers under the MHA to detain and treat people for a mental disorder apply even if a patient has capacity under the MCA. In *Nottinghamshire Healthcare NHS Trust v RC*<sup>191</sup> a young man with capacity had a severe personality disorder and was detained under the MHA. RC required a blood transfusion, but was a practicing (unbaptised) Jehovah's Witness. The Court held that RC had capacity to refuse a blood transfusion as it was not a medical treatment

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<sup>182</sup> Ibid. Of a sample of 100 cases, 51 were legal professionals; solicitor, barrister or legal executive.

<sup>183</sup> Mental Capacity Act 2005, ss 24–26. The provision for advance directions (known as advanced directives in New Zealand) are also an expression of a person's prior autonomy.

<sup>184</sup> Refer above: PPPR Act – law reform at 17.

<sup>185</sup> The current amendment proposes to reverse the independent witnessing requirements for EPOAs under the 2007 Amendments. The Law Society submitted that the 2007 amendments increased the cost and complexity of establishing EPOAs and as a result the number of people completing EPOAs has decreased not increased: New Zealand Law Society submission on Part 21 (Enduring Powers of Attorney) Statutes Amendment Bill 2015, dated 29 January 2016.

<sup>186</sup> See Chapter 8 Conclusion - Checklist for Reform.

<sup>187</sup> Department of Health *Mental Health Act 1983: Code of Practice* (TSO, Norwich 2015) at 22. The Code sets out the overarching principles of the Act, which are not included in the statute itself.

<sup>188</sup> Mental Health Act 1983, s 1(2).

<sup>189</sup> Mental Health Act 1983, s 8(1)(a).

<sup>190</sup> *MHA Code of Practice*, above n 187 at 342.

<sup>191</sup> *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWHC 1317 (COP). In this case, Mostyn J sat as a COP judge to consider RC's capacity and the advance direction to refuse treatment under the MCA, but as a High Court judge considering the lawfulness of the actions of the treating psychiatrist.

for the mental disorder.<sup>192</sup> It upheld the validity of his advance decision, despite self-harming behaviours and the fact that RC was pursuing a “self-destructive course” leading to inevitable death. Justice Mostyn recognised the ethical dilemma that confronted the treating psychiatrist who had the power under the MHA to override RC’s advance decision and impose treatment against his will but instead used the court process to confirm the validity of the advance direction.

- 1.106 In 1999, an expert committee, chaired by Professor Geneva Richardson, reviewed the mental health legislation in England and Wales, recommending specific legislation for people with long-term incapacity.<sup>193</sup> The report foreshadowed the problems with how to respond to informal patients not subject to compulsory powers under the MHA and the interface with the subsequent mental capacity legislation.

### Ongoing law reform in England and Wales

- 1.107 The comfortable assumption of the English Mental Health Act (of 1959 and 1983), that people could be admitted to hospital and detained there for psychiatric treatment, without formality, provided they did not object, was dealt a “serious blow”<sup>194</sup> by the European Court of Human Rights in Strasbourg (ECtHR)<sup>195</sup> following a decision in the House of Lords.<sup>196</sup> It exposed a gap in the interface between mental health and mental capacity law, known as the “Bournewood gap”: this is the inability of compliant people who lacked capacity to object to their detention, identified in a case involving Bournewood Hospital. Further changes were made to the Mental Capacity Act in an attempt to protect this vulnerable group of informal compliant patients who lacked capacity and did not have the benefit of the safeguards provided by the mental health legislation.

- 1.108 As Lady Hale explains in her textbook on mental health law:<sup>197</sup>

If the reality was that a person was being deprived of his liberty within the meaning of Article 5 [of the European Convention on Human Rights], there had to be some safeguards to protect him against arbitrary action, even if this was meant for his own good. Indeed safeguards against unjustified deprivation of liberty were needed, whether the reason for it was mental or physical disorder or simply to keep him safe.

- 1.109 The result was the Deprivation of Liberty Safeguards regime (universally known as the DoLS), inserted into the Mental Capacity Act 2005 by the Mental Health Act 2007.

