

## Addressing the Conundrum: the MCA or the MHA?

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### Introduction

The question of when to use the procedures provided for under the Mental Health Act 1983 or those provided for under the Mental Capacity Act 2005 to authorise the deprivation of liberty of those lacking capacity to consent to admission to psychiatric hospital has proved a very difficult one to answer in practice. It has only become more important over the past year as new light has been shed upon what precisely constitutes a deprivation of liberty. This paper outlines the background and the legal framework and provides a detailed flowchart to assist staff decide which legislative route to use.

### Background

The law in England and Wales allows for individuals with mental health problems requiring hospital assessment and treatment to be admitted into hospital on an informal basis under section 131 of the Mental Health Act 1983 ('MHA 1983').

However, there are instances when such individuals will have to be admitted into hospital on a formal basis either because they have the capacity to decide as to admission and treatment and refuse or because they lack the capacity to consent to their admission and the circumstances of their admission will amount to a deprivation of their liberty. In its decision in *HL v United Kingdom*<sup>4</sup> (Bournewood case) in 2004, the European Court of Human Rights held that reliance on the common law doctrine of necessity to detain informal patients incapable of consent to their admission did not comply with the requirement in Article 5(1)(e) of the European Convention on Human Rights that detention of persons of unsound mind must be through a procedure prescribed by law.

Subsequently, the Mental Capacity Act 2005 ('MCA 2005') was amended so as to allow – if certain carefully defined criteria are met – for the lawful deprivation of liberty of individuals in hospitals and care homes who cannot consent to their admission and treatment. This deprivation of liberty can be authorised by way of an administrative procedure – in other words without requiring a court order – the procedure is commonly known as the 'DoLS regime'.<sup>5</sup>

The MCA 2005 extends, in principle, to enable the detention of individuals in hospitals for treatment for their mental disorder, and there is, therefore, an overlap between the MHA 1983 and the MCA 2005. That overlap is regulated by the provisions of Schedule 1A to the MCA 2005.

In a judgment in March 2014, the Supreme Court<sup>6</sup> clarified the circumstances under which a person will be considered to be objectively deprived of their liberty. Importantly, the Supreme Court set down an 'acid test,' namely that the individual must be under continuous control and supervision and not free to leave. Further, the Supreme Court made clear that an absence of objection from the individual is irrelevant when deciding whether they are objectively deprived of their liberty. If the individual does not have the capacity to consent to the objective deprivation of their liberty (and if that deprivation of liberty is imputable i.e. attributable to the state, as will be the case in all detentions in

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<sup>4</sup> *HL v United Kingdom* (2005) 40 EHRR 32.

<sup>5</sup> Schedule A1 Mental Capacity Act 2005

<sup>6</sup> Supreme Court Ruling- [2014] UKSC 19 on appeal from: [2011] EWCA Civ 1257; [2011] EWCA Civ 190.

state-run psychiatric facilities) then the state body responsible will be acting unlawfully if it does not take steps:

1. To obtain authorisation under the 'DoLS regime' – i.e. to obtain authorisation under the administrative route set down in the MCA 2005;
2. To detain the individual under the MHA 1983;
3. To obtain a court order.

### **Flowchart**

This flow chart (Figure 1) has been developed to guide clinicians in the process of deciding which jurisdiction applies in the care of patients either at the point of admission or during their stay on a mental health unit and is based on provisions of the MHA and MCA as well as their Codes of Practice and case law.

For individuals about to be admitted or already in hospital, and where they are (or will be) deprived of their liberty, guidance as to which regime – i.e. MCA or MHA – should be applied has been given in a judgment given in 2013.<sup>7</sup> The judgment emphasised that it is only where an individual lacks capacity to decide whether to be admitted to a mental health hospital for purposes of receiving care and treatment and is not objecting either to being admitted to hospital or to all or part of the treatment that there is a genuine choice between the two regimes. If the (incapacitous) patient is objecting, the only route is the MHA 1983. If there is a genuine choice, then it will be for the decision-makers to determine which regime is the least restrictive way of achieving the objectives of assessment and treatment of the individual patient. The Code of Practice accompanying the MHA 1983 gives guidance on the interaction between the MHA 1983 and the MCA 2005, and the newly published revised Code includes a dedicated chapter addressing the overlap.

