Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Mental Health Act and Mental Capacity Act interface- practical applications in clinical practice

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Agenda

- Detention and Restraint: Powers under Common Law, Mental Capacity Act and Mental Health Act especially in A&E. Intervention, Retention, Treatment.
- Powers to Treat: Under Common Law, Mental Capacity Act and Mental Health Act
- Capacity Assessments: When and How?
- Deprivation of Liberty: When does it arise? What is required if it does?
- Recent relevant cases in Court

Legal Powers to Restrain and Detain (2)

- Under the common law doctrine of necessity there is a general power to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm. This would include seclusion and applies whether or not the patient lacks the capacity to make decisions for himself (R(Munjaz) v Mersey care NHS Trust (2003) EWCA Civ 1036).

- This would include someone on the verge of self harm. In other words where there is no opportunity to communicate or form a judgement about a person's capacity, taking immediate action to prevent a loss of life or serious self harm will be lawful

Legal Powers to Restrain and Detain (3)

- There is a common law power “for every constable and also every citizen” to prevent a breach of the peace “by arrest or other action short of arrest”.
- There must be an act done or threatened which actually harms a person or, in his presence, his property or which is likely to cause or which puts a person in fear of such harm.
- A breach of the peace can occur in public or on private property.
- Detaining someone in this way is only lawful for a short period. They must be released if there is no danger of renewal or continuation of the breach.
- Power might be used eg to restrain a patient whose words or behaviour are such that imminent violence is expected on a hospital ward.

Legal Powers to Restrain and Detain (4)

- Under S3(1) Criminal law Act 1967 reasonable force can be used to prevent a crime or effect or assist a lawful arrest.
- This power applies to both informal and detained patients.
- The power might be used to restrain the patient or place him in seclusion in self defence or in the defence of others or to protect property.
- One limitation of this power is that it could not apply in relation to someone who is “M’Naghten” insane because such a person is incapable of committing a crime.
- Such insanity is defined as “labouring under a defect of reason owing to a disease of the mind so as not to know the nature and quality of his act or, if he knew this, so as not to know that what he was doing was wrong”

Legal Powers to Restrain and Detain (5)

SS5/6 Mental Capacity Act permits restraint of a person (P) if a number of conditions are met:-

- Reasonable steps have been taken to establish whether P lacks capacity in relation to the matter in question
- It is reasonably believed that P lacks such capacity
- It is reasonably believed that this will be in P's best interests
- It is reasonably believed that restraint is necessary to prevent harm ***to P*** (ie not to a third party)
- Restraint is proportionate to the likelihood of P's suffering harm and its seriousness
- Restraint comprises the use or threat of force to secure the doing of an act which P resists or restricting P's liberty of movement whether or not P resists
- Restraint falls short of deprivation of liberty within Article 5 ECHR

What is the effect of these powers? (1)

“ The combination of (these) powers....provide sufficient authority for a mental health professional or members of the public to act swiftly to prevent a mentally disordered person from causing harm to himself, to another person or to property as long as the force used is both necessary and proportionate to the harm threatened. It must be emphasised that these powers only allow for an informal patient to be detained for a limited period and will fall away when the crisis has subsided; they cannot be used as an alternative to the procedures set out in the (Mental Health) Act”

(Jones: Mental Health Act Manual 14th ed.)

What is the effect of these powers? (2)

In other words these powers are to deal with an immediate crisis where intervention is urgently required to avert serious consequences eg serious assault on third party or self harm.

These powers cannot be used thereafter to hold onto the person indefinitely because it is considered to be in his best interests. To do so may quickly become a deprivation of liberty requiring a different authority.

These powers cannot be used to treat (in a broad sense) in a crisis.