- 1.110 This regime was enacted to “plug” the Bournewood gap. First, there was an amendment to the Mental Capacity Act in 2007 to insert certain procedural safeguards for detained incapacitated persons, called the “DoLS”. Second, a post-legislation scrutiny report was prepared by the House of Lords in 2014 that described the DoLS as not fit for purpose. Third, around the same time, a decision of the Supreme Court, *Cheshire West*, expanded the range of circumstances in which a person must be regarded as deprived of their liberty. So many

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<sup>192</sup> Mental Health Act 1983, s 58.

<sup>193</sup> Report of Expert Committee, *Review of the Mental Health Act 1983* (Department of Health, London, 1999).

<sup>194</sup> B Hale *Mental Health Law* (5th ed, Sweet & Maxwell, London, 2010) at 4.

<sup>195</sup> *HL v United Kingdom*, above n 4. The European Court of Human Rights held that the use of the common law power of necessity to detain people in this context, rather than using the Mental health Act 1983, was not adequate protect against the risk of arbitrary detention and was in breach of art 5 (1)(e) of the European Convention on Human Rights 1950 (ECHR) and also art 5(4) because of the lack of any adequate court review of the lawfulness.

<sup>196</sup> *Bournewood*, above n 5.

<sup>197</sup> Hale, above n 194 at 4.

more people in care homes and hospitals, as well as in community settings such as foster care placements, were deprived of liberty than had previously been understood. Some lawful justification for this was therefore required.

- 1.111 Under the MCA, the DoLS set out a set of procedures that must be followed to render the person's deprivation of liberty lawful: namely, when they are detained pursuant to a decision made by the court or under an urgent or standard authorisation given under the DoLS regime.<sup>198</sup> In *Cheshire West*, the majority in the Supreme Court held that, in cases involving the placement of mentally incapacitated persons, the test to be applied in determining whether they are being deprived of their liberty is whether they are under the continuous supervision and control of those caring for them and are not free to leave. But the DoLS regime does not authorise such deprivation of liberty outside a care home or hospital. So, the consequence was that, where it occurred in other settings, such as in a foster home, an application to the COP would be required to obtain the necessary authority, as DoLS does not extend to such settings.
- 1.112 The DoLS were originally designed to provide a comprehensive set of safeguards for what was thought would be a relatively small number of people who would be made subject to them (less than 6,000 people in England and Wales).<sup>199</sup> However, since the *Cheshire West* judgment there has been a significant increase in DoLS applications and in the associated resource implications for funding the scheme.<sup>200</sup> As an indication of the potential impact of the *Cheshire West* judgment, the Alzheimer's Society predicts that there will be one million people with dementia in the United Kingdom by 2025. The potential increase of people who may lack capacity poses a tremendous challenge for everyone: sufferers, carers and medical and social care professionals.<sup>201</sup>
- 1.113 The scale of the problem following *Cheshire West* is graphically summarised by Allen:<sup>202</sup>

We are presently witnessing something very unique, something historical. And that is the mass authorisation of deprivation of liberty of a significant proportion of the disabled population. Tens of millions of pounds are being diverted from health and social care budgets to enable such authorisations on an industrial scale. Up and down the country – as Art 5 ECHR takes hold – an additional layer of legal procedures are now required to oversee health and social care. We are in the throes of what might be called a great confinement.

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<sup>198</sup> In addition, deprivation of liberty may be necessary for life-sustaining treatment or doing any "vital act": Mental Capacity Act 2005, ss 4A and 4B.

<sup>199</sup> Interview with Tim Spencer-Lane, Nicholas Paines QC, Commissioner responsible for the DoLS and the Rt Hon Sir David Lloyd-Jones, Chairman of the Law Commission of England and Wales (Law Commission) (Alison Douglass, London, 28 April 2015). In a 12 month period in 2013-14 the total number of applications in England was 11,300. In the subsequent 12 month period in 2014-15 there were 113,300 DoLS applications, of which 36 percent were granted (40,000). These figures are considered to be the "tip of the iceberg" as some local authorities are not prioritising cases of alleged deprivation of liberty in supported living and community settings, such is the burden that has been placed upon them: Law Commission *Mental Capacity and Deprivation of Liberty: A Consultation Paper No.222* (TSO, London, 2015) at 17.

