

“Social Care and Human Rights” Essex Autonomy Project Summer School 2022, co-sponsored with the Essex Human Rights Centre

Wivenhoe House, University of Essex
27-28-29 July 2022

Introduction

These notes were made in the days and weeks after the Summer School. They are a distillation of the ideas I found interesting/ liberating/ exciting - and some personal reflections. The notes do not pretend to constitute a comprehensive account of the three days. Some of the speakers continue to work on their ideas specifically concerning deliverable, supported decision-making. It is my view that because they are a springboard to shaping legal capacity practice they merit sharing.

The Outset

Around 30 people introduced themselves. At different times during the Summer School the programme enabled productive discussions with and among people with lived experience of services, doctors, nurses, speech and language therapists, lawyers, psychotherapists, policy specialists and philosophers from England, Scotland, Wales, the Republic of Ireland, America, Canada and Korea.

The “Essex” framework approaches human rights with a threefold typology of obligations - respect, protect, fulfil¹ - by fostering an environment in which rights are enacted. Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (2006), featured prominently during the three days. Article 12 concerns “Equal recognition before the law,” and requires states to adopt

“...safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person...”

Although ratified by the UK in 2009, Article 12 rights are not yet a reality in people’s lives.

¹ Khalil, U. and Churchill, R. (2012) The protection of economic and social rights: A particular challenge? In H. Keller and G. Ulfstein (Eds) *UN Human Rights Treaty Bodies: Law and Legitimacy*. Cambridge: Cambridge University Press

Legal and Policy Landscape

Wayne Martin and Alex Ruck Keene introduced the topic. The UN Convention of the Rights of Persons with Disabilities (CRPD) provides an international, Human Rights derived impetus to legal systems with significant implications for autonomy and decision-making. The prospect of a British Bill of Rights was considered, and attention drawn to the Joint Committee on Human Rights report: Protecting Human Rights in Care Settings:²

“Since we launched this inquiry, the Government has introduced the Bill of Rights Bill 2022–23 into Parliament. Some of the provisions of that Bill will impact on the ability of vulnerable care users to have their human rights respected. For example, the restrictions on positive obligations flowing from ECHR rights risks having an impact on the right to life (Article 2 ECHR), the prohibition on torture and inhuman or degrading treatment or punishment (Article 3 ECHR) and the right to family life (Article 8 ECHR) in weakening these positive obligations on public bodies to protect those rights. Changes to duties on public bodies, for example removing the requirement for them to apply the law in a way that is compatible with human rights, so far as it is possible to do so, will risk increasing the occasions when care users’ rights are not respected in practice. Whilst we focus on the existing framework in this inquiry, we are mindful of the potential impacts of the changes that the Bill of Rights would bring to care users. The Government should consider very carefully the impact of its Bill of Rights proposals on those in care settings and the Department of Health and Social Care should publish such analysis” (para 2, page 5).

A great deal is at stake. The Bill of Rights Bill is silent on the CRPD. If enacted, it will not reflect compliance with CRPD. Positive rights require the state to ensure that we may exercise our rights and, while the state should ensure that our rights are not breached, the positive obligations are uncertain. There is little scope for effective challenge.

The Mental Capacity Act 2005 is influential around the world. Its statutory principles:

1. a person must be assumed to have capacity unless it is established that he lacks capacity
2. a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success
3. a person is not to be treated as unable to make a decision merely because he makes an unwise decision
4. an act done, or decision made, under the Act for, or on behalf of a person who lacks capacity, must be done, or made...best interests

² House of Commons, House of Lords (2022) *Protecting Human Rights in Care Settings* Fourth Report of Session 2022-2023, 22 July 2022

5. before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be achieved in a way that is less restrictive of the person's rights and freedom of action.

Scotland's legislation is principles-driven. England is reluctant to retro-fit principles into the Mental Health Act reforms, for example.

Principle 2 of MCA is arguably underdeveloped since it has not animated practice to date [Adrian Owen's practice merits consideration.³ He has used Magnetic Resonance Imaging to determine whether individuals with prolonged disorders of cognition can communicate.] Principle 4 is perhaps more straightforward: in the absence of capacity, Best Interests apply. In addition, there is qualified protection from liability for carers/ support/ clinicians who treat as if a person had capacity.

Many people were deprived of their liberty in order to receive care and support, Deprivation of Liberty Safeguards (DoLS) were introduced. They have produced an army of Best Interests Assessors. May they be described as inspired Human Rights workers or is their work directed by a tick-box template? Sometimes, the latter appears to be the case.