The judgment of the Supreme Court has made it all the more important that clinicians consider with care whether the patient in question has the capacity to consent to admission and treatment, because this will – in many cases – be key to determining whether they can be admitted informally, or whether the formal routes outlined above must be adopted. The following points are key:

1. The test for decision-making capacity is set down in s.2 MCA 2005, namely whether, at the material time, the person is unable to make the decision for himself because of an impairment of, or a disturbance in the functioning of, the mind or brain.
2. The relevant decision – or the relevant question – for purposes of determining whether a patient has the capacity to consent to what would otherwise be an objective deprivation of their liberty is set down in paragraph 15 of Schedule A1 namely 'whether or not he should be accommodated in the relevant hospital . . . for the purpose of being given the relevant care or treatment.'
3. Table 1 (also included in the flow chart) provides more detail as to the information relevant to the question – in other words, the information that the patient must be able to understand, retain, use/weigh and thereafter communicate their decision.

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<sup>7</sup> AM vs South London & Maudsley NHS Foundation Trust and the Secretary of State for Health [2013] UKUT 0365 (AAC)

4. It is vitally important to remember that even if a patient is unable to understand or retain or use/weigh the relevant information or communicate their decision, this only establishes a lack of capacity if that inability is because of the impairment of or disturbance in the functioning of their mind or brain.
5. Even if a patient has the capacity to consent to admission, such consent must be voluntarily given – in other words, the use (or implied use) of force or other duress would vitiate any consent to admission as an informal patient. The courts have emphasised the particular vulnerability of informal patients in psychiatric facilities and hence the need for particular care in assessing whether they are truly consenting to remaining there.<sup>8</sup>

There may be some instances in which neither the MCA 2005 nor the MHA 1983 can be used to authorise the deprivation of a patient's liberty in a psychiatric hospital.

Two are:

1. Where a patient is detained under the MHA 1983 but requires treatment for physical disorder to which they cannot consent and which will involve a further deprivation of liberty (for instance, force-feeding);<sup>9</sup>
2. Where there is a 'stand-off' that cannot be resolved between the decision-makers under the MHA 1983 and those under the MCA 2005 as to which route to use to authorise the deprivation of liberty.<sup>10</sup>

In either case, in order to ensure that the deprivation of liberty is lawful, it is necessary for the treating Trust to make an application to the High Court for an order to be granted under the inherent jurisdiction.

## Conclusion

In summary, individuals with the relevant decision-making capacity can be admitted to and treated on a mental health unit on an informal basis, whether or not the circumstances on that ward amount to an objective deprivation of their liberty. If the individual does not consent, or if they lack the capacity to consent, then it will be necessary for that deprivation of liberty to be authorised in order for it to be lawful.

Healthcare professionals must always be satisfied as to the authority that they have to deprive individuals of their liberty for purposes of providing them with care and treatment. That authority can be derived either from the individual's capacitous consent, or from the provisions of the MHA 1983, the MCA 2005 or a court order. It should also always be remembered that the authority that they then have to treat their patients may not derive from the same source as there will be instances when individuals might be deprived of their liberty under the MHA but receive certain aspects of their treatment under the MCA. An example is where the individual lacks treatment consenting capacity for physical health problems that are otherwise unrelated to their mental health problems.

Improving the clarity regarding the lawful practice and procedures around formal or informal admission of individuals to mental health units is something of importance for all countries which

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<sup>8</sup> Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2.

<sup>9</sup> A NHS and Dr A [2013] EWHC 2442 (COP).

<sup>10</sup> A Primary Care Trust and LDV (by the Official Solicitor), CC, B Healthcare Group [2013] EWHC 272 (Fam) and <http://www.rcpsych.ac.uk/pdf/Steve%20Oxberry%20article%20on%20capacity%20to%20consent.pdf>.

provide for alternative routes to admission. Although compliance with the technical requirements of the European Convention on Human Rights is only necessary for signatories to the Convention, the same broad principles as set out in the Convention apply in any country which makes it a prerequisite to detention that the person detained knows the legal basis upon which they are being held, and, in turn, that professionals involved in such detention are clear as to the powers that they have (and do not have).

Perhaps a possible way of promoting the familiarity of health professionals with the relevant legislative landscape is to introduce a medical law module during undergraduate study and to have regular refresher courses to 'top up' their knowledge thereafter to facilitate lawful practice during their working lives.