<sup>200</sup> There has also been resistance among some members of the judiciary who have stated their dissatisfaction with the *Cheshire West* judgment arguing that the law is "In a state of serious confusion": Mostyn J. This criticism was rejected by the Court of Appeal: "Even if *Cheshire West* is wrong, there is nothing confusing about it. In our view, the judge's passionate view that the legal analysis of the majority in *Cheshire West* is wrong is in danger of distorting his approach to these cases." *KW & Ors v Rochdale Metropolitan BC* [2015] EWCA Civ 1054 at [33], Lady Justice Black, MR.

<sup>201</sup> A Ruck Keene, V Butler-Cole, N Allen and others, 39 Essex Street "Mental Capacity Law Guidance Note" (London, 2014): [www.39essex.com/mental-capacity-law-guidance-note-brief-guide-carrying-capacity-assessments](http://www.39essex.com/mental-capacity-law-guidance-note-brief-guide-carrying-capacity-assessments).

<sup>202</sup> N Allen "The (not so?) great confinement" (2015) Eld LJ 45.

- 1.114 England is now reviewing the labyrinth of reforms at a time when there is a heavy burden on the National Health System to implement the DoLS, and in the wake of the Winterbourne View scandal affecting the rights of people with learning disabilities.<sup>203</sup> The Law Commission has consulted on a proposal to replace the DoLS that would cover both institutional and “community” settings, and is required to provide draft legislation to the Government by the end of 2016.<sup>204</sup>

### Problems with implementation of the MCA

- 1.115 In addition to the DoLS scheme, the second problem highlighted by the House of Lords’ report in 2014 was with the implementation of the MCA. There is a lack of awareness and understanding of the MCA which has led, in some instances, to perverse outcomes for people who lack capacity. As poignantly stated by Baroness Baker, the House of Lords Select Committee was “trying to get to the bottom of why this legislation, which everybody tells us is so good, is so patchily observed or widely ignored”.<sup>205</sup>
- 1.116 The report found that prevailing cultures of paternalism (in health) and risk aversion (in social care) had prevented the Act from becoming widely known or embedded. It called for the establishment of an independent oversight body, as the Act (and its core principles) had failed to become embedded in everyday practice.<sup>206</sup>
- 1.117 Too often, the empowering ethos of the MCA 2005 gave way to concerns of paternalism, risk and safeguarding, with decisions taken to overrule the wishes and feelings of the person lacking capacity rather than to support them. At the same time, the presumption of capacity had sometimes become an excuse for the provision of substandard care, or indeed denial of care entirely, on the basis of a highly suspect view that the person was agreeing and had capacity to agree to such inappropriate care. This was particularly evident when the choice of the person lacking capacity worked to the financial advantage of a service provider. There was little evidence of supported decision-making, notwithstanding its express requirements in the Act.<sup>207</sup>

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<sup>203</sup> The Winterbourne View hospital inquiry occurred at Winterbourne View, a private hospital in South Gloucestershire, England. A Panorama investigation, broadcast on television in 2011, exposed the physical and psychological abuse suffered by people with learning disabilities and challenging behaviour at the hospital, despite the fact that local services and the English national regulator (Care Quality Commission) had received various warnings. There have been subsequent reports for a new national framework: Transforming Care and Commissioning Steering Group *Winterbourne View – Time for Change: Transforming the commissioning of services for people with learning disabilities and/or autism* (NHS, London, 2014).

<sup>204</sup> These developments and how New Zealand might address the Bournemouth gap are discussed in Chapter 3 Liberty Safeguards.

<sup>205</sup> Select Committee on the Mental Capacity Act 2005, Volume 1 (2013) 771 cited in P Skowron “Evidence and Causation in Mental Capacity Assessments *PC v City of York Council [2013] EWCA CIV 478*” Med L Rev fwu014.

<sup>206</sup> HM Government *Valuing every voice, respecting every right: Making the case for the Mental Capacity Act – The Government’s response to the House of Lords Select Committee Report on the Mental Capacity Act 2005* (Williams Lea Group, London, 2014) <http://www.gov.uk/government>. The independent oversight body was a recommendation of the Government’s response, but has not yet eventuated.

<sup>207</sup> Mental Capacity Act 2005, ss 1(3), 3(2), 4(4). See also P Bartlett “Good Act, Poor Implementation: A Report of the House of Lords Post-Legislative Scrutiny Committee on the Mental Capacity Act 2005” (2014) 4 Eld LJ 123 at 157.