So: once the immediate crisis subsides then what? Use statutory powers

Patient is in Hospital A&E Dept (1)

Mental health assessment needed or underway but patient intent on leaving. There are no supplemental common law powers available to hospital to detain for this purpose outside the provisions of the MHA: *R(Sessay) v SLAM et al (2011) EWHC 2617*

- S5 is not available to detain as patient is not an inpatient. Beware "preadmission" wards.
- Assessment for S2 underway but incomplete, so invoke S4, which is designed for urgent necessity (see Code of Practice 4.33: LSSAs must have resources for a 24hour service)
- If patient intent on leaving before S4 can be completed S136 could be used by police as A& E is a place to which the public have access (?all parts of A&E)
- What if patient intent on leaving before the S136 can be invoked or you cannot get police to come?

Patient is in Hospital A&E Dept (2)

- In other words the MHA sets out a comprehensive scheme for admission of non-compliant patients
- Unlikely that there will be false imprisonment or deprivation of liberty under Article 5 if no undue delay during processing of S2/S4 application (eg 4-8 hours)
- In *Sessay* there was undue delay in processing, and no authority to hold patient in the meantime (hospital erroneously told patient was on S136)
- The question therefore is whether there is an authority to hold the patient during the assessment
- This applies whether or not patient has relevant capacity
- If the issue is the assessment for treatment of a physical condition, only MCA (and strictly limited common law) powers outlined earlier available

Patient is an Inpatient

- If patient has been detained under MHA there is power to hold him (S6) and implicitly to exercise discipline and control over him (including restraint and seclusion)*(Pountney v Griffiths (1976)AC 314)*
- If patient is an inpatient (ie not in A&E) but not detained under MHA, S5 can be used to hold onto patient but note limitations:-
  S5(2): it must appear to the RMP or AC in charge "that an application ought to be made" for admission under Part 2

Back to back use of S5 is not lawful so if 72 hour period runs out before application made.....

S5(4): patient must be receiving treatment for mental disorder
: patient must appear to be suffering from mental disorder
: need must be to restrain patient *from leaving*
: lasts only 6 hours

- If S5 does not apply or staff waiting for doctor or nurse to implement S5, must rely on strictly limited common law and statutory powers outlined earlier as interim measure (but not as an alternative if to be within Article 5)
- Why are nurses reluctant to use s5(4)?? There are nurse RC's in some parts of the country.. Not a training issue but a confidence issue?

Getting a refusing mentally disordered Patient to Hospital (1)

If purpose is for making arrangements for care and treatment (including making application for admission under Part 2) of person believed/appearing to be mentally disordered, the MHA sets out a comprehensive scheme (for both capacitated and incapacitated patients) (*R(Sessay) v SLAM et al (2011) EWHC 2617)* so:-

- S135 with a warrant to take patient to place(s) of safety if the patient is in private premises and entry refused
- (entry under S17(1)(e) PACE and for breach of peace also possible but does not cover removal)
- S136 if patient found by constable in place to which public has access (includes some parts of A&E). Can probably include taking via A&E on way to place of safety if treatment of physical injuries needed
- S5 not to be used to extend 72 hour place of safety period
- SS5-6 MCA not to be used for this purpose (nor common law)

Getting a Patient to Hospital (2)

- If person has capacity to decide whether to receive treatment in hospital for physical injuries unrelated to mental disorder no power to compel attendance
- If person (capacitated or incapacitated) refuses hospital admission for assessment/treatment of mental disorder, only the MHA powers under SS135/136 available
- If S2/3/4 duly completed there is power to convey to the hospital in face of refusal
- If person who lacks capacity has physical injuries from self-harm or otherwise or is believed to have taken a harmful substance or to be intoxicated with alcohol or drugs MCA SS5/6 may be used to restrain and take to hospital subject to this being proportionate and in the P's best interests

Mental Disorder

- New S1(2) definition of mental disorder: “mental disorder means any disorder or disability of the mind”
- The specific forms of mental disorder are abolished

Mental Disorder: the Exclusions

- Exclusion for drug & alcohol **dependency** retained
- Exclusion for promiscuity, other immoral conduct and **sexual deviancy removed**
- Explanatory notes (para 24) state that paraphilias (such as fetishism and paedophilia) are brought within the scope of the Act.

Dependence on alcohol or drugs

S 1(3) states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act.