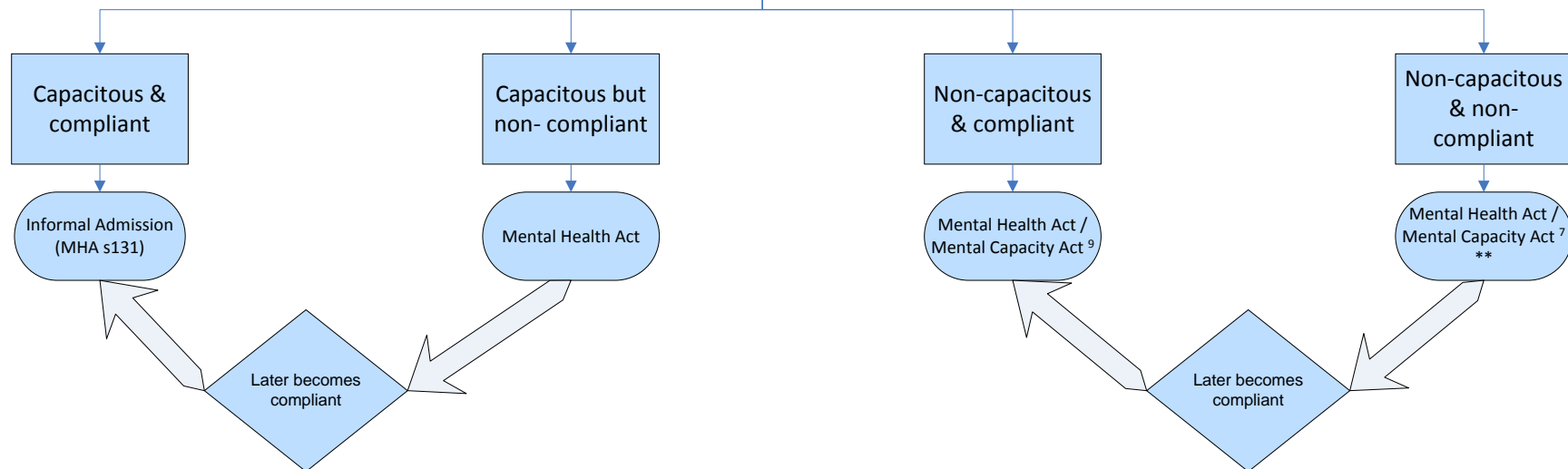
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## Admission to a psychiatric ward for mental health treatment

Assess decisional capacity to accept admission and whether the relevant person will comply with all the elements of what is proposed concerning his or her assessment or treatment<sup>1,4,5</sup>



Assessment of an individual's consenting capacity is an on-going exercise and should be often repeated

As a general rule there will be certain instances when an individual will be eligible to receive treatment simultaneously under provisions of the MCA and MHA for physical health and mental health reasons respectively (see below). For example where they meet the criteria to be treated under the Mental Health Act for their mental health problems and where they lack treatment consenting capacity for physical health problems which are otherwise unrelated to their mental health problems.

The decisional capacity of an individual to accept admission as well as to consent to assessment or treatment might change during their admission. Please adapt their care plan to the relevant aspect(s) of this flow chart.

**Also** If an individual is already on the ward and circumstances of their stay on the ward constitute a deprivation of their liberty but they are not being deprived of their liberty through a process prescribed by law i.e. MHA, MCA (DoLS) or a Court order, then consider the above flow chart and take steps to lawfully deprive them of their liberty if their care plan cannot be otherwise modified.<sup>14</sup> If the care plan cannot be modified then the route for lawfully depriving the individual of their liberty will depend upon which is best for the person in question<sup>1</sup>.

The content of this tool has been derived from the Mental Health Act, Mental Capacity Act and their Codes of Practice as well as from Case Law. However, it is meant for guidance only and is not a substitute for the relevant Legislations or their Codes of Practice. All resources referred to are available over the internet. [Oluwatoyin.Sorinmade@oxleas.nhs.uk](mailto:Oluwatoyin.Sorinmade@oxleas.nhs.uk), Oxleas NHS Foundation Trust, 17/02/2015.

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### When is an individual deprived of their liberty on the ward?

If they are not **free to leave** and are under **continuous control and supervision** <sup>2</sup>

#### **1. Is the person subject to continuous supervision and control ?<sup>2,3</sup>**

• All three elements must be present – the oversight must be continuous (though does not have to be ‘in line of sight’), it must amount to supervision, and have a clear element of control.

#### **2. Is the person free to leave?<sup>2,3</sup>**

• Note that the person may not be asking to go or showing by their actions that they want to. The key issue is how staff would react if the person did try to leave or if relatives/friends asked to remove them.