A "fix" was required for the deprivation of liberty. The report of the Joint Committee of Human Rights determined that, *inter alia*, some people have Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Notices in place without consultation; that there are unacceptable delays in authorising detention in care settings; and that there is no access to legal aid. *Cheshire West and Chester Council v P* yielded a new test for the deprivation of liberty: the person lacks capacity to consent to their deprivation of liberty, i.e. the regime/ care; the person is "under continuous supervision and control and...not free to leave" their placement; and the care is "imputable to the state." Since Lady Hale's broad definition addressed the inconsistency in practice and interpretation of the law, authorisations have soared. People deprived of their liberty have a right to challenge. Thus far, there is no date for the introduction of Liberty Protection Safeguards.

It was proposed that the task of delivering on people's human rights may be considered from case studies with elements of learning together how people without voice express their decisions; the barriers faced; the form that "practicable steps" take; and the ethical and legal considerations.

A Speech and Language Therapy (S<) Perspective

It was proposed by Hannah Atkinson, Laura Wilson, Jude Berrondo, Annie Greer and Victoria Joffe that S< provides a human rights mechanism. Wayne Martin identified two kinds of cases:

a) UNMASKING MENTAL CAPACITY: This would be a case where P in fact HAS decision-making capacity, but those around P are unaware of P's decision-making abilities because they cannot communicate with P. That is, P's mental capacity is *masked*. S< support

³ [Nature.com/articles/486178a.pdf](https://www.nature.com/articles/486178a.pdf) (accessed 1 August 2022)

helps because by *unmasking* P's capacity; it helps those around P realise that P had decision-making capacity all along – they just did not know!

b) REALISING MENTAL CAPACITY: This would be a case where P does NOT have decision-making capacity, and is unable, for example, to understand the decision he faces because of communication difficulties. S< enters the scene, and through S< techniques, P *comes to have decision-making capacity that P otherwise lacked*. S< in this case is not *unmasking* mental capacity. S< is *making it possible* for P to make a decision for him/herself.

Both are important, but the second is where the most upside potential lies for finally realising the promise of the second principle! The S< role is to support P to make a decision for themselves.

S< is a credible means of identifying what “practicable steps” look like. For example, the typical profile of someone with Traumatic Brain Injury (TBI) was considered: poor short-term memory; difficulties in spoken communication; problems with initiation, planning and executing tasks. Work begins with orientation to the here and now.

There are visual aid tools such as the Communication Aid to Capacity Evaluation (CACE) for people who have communication difficulties and the Mental Capacity Assessment Support Toolkit (MCAST). S< deploys time-intensive methods. It is possible that nuance is lost in the use of concrete images. Similarly, repetition may trigger a “get off my back” response.

Useful rules of thumb were set out:

- The way to go faster is to slow down
- “The biggest single problem in communication is the illusion it has taken place” (GB Shaw)
- Begin with “small, everyday decisions”

S< is not routinely available. A lot of work arises from referrals concerning swallowing. S< processes are therapeutic – most particularly if they identify what matters to individuals.⁴ There are a minority of individuals who are well resourced due to compensation for their injuries. The majority are without resources.

Is it feasible that what S< achieves may be achieved on a wider scale? May the curriculum design of different professionals accommodate some of the methods of S<? Minimally this would nod to the principle of progressive implementation in supported decision-making.

⁴ See, for example, www.inspireothers.org.uk (accessed 1 August 2022)

Interpretive Support

Michael Bach drew from his earlier work with Lana Kerzner which identified six elements of support:⁵

- independent advocacy – help to express will and preferences
- communicational and interpretive supports – help to express views
- representational supports – representing the persons will and preferences on the basis of a long-standing relationship
- administrative supports – addressing formal and procedural requirements
- life planning supports – making decisions in the context of broader values
- relationship-building supports – intentional help to build relationships

There is a growing group of people who are untouched by MCA practice in England and Wales. Interpretive support mobilises certain forms of thinking but begs the question: what is in place to require us to listen and recognise legal personhood and agency? What are the consequences of not doing so? The backdrop is promising because global reforms and ways of demonstrating that people have capacity have not been exhausted.