This means that there are no grounds under the Act for detaining a person in hospital (or using other compulsory measures) on the basis of alcohol or drug dependence alone. Drugs for these purposes may be taken to include solvents and similar substances with a psychoactive effect.

Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. If the relevant criteria are met, it is therefore possible (for example) to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs. This is true even if the mental disorder in question results from the person's alcohol or drug dependence.

The Act does not exclude other disorders or disabilities of the mind related to the use of alcohol or drugs. These disorders – for example, withdrawal state with delirium or associated psychotic disorder, acute intoxication and organic mental disorders associated with prolonged abuse of drugs or alcohol – remain mental disorders for the purposes of the Act.

Medical treatment for mental disorder under the Act (including treatment with consent) can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder which is the primary focus of the treatment.

paras 3.8 – 3.12, Mental Health Act Code of Practice

Clinically recognised conditions which could fall within the Act's definition of mental disorder

affective disorders, such as depression and bipolar disorder

schizophrenia and delusional disorders

neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders

organic mental disorders such as dementia and delirium (however caused)

personality and behavioural changes caused by brain injury or damage (however acquired)

personality disorders

mental and behavioural disorders caused by psychoactive substance use

eating disorders, non-organic sleep disorders and non-organic sexual disorders

learning disabilities

autistic spectrum disorders (including Asperger's syndrome)

behavioural and emotional disorders of children and adolescents

(Note: this list is not exhaustive.)

para. 3.3, Mental Health Act Code of Practice

Getting a Patient to Hospital (3)

- If taking to hospital is permitted under the SS5/6 MCA, then this is unlikely to involve a deprivation of liberty (see DOLS Code 2.14 and conflicting case law)
- If staff have gained access to home of person believed to lack capacity (ie without a warrant) SS5/6 MCA can be used to restrain them from self harming if proportionate and in best interests
- If police have gained access without a warrant, are asked to leave, but judge there to be a real and immediate risk of self harm if left alone and that the person lacks capacity to ask them to leave they may remain and use proportionate restraint in best interests. On the same basis they may restrain the person from leaving. If the person does leave S136 may be available
- In other words what has been made clear since *Sessay* is that there is a distinction between taking to hospital for treatment/assessment of mental disorder when only MHA powers are available and doing so for treatment of a physical condition.

Place of Safety (SS135/136)

- Place of Safety defined in S135(6): “residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948, **a hospital** as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient” (so could include A&E)
- No legal requirement for police to stay once P taken to place of safety but guidance given that they should
- If P taken to A&E en route to a place of safety for urgent treatment A& E does not become the place of safety
- P may be detained by staff in place of safety for up to 72 hours, but avoid delays (*Sessay*)
- P can be transferred from one place of safety to another within the 72 hours
- S135/136 do not authorise compulsory treatment for mental disorder or physical conditions, so general MCA principles apply.
- If Police cell is used as POS in rare scenarios it should not be for more than 24 hours (New Code)

Treatment in Hospital (including A&E)

- Most treatment is validated under common law by consent of adult of sound mind who is likewise entitled to refuse medical treatment, even if unwise, bizarre or irrational, including under an Advance Decision
- Form of consent largely irrelevant
- Principle protected by Article 8 ECHR – the respect for private and family life and by Mental Capacity Act 2005
- If adult lacks capacity or refuses to consent another authority is therefore required to make treatment lawful (MCA/MHA/COP)
- Treatment whether in an emergency or not, whether under MCA, Common Law or MHA is governed by Doctor's duty of care, breach of which causing damage can result in negligence claim. Duty would include acting within all statutory and other legal requirements and constraints. S139 protection may not apply

The True Emergency

If P refuses treatment and if no time (or impossible or impractical) to assess capacity/obtain valid consent take minimum steps necessary to preserve life or prevent a serious deterioration of P's condition (duty of care/urgent necessity at common law) (Common sense!)

