

The Interface between the Mental Health Act 1983 and the Mental Capacity Act 2005

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Introduction

1. There are, in one sense, multiple interfaces between the Mental Health Act 1983 and the Mental Capacity Act 2005: those concerning medical treatment, welfare and finances as well as restriction and deprivation of liberty. This paper focuses upon the latter since there is a confusing line of authority developing on the topic, and because there remain a number of questions to be answered and problems to be solved. It is fair to say that today's talk perhaps raises more questions than it provides answers.

The statutory framework of the relationship

2. A person may be the subject of a Statutory Authorisation (SA) if he, inter alia, fulfils the "mental health requirement" and the "eligibility requirement".
3. The "mental health requirement" is met if P is "suffering from mental disorder (within the meaning of the Mental Health Act, but disregarding any exclusion for persons with learning disability" (Sch. A1 para. 14(1)).
4. The "eligibility requirement" "unless he is ineligible to be deprived of liberty by this Act" (Sch. A1 para. 17(1)).
5. These requirements apply equally under the SA scheme and where DoLs authorisation is sought by the Court since:

If a person is ineligible to be deprived of his liberty by this Act, the court may not include in a welfare order provision which authorises the person to be deprived of his liberty (section 16A(1),

and

Schedule 1A applies for determining whether or not he is ineligible to be deprived of liberty by this Act (section 16A(4)(a).

6. Schedule 1A provides that P is ineligible if he falls within one of the cases in the 2nd column (and the corresponding entry in the 3rd column provides that he is ineligible).

In very simplified terms:

Case A

- subject to the hospital treatment regime and detained in hospital

Case B

- subject to the hospital treatment regime but not detained
- and subject to a SA or Court-authorized requirement not in accordance with the treatment regime, or the relevant care or treatment consists in whole or in part of medical treatment for mental disorder in hospital

Case C

- subject to the community treatment regime
- and subject to a SA or Court-authorized requirement not in accordance with the community treatment regime, or the relevant care or treatment consists in whole or in part of medical treatment for mental disorder in hospital

Case D

- subject to the guardianship regime
- and subject to a SA or Court-authorized requirement not in accordance with the guardianship or P objects

Case E

- “within the scope of the Mental Health Act, but not subject to any of the mental health regimes”
- and P objects

7. In respect to Case E - “Within the scope of the Mental Health Act” is defined by Sch. 1A para 12:

(1) ...

(a) *an application in respect of P could be made under s.2 or s.3 of the Mental Health Act, and*

(b) *P could be detained in a hospital in pursuance of such an application, were one made.*

...

(3) *If the grounds in section 2(2) of the Mental Health Act are met in P’s case, it is to be assumed that the recommendations referred to in section 2(3) of that Act have been given.*

(4) *If the grounds in section 3(2) of the Mental Health Act are met in P’s case, it is to be assumed that the recommendations referred to in section 3(3) of that Act have been given.*

(5) *In determining whether the ground in section 3(2) of the Mental Health Act is met in P’s case, it is to be assumed that the treatment referred to in section 3(2)(c) cannot be provided under this Act.*

Which takes priority – Mental Health Act 1983 or Mental Capacity Act 2005?

8. The difficult question, and one that does come up in practice, is what “could” in Sch. 1A para. 12 means. The answer is tied with the question of what might happen if the statutory assumption that recommendations for detention under the MHA have been given when in fact they have not and the responsible professionals are refusing to complete them.
9. In *GJ v A Foundation Trust, A PCT and the Secretary of State for Health* [2009] EWHC 2972 (Fam), [2010] Fam 70, Charles J, provided an answer. This was a case about Case E of Sch. 1A para.2 of the MCA, although Cases A – D were considered by the Court. The Judge said this:

45. *In my judgment, the deeming provisions alone ... are strong pointers in favour if the conclusions that (a) the MHA 1983 is to have primacy when it applies, and (b) the medical practitioners referred to in ss. 2 and 3 of the MHA 1983 cannot pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship with P) that they consider render one regime preferable to the other.*