Family-led initiatives based on principles of self-determination and autonomy tend not to be as persuasive as professionally led initiatives. It is supported decision-making that has given family-led practice new credibility. The concept of “interpretive support” reformulates respect for autonomy by identifying “key interpretive moments” and their validity. They are intentional acts without controlling influences. The ways in which these acts are understood may be produced independently or interdependently, drawing on the interpretations of the parents of people with learning disabilities, that is, on the traditionally downplayed experience and expertise of those who know a person well.

The task is to discern the best interpretation of a person’s will and preference. This is within the orbit of the planning theory of agency and means-ends coherence. Using ethnomethodology, we viewed a film of researchers spending time with three adults with profound impairments and their mothers and other interpretive supporters. [NB the film involved mothers only. Are there examples of fathers taking a lead in interpreting gestures and actions?] The researchers film mother-adult child exchanges and return to ask about the significance of particular utterances, gestures and for their reflections and interpretation. Necessarily there are examples of interpretive indeterminacy. Do people’s filmed actions reveal primary intention, preferences or planning intention? In the event of no consensus, what then?

If legal agency is accorded to the three adults, how may we know that the interpretation is valid? The answer lies in the different traditions of meaning at play. Although the possibility of self-interested projection cannot be set aside, interpretive knowledge remains to be fully described. Some interpretations may not have a lot to go on. At a time when inter-

⁵ *A New Paradigm for Protecting Legal Autonomy and the Right to Legal Capacity: Advancing Substantive Equality for Persons with Disabilities through Law, Policy and Practice*

dependence is undermined, it was proposed that examples of Community Partner Training⁶ may have promise in the reflection process.

Against the backdrop of siloed off knowledge, there must be scope for humility. Interpretive support should be felt and acknowledged as different. If a family's expertise is perceived as excessive or even intrusive, what is the status of the interpretation of others?

Mental capacity and legal capacity are integrated. The no-go topics in supported decision-making include non-therapeutic sterilisation, sex, marriage, voting, assisted suicide and gender-reassignment surgery.

Alex Ruck Keene noted that whatever framework is adopted, it has to work for everyone. Liability matters so if things go wrong, the professional carries the can. If I make a capacitated decision and things go wrong, then I am responsible. With reference to interpretive support, would liability transfer to interpretive supporters?

Is the process shaped by: wanting people with profound impairments to be recognised as their own actors; making us feel better; access to services? It is tempting to project a narrative. This is exemplified in the media coverage given to the parents whose infants and children are unable to survive independently of ITU support. It is high stakes territory.

Candid exchanges led to consideration of the circumstances of Lindsey Briggs v Paul Briggs.⁷ His wife argued that his post-accident life in a minimally conscious state was "torture." The Court of Protection agreed with his wife. Compare and contrast with Barnsley Hospitals NHS Foundation Trust v MSP. MSP had set out his clearly expressed wish to refuse treatment which he had shared with close relatives, albeit unwitnessed. He did not wish, *inter alia*, to have a stoma. He had submitted to an operation which was to reverse his stoma but the operation determined that it could not be reversed. His rights, will and preferences were respected and life sustaining treatment was withdrawn.

There's a distinction to be made between the higher order-big decisions and the micro, day to day decisions. Although there are no bullet-proof facts, over time, these micro-decisions appear to "sediment" and this process provides data points. Supervisory oversight of interpretive practice may set out the "reasoning steps." Interpretive support is nested in supported decision-making. Perhaps projection and bias feature in the mix, but are these reasons to undervalue the promise of interpretive support?

Article 17 of the CRPD confirms that "every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others." Interpretive support is a method for protecting the integrity of the person. It has yet to secure a foothold in structures of accountability. Wayne Martin and Michael Bach considered the hypothesis:

⁶ See, for example, [Community Partner Training - Penn CEAR Core \(cear-itmat-upenn.org\)](https://cear-itmat-upenn.org) (accessed 9 August 2022)

⁷ See [Court of Protection Rules Life Support Treatment Can Stop - GregsonsGregsons](https://www.court-of-protection.org.uk/court-of-protection-rules-life-support-treatment-can-stop-gregsonsgregsons)

Legal recognition for interpretive support can be used to leverage a fully inclusive regime of legal agency.

User Led Approaches

Peter Beresford and Raza Griffiths asked: How interested is the current government in social care and services for people with mental health challenges? Social care is not perceived as sufficiently evidence based; it is poorly valued, marginalised and has been hollowed out. There are lots of thinkers using social care who would wish to share their first-hand experience of receiving social care services.⁸ Their accounts highlight things going wrong, the impacts of outsourcing and funding cuts and poorly paid staff. In the NHS, damaging managerialism has foregrounded the marginalisation of Public Health which transferred to Local Authorities (LAs) in 2012. Arguably this undermined preparedness for the pandemic. Access to NHS dentistry and long-term care are suggestive of UK-wide rationing problems. Do the Care Act in England and the Social Services and Well-being Act in Wales allocate scarce public resources?