Support for this proposition from:

- GMC Consent Guidance para 79
- MCA S6(7) (while decision sought from Court)
- MCA S4(B) (while decision sought from Court – even if deprivation of liberty)
- MCA S26(5) (in context of an uncertain Advance Decision)
- MCA Code of Practice 3.6
- MCA Code of Practice 6.35 (unless satisfied Advance Decision exists)
- MHA Code of Practice 36.51 re P under 18

In other circumstances, in face of refusal, assess capacity under MCA.....

Treatment in the face of a refusal

Mental Capacity – S1 MCA Key Principles

- Presumption of capacity
- “All practical steps” must first have been taken to help
- Unwise decisions do not imply P is incapable
- Acts done re incapacitated P must be in best interests
- Regard must be had to whether less restrictive option available to achieve purpose.

The MCA S2 Definition of Lack of Capacity

- P lacks capacity if unable to make decision for himself *because of* impairment of, or disturbance in the functioning of, the mind or brain - “diagnostic test” (MCA S2(1))
- Impairment may be permanent or temporary (MCA S2(2))
- Focus is on the particular matter and the particular time when decision has to be made - “functional test” (MCA S3) - ie decision specific

The MCA S3 Test for Inability to Make Decisions

P unable to make decision if **on balance of probabilities** (S2(4)) unable to do any of the following:

- Understand the information relevant to the decision *(as presented appropriately and with assistance (4.16-4.19))*(and see S3(4))
- Retain that information *(long enough to make choice or decide (4.20))*(and see S3(3))
- Use or weigh that information as part of the process of making the decision
- Communicate his decision *(where impossible to tell if P is capable after all practical and appropriate efforts have been made 4.24))*

Mental Capacity?

PC and NC v City of York Council [2013] EWCA Civ 478:

1. Are they unable to make the specific decision at that time?

   Unable to make a decision if unable to:

   - **U**nderstand the information relevant to the decision (includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision), OR
   - **R**etain that information (retention for short period does not prevent him from being regarded as able to decide), OR
   - **U**se or weigh that information as part of the process of making the decision, OR
   - **C**ommunicate the decision (whether by talking, using sign language or any other means).

2. Is this <u>because of</u> a temporary or permanent impairment or disturbance affecting the functioning of mind or brain?

CC v KK and STCC 2012-Issue of capacity assessments by professionals?

- Psychiatrist and all professionals were of the opinion that KK lacked capacity to decide as to her residence
- KK was of the opposite view and gave a written statement and attended oral hearing
- Judge concluded that she had capacity

CC v KK and STCC 2012-learning points

- The roles of the court and the expert are distinct and it is the court that makes the final decision as to the person's functional ability after considering all of the evidence, and not merely the views of the independent expert (*A County Council v KD and L* [2005]

- Professionals and the court must not be unduly influenced by the "protection imperative"; that is, the perceived need to protect the vulnerable adult (*Oldham MBC v GW and PW* [2007] EWHC 136 (Fam); *PH v A Local Authority, Z Ltd and R* [2011]

- The person need only comprehend and weigh the salient details relevant to the decision and not all the peripheral detail. Moreover, different individuals may give different weight to different factors (*LBL v RYJ* [2010] EWHC 2664 (Fam) paras 24, 58).

CC v KK and STCC 2012-learning points

- Capacity assessors should not start with a blank canvas: "*The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed*"

- Capacity assessors should not conflate capacity assessments with what is in the patient's best interests!

What Makes a Good Capacity Assessment?

- Be clear about the capacity **decision** being assessed.
  - Ensure P (and you) have the concrete details of the choices available (eg between living in a care home and living at home with a realistic package of care).
  - What are the salient details to understand/comprehend (ignoring the peripheral and minor details)?
  - Avoid the protection imperative.
- Demonstrate the efforts taken to promote P's ability to decide.
- Evidence each element of the capacity assessment:
  - What is the impairment/disturbance? Is it temporary or permanent?
  - Why could P not understand, or retain, or use/weigh, or communicate in spite of the assistance given?
  - How is the inability because of the impairment/disturbance (as opposed to something else)?
  - Why is this an incapacitated decision as opposed to an unwise one?

