

Guidance on use of Mental Capacity Act 2005 re 16/17 year olds

1. Introduction:

When making plans and care or treatment arrangements for 16 and 17 year olds it is necessary to determine whether the young person (YP) has the capacity to consent to the arrangements that are being made for him/her. This is essential as the safeguards and steps that need to be put in place may vary if the YP lacks capacity to consent.

Practitioners and managers need to be aware of the inter-relationship between the Mental Capacity Act 2005 and other related legislation which include the Children Acts 1989 and 2004, the Children and Families Act 2014, the Human Rights Act 1998, the European Convention on Human Rights and the Mental Health Act.

The MCA 2005 does not apply to under 16s but does apply to 16 and 17 year olds

The following are the key principles:

- A person (including a YP) is assumed to have capacity. It is not for the person to prove they have capacity but for others to provide evidence that they do not;
- A person must be given all practicable support to help make their own decision
- A person with capacity can make an unwise decision-- if a person understands the consequences of their decisions, it is theirs to make;
- Acts done on behalf of someone who lacks capacity must be in their best interests. When considering best interests it is important to check the person's previously expressed wishes, feelings, beliefs and to consult with interested others eg family, friends, carers, professionals
- The acts must be done by the least restrictive means: before an act is done or a decision made, it must be considered whether it can be achieved in a way that is less restrictive of the person's rights or freedoms of action.

The lack of capacity must arise as a result of an impairment or disturbance in the functioning of the brain or mind (a mental disorder) and may be temporary or permanent.

Making a competent decision entails:

- Understanding the information relevant to the decision (including the foreseeable consequences of deciding one way or another or of failing to make a decision)
- Being able to retain the information (even if for only a short time)
- Using the information to make the decision
- Being able to communicate the decision

Practitioners need to bear in mind:

- the best interests of the YP must always be a significant consideration
- everyone who works with children has a responsibility for keeping them safe and to take prompt action if welfare needs and safeguarding concerns are identified
- the developmental process from childhood to adulthood, particularly during adolescence, involves significant changes (physical/emotional/cognitive development) and these factors need to be taken into account in addition to a YP's personal circumstances when assessing whether they have a mental disorder
- the YP's wishes, views and feelings should always be sought, their views taken seriously and they should be kept as fully informed as possible; explanations should be given in a way they understand
- any intervention in the life of a YP that is considered necessary by reason of their mental disorder should be the least restrictive option and the least likely to stigmatise them. It should also result in the least possible separation from family/friends/their community.

The following concepts are all relevant and require careful consideration for YPs of this age group:

- consent
- assessing capacity (YPs) or competence (children) to make decisions
- best interests
- the role of those with parental responsibility and the 'scope of parental responsibility' and
- deprivation of liberty (DOL)

Consent

Assessing competence in under 16s

The test for assessing whether a child under 16 can give valid consent differs from that of a YP aged 16 or 17. The test for children under 16 is determined by considering whether they are 'Gillick competent'. The concept of Gillick competence reflects the child's increasing development to maturity. The understanding required to make decisions about different interventions will vary considerably. A child may have the competence to consent to some interventions but not others. The child needs to be given the relevant information in an appropriate manner and given as much support as possible to help them make the decision.

Assessing capacity 16 and 17 year olds

A YP can give valid consent if he/she has capacity. Assessing the capacity of YPs is determined on the balance of probabilities in accordance with the principles set out above that there is reasonable evidence they lack capacity to make the relevant decision.

For complex decisions a multi-agency approach is best. Capacity is based on subject, time and situation and it can fluctuate. Age, appearance or behavioural aspects which might lead to unjustified assumptions cannot be used to determine whether a YP has capacity

A Best Interests meeting may be needed for cases that involve complex decisions or differing opinions about what is the least restrictive option or where many different parties are involved. A consensus decision may not be reached but the meeting may provide useful discussion and information gathering to further the Best Interests process for the decision maker. The decision maker is the person identified for this role in advance of the meeting who must have a professional qualification.