• If a person lacking capacity to consent to the arrangements is subject both to continuous supervision and control and is not free to leave, they are deprived of their liberty and that deprivation must be authorised under the MHA, DoLS regime or by way of a court order to be lawful.

• It may not be a deprivation of liberty, although the person is not free to leave, if the person is not supervised or monitored all the time and is able to make decisions about what to do and when, that are not subject to agreement by others.

**\*\* The MHA will be most appropriate here except if a Health and Welfare attorney or deputy, acting within their powers, had consented to the things to which the person is objecting. They can then be deprived of their liberty under the MCA (DoLS) <sup>6</sup> and then treated for mental health purposes <sup>7,8</sup>, using wider provisions of the Mental Capacity Act except the treatment relates to certain instances such as in section 57, section 58A treatments etc<sup>9</sup>**

**However, note that the Mental Capacity Act might not be the safest option e.g.**

Degree of restraint needs to be used which is justified by the risk to other people but which is not permissible under the Mental Capacity Act as it cannot be said to be proportionate to the risk to the patient personally.

There is some other specific identifiable risk that the person might not receive the treatment they need if the Mental Capacity Act is relied on ( e.g. it is thought that patient might recover relevant capacity and will then refuse to consent to treatment as might obtain in manic episodes etc.), and that either the person or others might potentially suffer harm as a result.<sup>10,11</sup>

Also the Deprivation of Liberty Safeguards will not apply to individuals under 18 years of age.<sup>12</sup>

### Reference

1. AM v (1) South London & Maudsley NHS Foundation Trust and (2) The Secretary of State for Health [2013] UKUT 0365 (AAC) paragraphs 17, 39 and 49
2. Supreme Court Ruling- [2014] UKSC 19 On appeal from: [2011] EWCA Civ 1257; [2011] EWCA Civ 190
3. CQC Briefing for providers on the Deprivation of Liberty Safeguards 4 April 2014
4. [2013] EWHC 272 (Fam) and <http://www.rcpsych.ac.uk/pdf/Steve%20Oxberry%20article%20on%20capacity%20to%20consent.pdf>
5. Mental Health Act Code of Practice Mental Health Act 1983 paragraph 23.31
6. Deprivation of Liberty Safeguards Code of Practice (2008) paragraph 4.45
7. Mental Capacity Act section 4 and Section 5.
8. Mental Health Act Code of Practice paragraph 4.14
9. Mental Health Act Code of Practice paragraph 23.52
10. Mental Health Act Code of Practice paragraph 4.21
11. Deprivation of Liberty Safeguards Code of Practice (2008) paragraph 4.48
12. Deprivation of Liberty Safeguards Code of Practice (2008) paragraph 3.8
13. Deprivation of Liberty Safeguards Code of Practice (2008) paragraph 9.1

### Likely relevant information to assess consent to

admission <sup>4</sup> (nb precise information will depend upon the ward)

1. That the person will be admitted to a mental health hospital for the purpose of care and treatment for a mental disorder;
2. That the doors to the ward will be locked;
3. That staff at the hospital will be entitled to carry out property and personal searches;
4. That the person will be expected to remain on the ward at least until being seen by a doctor, and most likely for at least the first 24 hours of their admission;
5. That the person will be required to inform the nursing staff whenever they want to leave the ward, providing information about where they are going and a time of return;
6. That the nursing staff may refuse to agree to the person leaving the ward (including use of the Mental Health Act) if the nursing staff believe that the person may be at risk (from themselves, or from other people) or may pose a risk to others if they leave the ward;
7. That if the person leaves the ward without informing the staff, or fails to return at the agreed time, the staff will call the police who will make attempts to find them;
8. That the person's description will be recorded by staff for the purpose of 7 above;
9. In addition, it is important to include the likely consequences of the person not being admitted. This will of course vary with each individual and their personal circumstances.

### Relevant Information to assess consent to Treatment <sup>5</sup>

Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it.

Permission given under any unfair or undue pressure is not consent.

**Table 1. Likely relevant information to assess consent to admission (nb: precise information will depend on the ward).<sup>11</sup>**

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<sup>11</sup> A Primary Care Trust and LDV (by the Official Solicitor), CC, B Healthcare Group [2013] EWHC 272(Fam) and <http://www.rcpsych.ac.uk/pdf/Steve%20Oxberry%20article%20on%20capacity%20to%20consent.pdf>.