Assessing Inability to Make Decisions

- If P has capacity to refuse treatment what other options are available? *(Wooltorton).* The issue whether the treatment is for mental disorder and whether P is detainable under MHA must be addressed (for ADRT's presumption in favour unless evidence to the contrary)

- *Re F ((2009) EWHC B30):* Court can make interim order in person's best interests even where there is insufficient evidence to rebut the presumption of capacity. (Note MCA S6(7) re provision of life sustaining treatment in meantime)
- Note recent research suggesting a tendency for clinicians substantially to overestimate patients' capacity (Lepping: BJPsych (2011) 199, 355-356)
- Properly applied the MCA should mean that the need to consider admission under MHA in order to treat is rare- relative to appropriate use of MCA .

- Note CQC advice that all patients' capacity be assessed on admission. Important to determine whether S131 MHA could be used. Sets a baseline, but important to review and be alert to fluctuating levels of capacity. Also for purposes of forms T2/T3

MCA Code of Practice Guidance (1)

- Anorexic or massive stroke victim may be unable to use or weigh(4.22)
- Re fluctuating capacity – may include bipolar disorders (4.26)
- Need to review assessments of capacity as new skills may be learnt (4.29)
- Repeated inappropriate decisions may indicate lack of capacity (4.28; 2.11)
- The more serious the consequences of the decision the more important the understanding required (4.19) (?)

MCA Code of Practice Guidance (2)

- Provide all info in way P can understand; take time; don’t overburden with detail; enlist help (eg advocate); be aware of cultural, religious and ethnic factors; use pictures, computers, sign language etc
- Put P at ease; consider time of day, location, effect of medication
- Enable P to speak to similar P; delay if acute distress; use material from voluntary organisations
- See 3.1-3.16; 4.36

MCA Code of Practice Guidance (3)

- Rarely necessary to involve professionals
- Guidance re legal requirement for formal assessments (4.54) and when to involve professionals (4.53)
- Cannot force an assessment – consider MHA (4.59)
- Professionals should record assessments (4.61)
- Pointers (4.49):-
  - Does the assessor understand?
  - Friends/family may provide background info but…..
  - Keep it broad and simple
  - Can P paraphrase it back?
  - Consider repeating the test

Recent Cases (1)

RT v LT et al (2010) EWHC 1910: In determining capacity the language of the MCA was crystal clear and earlier judicial authorities unlikely to be of assistance. Useful example of Court logically and deliberately applying the provisions of SS2,3 MCA to decide whether P had capacity to make specific decisions in respect of her residence and care needs. See also similar step by step application of MCA by judge in *A PCT v P et al.(2009) EW Misc 10 (EWCOP)*

Recent Cases (2)

- *AVS v A NHS Trust e al ((2011) EWCA Civ 7):* Court would not compel a clinician to carry out treatment which s/he did not consider medically justified.(NB an advance decision cannot compel treatment). Declaration (S15) pointless without clinician prepared to carry out treatment. Note Court power under S17 to direct another to take over responsibility for P's healthcare.

- *NHS Foundation Trust v D ((2010) EWHC 2535 (COP)):* Delusional belief re medical profession rendered schizophrenic P incapable of "using or weighing" information under S3(1)(c). P's wishes and feelings given little weight under S4 as they were bound up with her delusional beliefs.

Recent Cases (3)

- *LBL v RYJ and VJ ((2010) EWHC 2665 (COP)):* If a person has capacity in relation to an issue the inherent jurisdiction of the Court cannot be invoked to impose a contrary decision, but merely to support him should it be necessary to overcome external pressures or physical restraints which prevent his decision being carried out

- *A LA v DL et al ((2011) EWHC 1022 (Fam)):* Inherent jurisdiction of court available to an adult who was not incapacitated in MCA terms but who was or was reasonably believed to be incapacitated from making the relevant decision by reason of eg constraint, coercion, undue influence or other vitiating factors. (ie P *able* to make decision but prevented by eg coercion)

How to Proceed if Patient lacks Capacity? (1)

- General rule remains that no-one can consent on behalf of another adult. However…..