- 1.118 The English experience to date has demonstrated that even the most up-to-date law that has a clear explanation of its core principles, is difficult to embed. It requires participation from the professionals and the appointed decision-makers who must implement the law.

### Vulnerable adults and the inherent jurisdiction

- 1.119 Traditionally, the law's protective function was engaged by a person's lack of capacity. More recently, the English courts have developed the notion of "vulnerable adults", adults who are capacitous<sup>208</sup> (and therefore are not subject, now, to the MCA) but who are nevertheless thought to need protection.

- 1.120 Until 1959, the English High Court and its predecessors had jurisdiction over the lives of adults who lacked capacity. However, according to Munby LJ (now President of the CoP), although the court's inherent jurisdiction in relation to incapacitated adults' *financial* affairs was transferred to the (old) Court of Protection, the corresponding jurisdiction in relation to personal care and welfare was "inadvertently abolished".<sup>209</sup> As a result, the court's inherent jurisdiction has been rediscovered to fill this gap.<sup>210</sup>

- 1.121 In the leading judicial statement in this respect, Munby P identified the "vulnerable adult" as:<sup>211</sup>

(S)omeone who whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

- 1.122 In the same judgment, Munby P described the inherent jurisdiction as follows:<sup>212</sup>

... the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.

- 1.123 The Court of Appeal subsequently made clear that this jurisdiction had survived the coming into force of the MCA, in *DL v A Local Authority*<sup>213</sup> where elderly parents with capacity were abused and unduly influenced by their son to the extent that DL was seeking to coerce his father into transferring the ownership of the house into DL's name and the mother was forced to move into a rest home. The Court found the parents' capacity to make balanced and considered decisions about their relationship with their son was compromised and invoked the inherent jurisdiction to make orders to control DL's behaviour.<sup>214</sup>

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<sup>208</sup> The Latin term for capacity/incapacity is "capax" and "incapax".

<sup>209</sup> Munby LJ "Taking Stock: The Mental Health and Mental Capacity Reforms" Keynote address to the Cardiff Law School Conference at Manchester (15 October 2010) (emphasis in the original) in A Szerletics *Best interests decision-making under the Mental Capacity Act: Green Paper Technical Report* (Essex Autonomy Project, University of Essex, 2011) at 7.

<sup>210</sup> The *parens patriae* power ceased to exist for adults who lacked capacity and was put on a statutory footing under the Mental Health Act 1959 and limited powers of guardianship under the Mental Health Act 1983.

<sup>211</sup> *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam) [82].

<sup>212</sup> *Re SA*, at [77].

<sup>213</sup> [2012] EWCA Civ 253.

<sup>214</sup> Subsequent case law has used the inherent jurisdiction to authorise deprivation of liberty of a deluded man who lacked capacity but was under the MHA to receive force feeding: *A NHS Trust v Dr A* [2013] EWHC 2442 (COP) Baker J. In *NCC v PB and TB* [2014] EWCOP 14 [2015] COPLR 118, Parker J



1.124 The wide-ranging jurisdiction and the basis upon which it might intervene in an individual's decisions has, however, been criticised as leading to a confused and outmoded concept of the vulnerable older adult, as it conflates what is considered as in a person's best interests under the MCA, with the goal of facilitating an individual's autonomous decision-making capability.<sup>215</sup> The use of the inherent jurisdiction has none of the accompanying safeguards for assessing what is in a person's best interests under the MCA. It blurs the dividing line between those people on whose behalf decisions can be taken by a court and those people who need protection but in respect of whom decisions cannot be taken. As Ruck Keene says:<sup>216</sup>

[The inherent jurisdiction] risks leading to a situation where decisions are taken on behalf of the capacitous but vulnerable, rather than steps being taken to create a safe space for them to take their own decisions, at which point the entire point of the MCA disappears.

