PERINATAL BURSARY MASTERCLASS FEBRUARY 2021

MENTAL HEALTH AND CAPACITY LAW AND THE COURT OF PROTECTION IN THE PERINATAL CONTEXT

Case 1: AS

AS is a 35 years old woman in her third pregnancy. She came to the attention of the Perinatal Service at 25 weeks' gestation. She has a diagnosis of Paranoid Schizophrenia and is care coordinated. She is on a regular regime of antipsychotic medication. She also suffers from Huntington Chorea. She lives with her husband and a friend of the family helps care for her and the children. The family as well as the carer are originally from Lithuania, and require an interpreter.

Because of her neurological condition, AS's mobility is limited. She can walk if helped, and her arms movements are quite limited so she needs help to dress and eat. Her speech is also altered, to the point that interpreters struggle to understand her, and her facial mobility is reduced. However she is able to express discomfort and fear.

There is no clear indication of her mental state as communication is difficult. However, since becoming pregnant, she has steadfastly refused all investigations, including blood pressure monitoring, booking bloods, foetal heart beat monitoring, scans. When told that an investigation such as described above is due, she looks frightened and just repeats loudly "No!"No!"No!" until she is reassured that it won't be done. On one occasion at 28/40, her husband and carer have been able to persuade her to be examined and a normal foetal heartbeat is detected. It is unclear why she does not wish for any maternity monitoring, as when asked she just does not answer. No other behavioural abnormality is reported by husband or carer, and the care coordinator has not found that there are any changes in behaviour that may warrant a change to medication plan or admission to hospital in her vulnerable condition.

The perinatal service consultant is concerned that there is no clear plan should an obstetric intervention be warranted e.g. induction, forceps/ventouse or c-section, in case she refuses it.

1. Is her refusal to receive maternity monitoring driven by her mental disorder?
2. What (if anything) can be done when communication seems to be the key ability that determines MS's apparent lack of capacity?
3. Although the MCA applies to decision-making in an emergency, does this absolve the Trust for planning in advance?
4. What, if any, formal procedures will the Trust have to invoke in order to provide medical interventions surrounding (1) monitoring; and (2) delivery of the baby?
5. What difference would advance care planning have made in this case?

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Case 2: CP

CP is a woman in her late 30s who was surprised to discover she was pregnant at 24 weeks' gestation, as the result of a casual affair which has now ended. She has had sporadic contact with mental health services before, and at one point she was told she may have some traits of Emotional instability. She is also a heavy alcohol drinker and has had alcohol regularly, to the point of harmful use, until she discovered the pregnancy. She has been able to decrease but not stop alcohol consumption after finding out she is pregnant. She also smokes 10 cigarettes per day (decreased from 15-20 per day), and occasionally (once per month or so) smokes cannabis with some of her friends. CP has struggled in childhood, especially in the relationship with her mother who she describes as dismissive of her and always critical of her. She was told that her mother was severely depressed after her birth, and for the first 6 months or so had relinquished her care to other relatives. Their bond was never really recovered in CP's opinion.

CP has been feeling ambivalent about this pregnancy, and is especially concerned that due to her age she might not become pregnant ever again. This was her main reason for not having a termination. Her mood deteriorates as her due date approaches with increasing distress and anticipatory anxiety, especially concerning how she will cope with this baby. Her alcohol consumption increases. A social worker has been in contact with her for an initial assessment following referral done by maternity.

At delivery, labour is not progressing well. CP is on her own and is quite distressed, irritable, snapping at midwives and doctors, tearful. The obstetrician informs CP that the foetus is in distress, and that they will need to consider a c-section. An anaesthetist is called and she is given information about general anaesthesia and epidural. CP was already aware before that anaesthesia can be associated with an increased risk of thromboembolisms, and refuses to go through with the c-section. The risks to the foetus are explained to her again, but she remains determined that she will not consent to an operation. The only reason she gives for her refusal is the risk of thromboembolisms, and does not agree that this risk is minimal compared to the risks faced by her unborn, which she appears able to understand. The medical team and the midwives remain with her in case she should change her mind, and they all listen as the foetal heartbeat slows down and eventually stops. CP then delivers naturally a stillborn baby.