  There may be a Lasting Power of Attorney

  A Deputy may have been appointed

  The Court of Protection can consent

- Remember “all practical steps”……

How to Proceed if Patient lacks Capacity? (2)

- Existing case law re when must go to Court probably survives MCA ie:-

  Sterilisation of under 18 year old

  Non-therapeutic sterilisations for adults

  Withdrawal of nutrition from PVS patients

  Bone Marrow and Organ donation

New COP guidance says for all invasive procedures and major surgery

- May be necessary to involve Independent Mental Capacity Advocate (eg “serious medical treatment”)

How to Proceed if Patient lacks Capacity? (3)

The legal basis for intervention

- "Acts in connection with care or treatment" (S5 Acts) substantially modify common law doctrine of necessity
- S5 Acts defensible provided first taken reasonable steps to establish if P lacks capacity, must believe that he does and that acting in P's best interests.
- Restraint permissible only if necessary to prevent harm to ***P*** and is proportionate to likelihood and seriousness of harm (S6)
- Restraint amounting to a deprivation of liberty (Article 5 ECHR) is not permitted except as provided by S4A (DoLS; S16 Order; S4B emergency provisions)
- Common law still permitted in an emergency
- MCA does not apply to treatment for *mental disorder* of detained patients whose treatment is regulated by Part 4 MHA (S28(1) MCA)

How to Proceed if Patient lacks Capacity? (4)

The Requirement of Best Interests (1)

Bolam test replaced by Statutory Best Interests Checklist (MCA S4) (statutory obligation, not Code of Practice guidance):-

- Must be equal consideration and non discrimination
- Must consider all relevant circumstances
- Must consider whether P will regain capacity and if so, when
- Participation of P to maximum extent possible

How to Proceed if Patient lacks Capacity? (5)

The Requirement of Best Interests (2)

- If life sustaining treatment, decision not motivated by desire to bring about death
- Must consider (so far as reasonably ascertainable) P's wishes, feelings, beliefs and values esp in writing
- Must consider the views of other people as to P's best interests and wishes
- Not exclusively best *medical* interests (Re Y)
- Availability of less restrictive alternative?

Mental Capacity 4: Best Interest Decision Record for specific decision above.

1 Best Interests Checklist

Activity Undertaken	Yes	No	N/A	✎
Has the Service User been involved in the Decision?				
Have appropriate records been consulted?				
Have Family and Carers been consulted as appropriate?				
Has an advocate been accessed?				
Have other staff been consulted				
Have Advance Statements of wishes and feelings been considered?				
Have less restrictive options been considered?				
Have all relevant circumstances been considered?				
Note 1: If the decision concerns life-sustaining treatment, the decision maker must not be motivated by a sole desire to bring about death				
Note 2: Best interests decisions must be non-discriminatory				

Details (Enter any details in this box, eg names of people consulted, wishes considered but not followed, other options rejected. The level of detail should reflect the seriousness of the decision.)
Tick column marked ✎ to indicate what comments refer to.

2 Record Decision in Service User's ICR. (Detail to be proportionate to seriousness of decision)

Signed	Name	Date

What Makes a Good BIs Assessment?

- Document what you have seen and to whom you have spoken (and, crucially, what they have said!).
- In particular, record P's past and present wishes, feelings, values, beliefs (eg how strong, how consistently held are they?).
- Evidence how you have engaged P and improved their ability to participate in the assessment.
- Evidence how you have engaged consultees, their views, and what they know about P.
- Demonstrate application of the Code and the best interests checklist.
- Be clear about the concrete options (eg between living in a care home and living at home with a realistic package of care).
- Evidence your balance sheet of those options (with indication of the factors' weight and likelihood).