Evidence needs to be recorded carefully in the Best Interests meeting minutes. The meeting does not make the decision. A Best Interests decision should always be communicated in writing to the person concerned and those involved in the care and/or treatment who were consulted as part of the process. The decision maker will need to demonstrate in their record keeping that they have made a decision based on all the available evidence and taken into account all the conflicting views. Where there are disputes, it may be helpful to involve an independent advocate or to make an application to the **Court of Protection** for their ruling about what is in the person's best interests. The Court expects the decision maker to take all reasonable steps to build a consensus before making their decision. The evidence for this must be clear in the minutes of the Best Interests meeting before the application to the Court of Protection.

The role of those with parental responsibility and decisions within the scope of parental responsibility

The degree to which parental responsibility will be the determinative factor in making decisions for a child varies in accordance with the age, development and maturity of a child. For example, constraints which are universal for a 5 year old (not going out alone) may be liberty-restricting for a 16 year old with the capacity to make his/her own decisions

If a YP of 16 or 17 lacks capacity within the meaning of the Act, those with parental responsibility should be consulted about his/her best interests. However, practitioners must be satisfied that it is appropriate to rely on parental consent (remembering that, in these circumstances, a parent **cannot consent** to the YP being deprived of his/her liberty --see below)

In deciding whether the particular decision can be taken on the basis of parental consent, practitioners need to consider a range of factors to test whether the decision falls within the scope of parental responsibility:

1. Is this a decision that a parent should reasonably be expected to make?
Significant factors determining this are likely to include: the type and invasiveness of the proposed intervention; the age and maturity of the YP; the extent to which the decision accords with the wishes of the YP or whether the YP is resisting the decision.
2. Are there any factors which might undermine the validity of parental consent?
eg where the parent may lack capacity because of his/her own impairments; where parents disagree about what is best for their child and what action

should be taken; where the parent is not able to focus on what course of action is in their child's best interests eg if they have gone through an acrimonious divorce and find it difficult to separate the decision about consent, for the particular action to be taken, from their own hostilities.

If there is doubt about whether or not parental consent can be relied on to authorise the particular intervention, professionals should take legal advice so that account may be taken of the most recent case law.

Deprivation of Liberty

Parental responsibility cannot be exercised to consent to depriving a YP of his/her liberty. When a YP lacks capacity, this can only be authorised by:

- the Court of Protection/inherent jurisdiction
- Under the MHA 1983

The Deprivation of Liberty Safeguards (DOLS) Code contained in the MCA 2005, which sets out a third process by which deprivation of liberty can be lawful, is not applicable to under 18s

Decisions about whether a YP's care/treatment arrangements amount to a deprivation of liberty must be considered on a case by case basis

The 'acid test' has been defined as 3-fold:

- Lack of capacity to consent to the care/treatment
- Continuous supervision or control
- Not being free to leave

Deprivation of liberty can occur in community or domestic settings (eg foster care, supported living accommodation), residential settings, hospitals ie settings for which the State is responsible

The care/treatment arrangements in place must be compared with those of a YP of the same age, whose freedom is not limited, in order to determine whether the restrictions in place amount to deprivation of liberty or are part and parcel of the 'universal constraints' that are applied by a responsible parent, which lessen over time in accordance with the YP's level of maturity (eg a degree of freedom with sensible precautions, protection against avoidable risks but not excessive caution, access to the outside world and friends).

In a recent case (Re D (A Child: Deprivation of Liberty)) it was held that a 15 year old boy with ADHD, Tourette's and Asperger's, who required severely restricted care, was not deprived of his liberty even though the 'acid test' was satisfied. This was because the parents' consent to the particular care he was receiving, bearing in mind his condition, fell within the 'zone of parental responsibility' and it would have been 'wholly disproportionate and fly in the face of common sense to rule that the parents' decision had not fallen within the parameters of parental responsibility'

On the other hand, in the Cheshire West case (which formulated the acid test) it was held that less restrictive measures for a 17 year old girl with multiple disabilities did amount to a deprivation of liberty largely because, compared to a similar 17 year old without disabilities, the restrictions amounted to lack of freedom –illustrating the lessening of PR over time

The YP's compliance/lack of objection to the arrangement is not relevant to the determination and it is not relevant how good the care is. The test is an objective one and applies irrespective of disability. The rationale is to protect those who lack capacity by ensuring that any deprivation of liberty is scrutinised and lawful and is in the YP's best interests.

The right to 'liberty and security of person' is enshrined in Art 5 ECHR and everyone has this right whatever their circumstances

Below is a list of measures that might result in deprivation of liberty:
(See also attached appendix from Law Society.)