1.125 A justification for the expanded jurisdiction is the difference between having capacity and being autonomous: a person may have capacity but be unable to exercise it because they are in an abusive relationship. Protection of autonomy requires the courts to protect people who are robbed of their autonomy and who are pressurised or forced by others (or by delusion) into acting against their genuine wishes.<sup>217</sup>

1.126 The real dividing line between the MCA and the inherent jurisdiction remains uncertain, as does the extent to which undue influence, exerted by others, has a bearing on a person's capacity for decision-making, whether in respect of property or personal care and welfare decisions. In *Re BKR*, a recent case decided by the Singapore Court of Appeal (where the Singapore MCA is almost identical to the English MCA), the Court took into account an elderly woman's susceptibility to undue influence in finding she lacked capacity. The Court observed that there was a "confluence of mental impairment and undue influence", and that the proven or potential presence of undue influence is relevant to an account of the person's circumstances and a finding of incapacity.<sup>218</sup>

1.127 The problem that has emerged under English law is that there are some individuals who retain capacity but who are in need of protection. Incapacity as defined under the MCA requires the inability to make a decision to be linked to a person's impairment ("impairment of, or a disturbance of the functioning of, the mind or brain").<sup>219</sup> Not only is this approach viewed as discriminatory under human rights law (CRPD), it has created a problem because the court

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observed that in determining whether the causative nexus between an individual's mental impairment and the inability to make a decision under the MCA, the question was whether the impairment was an "effective, material or operative cause of the incapacity, even if other factors come into play."

<sup>215</sup> L Pritchard-Jones "The good, the bad, and the "vulnerable older adult"" (2016) *J Soc Welf Fam Law* DOI: 10.1080/09649069.2016.1145838 1 at 13. This article examines the Care Act 2014 and recent judgments involving the court's inherent jurisdiction to protect vulnerable adults. See also M Dunn, I Clare and A Holland, "To Empower or to Protect? Constructing the Vulnerable Adult in English Law and Policy" (2008) 28 *Leg Stud* 234.

<sup>216</sup> Email communication from A Ruck Keene (Barrister, London) to A Douglass (20 May 2015).

<sup>217</sup> Herring, above n 25, at 58.

<sup>218</sup> *Re BKR* [2015] SGCA 26 (Singapore Court of Appeal) at 88ff. The question before the court was whether BKR, an extremely wealthy elderly woman, had capacity to make decisions regarding her property and affairs in the face of competing interests among her adult children. A line of English cases were cited, emphasising that susceptibility to undue influence is only relevant where it is caused by mental impairment. For example, *London Borough of Redbridge v G* [2014] EWHC 485 (COP), where the court took account of both the person's impairment in the functioning of G's mind and also the influence C and F had over her in coming to the conclusion that G lacked capacity to take material decisions.

<sup>219</sup> Mental Capacity Act 2005, s 2(1).

can only intervene under the MCA when the inability to make a decision is due to the impairment.<sup>220</sup> The inherent jurisdiction has been used to fill this lacuna in the English law.

### **MCA – a summary**

- 1.128 There are some very positive features of the Mental Capacity Act, notably much greater transparency (of both the standards and the process) concerning decision-making regarding people who lack capacity, under a single piece of legislation that has codified much of the common law. The Act provides for the specialised jurisdiction of the Court of Protection with corresponding expertise; a Code of Practice to accompany it; a streamlined procedure for dealing with serious medical treatment cases; and a register of powers of attorney, with oversight by the Office of the Public Guardian which can investigate potential abuse and initiate reviews by the Court of Protection.<sup>221</sup>
- 1.129 Despite the distraction of the ongoing reform of the DoLS, the mental capacity legislation in England has provided a real focus and visibility for mental capacity law and practice. There is corresponding recognition that issues of capacity permeate many fields of law and practice, not just those within the scope of the Court of Protection. Better training of lawyers and judges has been regarded as essential to develop a new legal culture that takes into account the needs of vulnerable individuals who as members of society encounter the legal system.<sup>222</sup>
- 1.130 The changing legal landscape and the impetus for ongoing reform of capacity law in the United Kingdom and elsewhere is due, in part, to contemporary thinking about the adequacy of the law's approach to autonomy and about the growing role to be played by human rights instruments in the construction of capacity as a legal concept.

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<sup>220</sup> See Chapter 4 Defining Capacity.

<sup>221</sup> These features as well as some of the legal provisions are set out in the checklist for reform of New Zealand's law.

<sup>222</sup> Ashton, above n 26 at x (Introduction). See S Miles "Time to accredit mental capacity work" (2015) 5 Eld L J 3.