Who Determines Capacity and Best Interests? (1)

- MCA does not identify the decision maker
- Doctor wishing to provide treatment will be decision maker
- MCA Code of Practice assumes person directly concerned with decision to be made is the decision maker (4.38; 5.8-5.10)
- What is position where several stakeholders? (5.11)
- Avoid unnecessary involvement of professionals
- There may be a valid and applicable Advance Decision

Who Determines Capacity and Best Interests? (2)

- An attorney may have been appointed under a LPA, or a Deputy appointed by the Court of Protection

- Where doubt about capacity or best interests, validity of LPA or Advance Decision, apply to Court of Protection and in meantime give treatment necessary to preserve life or prevent serious deterioration

MHA/MCA Main Area of Overlap

- Both Acts may affect people with mental disorders who need treatment for those disorders, but who lack the necessary capacity to make decisions about the proposed treatment so which legal framework should be used?
- S.28(1) MCA: Nothing in this Act authorises anyone to give ***medical treatment for mental disorder***, or to consent to it on behalf of P, if P's treatment is regulated at the time by Part 4 of the MHA
- MCA Advance Decision not effective to refuse Part 4 MHA treatment of P is detained under the MHA (except for ECT)
- If the medical treatment does not come within Part 4 MHA – ***because it is not medical treatment for mental disorder*** - then the patient's legal status as a detained MHA patient is irrelevant for the purpose of treating under the MCA and the MCA can therefore be relied on for medical treatment.

Advance Decisions to Refuse Treatment (“ Advance Decisions”) (1)

- Must be *valid* and *applicable*
- Will not be *valid* if

  Subsequently withdrawn

  Overridden by subsequent applicable LPA

  P has acted in a way clearly inconsistent with the decision

Advance Decisions to Refuse Treatment (“ Advance Decisions”) (2)

Will not be *applicable*

- If P has actual capacity
- To treatments or circumstances not specified
- If circumstances exist which were not anticipated and likely to have affected decision

If valid and applicable has effect of contemporaneous capacitated refusal

Advance Decisions to Refuse Treatment (“ Advance Decisions”) (3)

- Largely codification not change in the law
- Must be 18 to make Advance Decision
- Only applies to *refusals* of *treatment*
- Cannot apply to provision of basic or essential care
- Treatment for mental disorder of patient detained formally under MHA not covered (but note ECT provisions)
- Advance Decision not apply to life sustaining treatment (S4(10)) unless so verified in writing, signed by or at person’s direction and witnessed in writing. Otherwise no particular formality required. (Transitional provisions)

Advance Decisions to Refuse Treatment (“ Advance Decisions”) (4)

- No liability for treating a person unless Dr etc satisfied valid and applicable advance refusal existed (S26(2))
- If Dr etc reasonably believes valid and applicable advance refusal exists no liability if withdraws or withholds treatment (S26(3))
- If Dr etc suspects Advance refusal exists must make reasonable efforts, time permitting, to find out what it says, but can act in an emergency
- If in doubt and decision needed from Court can provide life-sustaining treatment or prevent serious deterioration (S26(5))

A LA v E (2012) EWHC 1639 (COP)

- 32 year old P with anorexia (et al) refusing food. Multiple previous MHA admissions. Two Advance Decisions to refuse life sustaining treatment. Care team and parents agreed no further treatment other than palliative. Case referred to court at late stage: Held:-
- Currently lacked capacity –unable to “use or weigh”, as refusing calories was “the card that trumped all others”
- First advance decision not valid as E lacked capacity at the time – evidence of professionals’ confusion and parents’ doubt.
- Second advance decision not valid – general medical view that E had capacity at the time but there had been no formal contemporaneous capacity assessment made
- Best interests to treat, weighing value of E’s life against her personal independence, despite prolonged use of invasive force. E’s statements were ambivalent. No absolute presumption that all possible steps to preserve life required
- Presumed that treatment would be continued under MHA
- Judge required assurances of continuing funding of treatment

The NHS Trust v L and others 2012 EWHC 2741 (COP)