- restraint is used, including sedation;
- professionals exercise complete and effective control over care and movement for a significant period;
- professionals exercise control over assessments, treatment, contacts and residence;
- the person would be prevented from leaving if they made a meaningful attempt to do so;
- a request by carers for the person to be discharged to their care is likely to be refused;
- the person is unable to maintain social contacts because of the restrictions placed on access to other people;
- the person loses autonomy because they are under continuous supervision and control

It is important to note that, if the measure being considered is universal for a YP of the same age and maturity who is disability free, then it will not amount to a factor to be taken into account in deciding whether the deprivation of liberty criteria has been reached.

Good practice in this area includes the following:

- decisions should be taken and reviewed in a structured way and the reasons behind them recorded
- proper documented assessment of whether the person lacks capacity to decide whether to consent to the care being proposed
- alternatives to admission to hospital or residential care should be carefully considered and any restrictions on liberty in these settings should be kept to the minimum necessary
- care should be taken to ensure as far as possible that the YP remains in contact with those close to them

- where appropriate local advocacy services should be used to provide support to YP and their families
- the assessment of the YP's capacity and his/her care plan are kept under review

For adults over 18, the managing authority of a hospital or residential home has to make an application to a 'supervisory authority' to request authorisation of the deprivation of liberty. The Local Authority where the residential home is based is the supervisory body and not the LA responsible for placing the person in that setting. The Government is currently consulting on changes to the way deprivations of liberty are authorised.

Deprivation of liberty can be authorised for under 16s lacking capacity using the inherent jurisdiction of the High Court division of the Family Court

1. Practice Implications for Children's Services

Build into existing planning arrangements

Where there are mental health concerns that may influence future planning/decision points, mental capacity should be considered at key planning points, before a child reaches their 16th birthday or at the point of contact with services if they are already over 16.

The following are examples of potential opportunities to address mental capacity where relevant.

- For Looked After Children, this could be at their 15 year old LAC Review and then discussed regularly at future reviews.
- For children in residential schools, this could be the Education, Health and Care (EHC) Planning meetings at age 15.
- At any point in child protection planning and reviews
- During planning for transition to adult services

Relevant circumstances for consideration could be placement planning, consent to medical intervention or mental health treatment.

Settings for consideration

The legislation can apply to YPs in all settings including the following.

- Hospital admissions for physical or mental health reasons
- Secure settings
- Health settings
- Children's Homes depending on the regime
- Residential schools
- Foster care
- Section 20 accommodation

- Supported Housing
- Parents' own home

Workforce Development

The key part of this process is the assessment of mental capacity and how it informs decision making, which is based on good social work practice, including recording. Once the legislation and its implications are understood, putting this into practice should be a question of building on the skills of existing qualified staff, using the framework outlined in the section on legal context.

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Free e-learning module: www.scie.org.uk/publications/elearning/mentalcapacityact/
(This will be released in early 2016 with an updated sections on DOLS)

Appendix A

Law Society guidance re what could constitute Deprivation of Liberty for under 18s

Decision on where to reside being taken by others;

Decision on contact with others not being taken by the individual;

Restrictions on developing sexual relations;

Doors of the property locked/chained/bolted for security reasons or to prevent the yp leaving;

Staff accompanying the yp to access the community to support and meet their care needs;

Access to the community being limited by staff availability;

Mechanical restrain such as wheelchairs with a lapstrap or harness;

Varying levels of staffing and frequency of observation by staff;

Provision of safe spaces or chill out rooms during the day or night from which the yp cannot leave of their own free will;

Restricted access to personal allowances;

Searching of the person and./or their belongings;

Restricted access to personal belongings to prevent harm;

Medication with a sedative or tranquilising effect;

Physical intervention such as with personal care tasks, breakaway techniques, physical touches or holds;

Restricted access to modes of social communication;

Positive behavioural reward systems which might thereby involve restrictions on favoured activities;

Disciplinary penalties for poor behaviour;

Lack of flexibility in terms of having activities timetabled, set mealtimes, expected sleep times;

Managing food intake and access to it;

Police called to return the person if they go missing;

Restricted access to parts of the property eg kitchen, certain cupboards to minimise health and safety risks.