1. What is the basis of her decision – are her fears genuine or are they masking her ambivalence?
2. Is her decision based on ambivalence towards pregnancy and if so, is that definitely indicative of loss of capacity or is it legitimate decision-making?
3. Were the medical team entitled not to intervene given the risks to the foetus during labour?

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Case 3: E

E is a 30 years old woman, 16 days postnatal. She had a long and traumatic labour and finally delivered by emergency C-Section due to foetal distress. She becomes psychotic in the week after delivery, believing that her baby was dying and that she was already dead, hearing voices that told her the above. Her mental state is fluctuating with times when she is more coherent and rational, and times when she was perplexed and appeared confused. She has been admitted to a psychiatric Mother and Baby Unit ('MBU') under Section 2 of the MHA, and started treatment with antipsychotic and antidepressant medication. She has become a little more settled and could sleep with her medication, but there were no significant changes to her delusional beliefs yet. After 4 days in the MBU she develops a temperature, her scar from the C-Section becomes more painful, and on examination by the ward staff it looks infected. Staff advise her she should go to go to the general hospital to treat the infection but E refuses as she does not want to leave her baby, as she maintains her delusional beliefs that her baby is dying and that she is already dead, therefore she sees no threat in having a serious infection. She resists and becomes distressed and agitated when staff insisted she needed to be transferred. When her husband, who had been informed, pleads with her to get the treatment she needed, she accuses him of wanting their baby to die alone. MBU staff have organised a formal capacity assessment and invite E's obstetrician to attend and join the psychiatrist on MBU.

1. Does she lack capacity to consent to the treatment?
2. If she does, then it is in her best interests to investigate/treat the infection?
3. If it is, then is necessary and proportionate to the risk of harm she would suffer otherwise to restrain her to carry out the investigation/treatment or to bring about the transfer to the general hospital to be investigated/treated.
4. Do the team need to take this case to the Court of Protection?

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Case 4: SB

SB was a 37 year old woman who suffered from bipolar disorder which had at times been controlled by medication, although she had also suffered from relapses and remitting symptoms. She became pregnant in December 2012 and her evidence was that at that point she had wanted to have a baby. The evidence also suggested that until April 2013, she had conscientiously attended scans and had showed every sign of wanting to keep the baby. She had then ceased taking her prescribed medication. She started to exhibit behaviours which led members of her family including her husband and mother to believe that she had become unwell.

On 17 April 2013, SB attended a clinic seeking to have an abortion. For various reasons, although appointments were made on two separate occasions for the procedure to be carried out, she did not in fact have the termination. Despite that, she had maintained her wish to terminate the pregnancy and therefore not only consented to the abortion but was herself "very strongly" requesting it. At the beginning of May 2013 she was compulsorily detained under s.2 Mental Health Act 1983, suffering from persecutory delusions in relation to her husband and mother.

The hospital where she was detained believed that she did not have capacity in the relevant regard and issued proceedings in the COP seeking a determination by the Court and associated declarations as to whether (1) she lacked capacity to make decisions about the desired termination of her pregnancy; and (2) if she lacked capacity, whether it was in her best interests to undergo an abortion procedure.

Mr Justice Holman noted that decision was being taken within the framework of the existing law and in accordance with the provisions of the Abortion Act 1967. He also reiterated the cardinal principle of the MCA that: a person is presumed to have capacity in the relevant regard unless it is established that they do not and further that if they have capacity then they also have autonomy to make a decision which may be unwise or which others do not agree with.

Both the treating and independent psychiatrist believed that SB lacked capacity, believing that she understood the procedure, but that her capacity to use or weigh was based on flawed evidence and paranoid beliefs, and that there was a strong temporal relationship between the development of paranoid ideas and the decision to opt for termination.

Mr Justice Holman, however, disagreed with the experts and, although he acknowledged that certain of P's beliefs in relation to her mother and husband were based on paranoia, his evidence of SB's ability to use or weigh included the following: the fact of her current situation (as a person detained), her ability to care for the child in the future and that the fact that carrying the child made her feel suicidal. SB was judged to have capacity to make the decision to have a termination and went ahead with the procedure.

1. In what key does SB's case illustrate the principle of 'decision-specificity' in relation to mental capacity?
2. Do you agree that the judge was right to go against expert (and family) opinion, and do you agree with the evidence which he gave for SB having the ability to use or weigh?
3. What difference could advance care planning have made in this case?