- L was a highly intelligent 29 year old with severe Anorexia Nervosa and OCD. Had spent 90% of her previous 16 years in inpatient units. In Jan 2012 her s3 was rescinded after all RX options have been exhausted

- Trust then sought a declaration that it was not in her best interests to be subject to forcible feeding or medical Rx notwithstanding that she would inevitably die without it

The NHS Trust v L and others 2012 EWHC 2741 (COP)

- Court decided that it was in L's best interests for clinicians

1. To provide nutrition and hydration and medical Rx where she complied with it
2. To administer dextrose to immediately save life, with minimal force if necessary
3. Not to provide nutrition and hydration if she resisted after all reasonable steps have been taken to gain her cooperation
4. To provide palliative care should she enter the terminal stage of her illness

The NHS Trust v L and others 2012 EWHC 2741 (COP)

- Decision is of interest, not because it provides new legal principle, but simply because it is one of the exceptionally rare occasions when the courts have sanctioned withdrawal of nutrition and hydration from a patient with AN.

- Here it was believed to be a virtually 0% prospect of recovery

- This can be contrasted with A LA v E and others 2012 which enforced re-feeding was authorised where the prospect of recovery were considered to be 20%

- Clearly there comes a point where the "sanctity of life" must give way to the "concept of dignity"

Hierarchy of decision making

1. Valid and applicable **Advanced Decision to refuse Treatment**
2. Donee under **Lasting Power of Attorney** (unless created later than above)
3. **Court of Protection** decision (court can always examine the validity of the above 2)
4. Court appointed **deputee**

Summary (1) - Treatment

Patient has capacity?

- Patient consenting: Informal/common law authority
- Patient not consenting - live with it
  - admit under MHA,
  - enforce treatment under MHA Pt 4 save ECT
  - if placed on CTO recall under Part 4A

Patient lacks capacity/cannot be assessed?

- MCA sections 5/6: Informal treatment of physical disorder
- MCA sec 5/6 informal treatment of mental disorder
- MHA sec 2 for an actively refusing patient with mental disorder
- If on CTO sometimes treat without recall (Part 4A) (passive acceptance and or with LPA or deputy substituted decision)
- The complication of Advance Decisions
- Emergency treatment to preserve life/prevent serious deterioration
- Go to COP

Summary (2) - Detention

It will be unlawful to detain someone in A&E unless there is an authority:

- Under MHA if P has been held under the compulsory powers (eg SS135/136/2/4
- Under common law in crisis to protect from immediate risk of significant harm
- Under MCA SS5/6 where restraint used falls short of a deprivation of liberty (unlikely to)
- Under MCA where application made to court for a decision in cases of uncertainty (Judges available 24/7)

The Objective Element: The Acid Test

Confined to a particular restricted space for a not negligible length of time? Essential ingredients:

1. Subject to continuous supervision and control, AND

2. Not free to leave

The following are not relevant:

- Whether they comply or object
- Relative normality of the placement
- Reason or purpose behind a placement

Lady Hale: “If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.”

AM v SLAM (2013) UKUT 0365 AAC (6)

An oversimplification? Four categories of mental health P:

1. **Non compliant capacitated**. MCA not available, so only MHA (eg SS2/3) potentially available
2. **Compliant capacitated**. MCA not available. Informal admission (S131) – (but will they remain compliant?)
3. **Non compliant incapacitated**. Ineligible for DOLS, so only MHA available. Note S6 MCA limits.
4. **Compliant incapacitated**. DOLS and MHA are alternatives if P requires assessment or treatment in psychiatric hospital where might be deprived of liberty

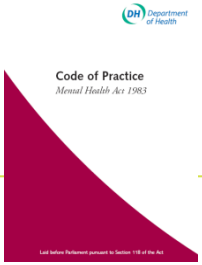
NB(1) If P is deprived of liberty, where is the Authority?

NB(2) New Tribunal PD requirements for reports

Supervised Community Treatment

Community Patients

Supervised community treatment will address the specific problem where patients leave hospital, do not continue with their treatment, their health deteriorates and they require detention again – the so called 'revolving door'



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