Assessment and eligibility rules in social care render few people eligible for free care. Since a LA's spending must be reconciled with its budget, resource-led rather than person-centred provision prevails. People's personal experiences may be charted.⁹ The rationing in the NHS tends to be framed in a different way to that of rationing in social care – which does not bode well for the integration agenda. Having a “primary health need” is a significant distinction in the health and social care firmament. It frames many disputes. The NHS' waiting lists are a familiar measure. Social care has no equivalent. The possibility of a National Care Service may justify social care – if its structure follows its values. Perhaps a social care rallying cry to match, “Do no harm” is merited?!

The odds are stacked against people with support needs and their families. Means-tested, fragmented and single-issue systems with managerialist tendencies inflict unintended harms.¹⁰

Powerful correctives reside in developments and critical commentaries such as the National Survivor User Network (NSUN);¹¹ To Our Own Tunes;¹² and A Call for Social Justice.¹³

Mental Welfare Commission for Scotland

Arun Chopra described the Commission's work and reach. It is independent and exists to ensure that people with mental illness, learning disabilities, dementia and related conditions

⁸ See, for example, <https://shapingourlives.org.uk/> (accessed 9 August 2022)

⁹ See, for example, [Mad Studies Network | A collection of resources and posts bringing together an international network of mad studies endeavours. \(wordpress.com\)](#) (accessed 9 August 2022)

¹⁰ Clements, L. (2020) *Clustered Injustice and the level green*. London: LAG

¹¹ [Home - NSUN website](#)

¹² [Microsoft Word - TOOTS Charter and Guidelines document 2012 \(nsun.org.uk\)](#)

¹³ [KINDRED-MINDS-MANIFESTO_EXECUTIVE-SUMMARY_FOR-WEB_FINAL.pdf \(nsun.org.uk\)](#)

are supported to live the lives of their choice.¹⁴ It receives over 5k calls a year, it undertakes visits and investigations and it shares information about research and practice in terms of the Mental Health Act and Adults with Incapacity Act, for example. Mental health professionals must “pay regard” to people’s statements of what they want when they have capacity. Such statements are invaluable in ensuring that people’s preferences are heard. However, few people have made Advance Statements. The challenges are familiar: lack of awareness, unclear process, don’t want to think about becoming unwell, and no regard will be paid to them anyway...

National Office for Human Rights and Equality Policy

Caoimhe Gleeson and Patricia Rickard-Clarke described the Assisted Decision Making (Capacity) Act (2015) Ireland (the ADMCA)¹⁵ as progressive insofar as it avoids the discriminatory use of a diagnostic threshold; it includes measures to ensure that substitute decision-making is a step of last resort; and it allows for such decision-making supporters as decision-making assistants, decision-making representatives and co-decision-makers, with the latter applying in more high-support contexts.

An edited text, *The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections*¹⁶ is a fabulous collection of 2k word essays produced by the National Office for Human Rights and Equality Policy with the School of Law at University College, Cork and the Decision Support Service. Powerful personal accounts, the legal context and ambitions for the ADMCA – which, fingers-crossed, will be operational by the end of 2022 – render this an important and compelling text.

Safeguarding Ireland is an intersectoral body registered as a charity.¹⁷ Its mission is to promote the safeguarding of vulnerable adults to protect them from all forms of abuse by persons, organisations and institutions and to develop a national plan for promoting their welfare. It commissioned *Identifying Risks Sharing Responsibilities: the Case for a Comprehensive Approach to Safeguarding Vulnerable Adults*. This describes the cultural challenges faced. Control is centre-stage in the abuse landscape. It is endemic. Pressing issues arise as people age, with adults over 80 years 30% more likely to be subject to financial exploitation through misrepresentation or undue influence, for example. Some victims may not perceive their exploitation as abusive, most particularly if it has escalated over a lifetime.

The ADMCA will address adult safeguarding in health and social care services. *Identifying Risks Sharing Responsibilities* highlights the necessity of a “whole of society” response affirming that preventing and confronting abuse are shared responsibilities requiring a legislative framework.

¹⁴ [About us | Mental Welfare Commission for Scotland \(mwscot.org.uk\)](https://www.mwscot.org.uk) (accessed 18 August 2022)

¹⁵ [Assisted Decision-Making \(Capacity\) Act 2015 - The Department of Justice](https://www.justice.gov.ie)

¹⁶ [admca-personal-and-professional-reflections.pdf \(decisionsupportservice.ie\)](https://www.decisionsupportservice.ie) (accessed 22 August 2022)

¹⁷ [Safeguarding Ireland | Promoting the rights of vulnerable adults](https://www.safeguardingireland.ie)

Lessons from COVID

Tania Cocksedge prompted discussion concerning the legacies of COVID. The pandemic yielded unsought lessons: it had devastating impacts on older people and people with disabilities, most particularly those in congregate settings such as residential care and nursing homes. In addition, restrictions on liberty and contact with loved ones compromised the promise of person-centred care. Hospitals discharged patients to accommodate those with COVID – with heart-breaking consequences. No “lived experience” at the executive level informed decisions to subtract social care from some hospitals by removing social workers.

Do Not Attempt Cardio-Pulmonary Resuscitation?

Karen Chumbley, Alex Ruck Keene and Wayne Martin examined this topic. If your heart or breathing stops, a DNAR (do not attempt resuscitation) or a DNR (do not resuscitate) instructs medical and nursing staff not to intervene. Despite recollections of one GP practice’s “blanket DNACPR” use¹⁸ during COVID, this discussion was a revelation. There are lurking fears of “mission-creep” becoming the basis for withholding other forms of healthcare. Clinicians confirmed that CPR is a painful and intrusive intervention. Helpfully too, it was confirmed that a DNACPR is not a “do not treat at all” notice. People may still receive antibiotics and their last memories will not be at the receiving end of the pounding CPR process.

Examples of care home nurses who have been prosecuted for declining to undertake CPR on elderly people *without* DNACPR notices have led the Essex Autonomy Project at the University of Essex to consider ways of reframing the subject. It has developed a series of four very short ‘sketch-up’ videos explaining CPR, DNACPR Recommendations, Consultation requirements, and recourse when things may go wrong. The videos provide accessible explanations of the low success-rate of CPR interventions.¹⁹ The disproportionate coverage given to CPR in TV programmes such as “Casualty” and “Holby City” have been lamentably poor at depicting reality! There is no substitute for compassionate communication and respectful conversations about death. There is a compelling case for drafting a Consensus Statement...How may I/ the National Mental Capacity Forum assist?

Systems of Institutionalised Care

John Adlam, Chris Scanlon and Arun Chopra encouraged consideration of the powers and privileges operation in institutions. There are circumstances in which people are unwilling care recipients, in prison and inpatient mental health services, for example. In the context of

¹⁸ [Welsh surgery apologises over 'do not resuscitate' instruction | NHS | The Guardian](#)

¹⁹ The videos are available online at <http://autonomy.essex.ac.uk/dnacpr> .

unwilling care recipients, are they beyond the domain of consent? What options are available to ascertain a detained person's views? Are there red lines or zones?

Structural resources and living conditions impact on familial relationships, not all of which are nurturing and constructive. What protections are there when a person's known wishes and feelings accord with their clinically determined Best Interests but not those of their Guardians, who are relatives? A person's apparent passivity and subordination under Guardianship, where another person makes decisions, is not necessarily static. Coercion has many faces and takes place in many settings. There are difficulties attached to the application of the law in the context of close relationships, most particularly when the unwilling care recipient is emotionally burdened with not wishing to compromise the relationship.

The circumstances under which people receive involuntary treatment prompts questions concerning the pursuit of health and the legal requirements of due process. The clashing values of medicine and law are exemplified in giving treatment regardless of a detained person's objections. The pervasiveness of structural disadvantage cannot be ignored. Black and ethnic minorities make up 1.3% of Scotland's population and yet they constitute 13% of people subject to Compulsory Treatment Orders.²⁰

Low political priority is afforded to people who are excluded, detained, restrained and medicated. They are effectively written off. The concept of "least restrictive setting" does not require positive outcomes for the detained person. It even tolerates neglect and conflicts with the medical goal of reducing mental suffering. The excluded person loses their voice - perhaps in terms of the degree, source and duration of the coercion exerted. The refusal to be ignored and unheard is instrumental in disrupting the inequalities that silenced them in the first place.

There is no linear process of institutional change. There are punctuated equilibriums made up of long static periods, shifts which may be attributed to gradualism, and disruptive, short-lived trajectories

Co-production?

"It is easy to do co-production badly!" There are so many examples of faux co-production where the intention of redistributing power is questionable. It is necessary for professionals to ask, "What is the service user perspective?" Refusing care and treatment, for example, is rarely a blanket refusal for all care and treatment. Perhaps clinicians should be advised of the distinction between refusing treatment and refusing the circumstances of treatment? In terms of supported decision-making, is what works well established?

²⁰ Mental Welfare Commission (2021) *Race Inequality and Mental Health in Scotland: A Call to Action*

It was proposed by John Adlam and Christopher Scanlon that there is “a tilted hyphen” in co-production with excluded people in inhospitable environments²¹ because it is not typically undertaken on equal terms.

In respect of being attentive to a person’s will and preference, it was helpful to be reminded of the Village Approach: it takes a village; it takes communication; it takes support; and it takes time. In Ireland, a registrar will check: what are the options? What is the least intrusive approach? And would a co-decision-maker work for this person? In Scotland, England and Wales, the parallel position is to set out what has been done to support this person.

The many ways in which we lose power will not be resolved by supported decision-making. It is hugely challenging when there is no consensus among professionals and/ or when relational autonomy comes into play: a person’s relatives may be supportive, loving – and controlling.

Push Back?

I suggested that if empowerment is not solely to empower the powerful, at a community level, significant initiatives are emerging which take seriously the impact of context. Change is uneven and slow. The means by which it occurs are diffuse and complex. Too much lip service is paid to “learning the lessons” but it is rare to see explicit attention given to crafting programmes of work which are adaptive to particular settings and sufficient to achieve broad impact.²²

We should not be grateful for pleasing assertions within content-free policies which set out the millions of pounds that have been invested. Such “gesture policies” are rarely read or invoked because they have no implications for the reality of people’s lives.

There are theoretical connections to be made. For example, the families of people with learning disabilities spent years of their lives challenging their relatives’ “choices” to self-neglect, remain in bed all day and engage in unsafe sex, for example. The MCA makes it fractionally more challenging for support staff to assert, without evidence, that such decisions are merely unwise. This is not the only population to endure continually displaced relationships, material poverty and exposure to extreme harms in outsourced services. Families have learned to be creative and stubborn advocates!

Opportunities do arise which enable us to draw on experience to make a “systems oriented” response. For example, the Law Commission’s 2021 consultation concerning *Corporate Criminal Liability* prompted a response. It was informed by reviews in the wake of scandals and some familiarity with the quasi-public functions of companies providing care services and their persistent breaches of regulations and standards. The Law Commission’s formal response to the consultation was encouraging. It noted of the corporate offence of ill-

²¹ Scanlon, C. and Adlam, J. (2022) *Psycho-social Explorations of Trauma, Exclusion and Violence: Un-housed Minds and Inhospitable Environments*. London: Routledge

²² Flynn, E., Arstein-Kerslake, A., de Bhailis, C. and Serra, M.L. (Eds) *Global Perspectives on Legal Capacity Reform: Our Voices, Our Stories*. London: Routledge

treatment and wilful neglect that “the degree of fault required for a care provider to be convicted under this legislation is surprisingly high considering the way in which corporate offences in other fields have been formulated.” It requested a proposal which has since been submitted.²³ The submission complements that of Alex Ruck Keene concerning Vulnerable Adults.

Concluding thoughts

Attending the Summer School should feature in the job description of the National Mental Capacity Forum’s Chair. With an impressive array of topics, it was one part ideas generator and one part travelogue as people from different professions and backgrounds looked through different sides of a prism. Some perspectives were new to me: interpretive support and its interrogation - and some facts had not been obvious to me concerning the likelihood of recovery post CPR. The event set aside any binary bias that may linger, i.e. has capacity/ does not have capacity. It underlined complexity where it is tempting to see simplicity: the Mental Capacity Act is deployed with real consequences and our interventions are constantly changing. Our decisions may be enhanced or diminished by context.

The event reminded me of why I applied to become the Chair of the NMC Forum. A Forum has to be outward-looking, relevant and ready to draw on collective wisdom. There is a great fund of willingness and resourcefulness to ensure that our practices are as inclusive, informed and creative as possible.

Margaret Flynn

August 2022

²³ By M. Flynn, A. Griffiths, K. Keywood and L. Pritchard-Jones