46. *This is because they point to the conclusion that when the MHA 1983 is being considered by those who could make an application, founded on the relevant recommendations, under s. 2 or s. 3 thereof they, like the decision maker under the MCA, should assume that (a) the treatment referred to in s. 3(2) (c) MHA 1983 cannot be provided under the MCA, and (b) the assessments referred to in s. 2 cannot be provided under the MCA in circumstances that amount to a deprivation of liberty.*

47. *Also, the assumption that the relevant recommendations will be made by the relevant medical practitioners points to the conclusion that Parliament intended the MHA 1983 to be used when, as provided by paragraphs 12(3) and (4) of Schedule 1A to the MCA, the grounds in s. 2(2) and or s. 3(2) MHA 1983 are met in the relevant case.*

...

58. *In my judgment, the MHA 1983 has primacy in the sense that the relevant decision makers under both the MHA 1983 and the MCA should approach the questions they have to answer relating to the application of the MHA 1983 on the basis of an assumption that an alternative solution is not available under the MCA.*

59. *... it does mean ... that it is not lawful for the medical practitioners referred to in ss. 2 and 3 of the MHA 1983, decision makers under the MCA, treating doctors, social workers or anyone else to proceed on the basis that they can pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of*

a therapeutic relationship with P) that they consider render one regime preferable to the other in the circumstances of the given case.10.

10. Charles J did acknowledge that perhaps there was a range of professional opinion in a number of cases as to whether P “could” be dealt with under the MHA, and that that could cause “complications” (para. 63). However, he stated as follows:

... in areas of doubt the Court of Protection, other decision makers under the MCA and decision makers under the MHA 1983 must recognise the primacy of the MHA 1983 and take all practical steps to ensure that that primacy is recognised and given effect to (para. 65)

11. In a case of apparently intractable conflict, the “decision-maker” in the shape of the Court should determine whether the criteria under s. 2 or s. 3 MHA “are met” (para. 71(c) and 80).
12. This, however, did not address the problem which arises where, even if the Court had decided that the criteria “were” met, the necessary recommendations would not be forthcoming (since a Court cannot apply for detention under the MHA in this fashion). The only solution then, it had to be deduced, was an application for judicial review against the relevant professionals for failing to act in accordance with the primacy of the MHA.
13. More assistance came from the Department of Health in the form of a letter written by them to the Tribunal in the case of *DN v Northumberland, Tyne and Wear NHS Foundation Trust* [2011] UKUT 327 (AAC):

In general, the possibility that a person’s needs for care and treatment could be met by relying on the MCA – with or without an authorisation under the MCA DOLS – is relevant to decisions that have to be made under the MHA in the same way as all alternative possibilities. Decision-makers under the MHA must, inevitably, consider what other options are available when deciding whether it is right for compulsory measures under the MHA to be used, or continue to be used. The use of the MCA (with or without an authorisation under MCA DOLS) may be one of those options. All such alternative options must be considered on their merits. The fact that

someone could be deprived of their liberty and given treatment under the MCA does not automatically mean that it is inappropriate to detain them under the MHA, any more than (say) the possibility that someone with capacity may consent to continuing treatment for their mental disorder automatically makes their continued detention under the MHA improper. There are, however, specific circumstances in which the fact that someone is, or could be made, subject to compulsory measures under the MHA means that they cannot also be deprived of their liberty under the MCA. Those circumstances are set out in the “eligibility requirement” in paragraph 17 of Schedule A1 to the MCA, the meaning of which is defined by Schedule 1A to the same Act. A person who is ineligible as determined in accordance with Schedule 1A cannot be deprived of their liberty under the MCA and therefore cannot be the subject of any authorisation under the MCA DOLS. Schedule 1A sets out five cases in which a person is ineligible. Case A is (in summary) where a person is currently detained in hospital under the MHA. That person cannot simultaneously be subject to an authorisation under the MCA depriving them of their liberty either in that hospital or anywhere else. However, that is not to say that a person cannot (in effect) be discharged from one regime to the other. There is nothing to prevent a prospective application being made for an MCA DOLS authorisation in anticipation of, or the expectation that, the person concerned will be discharged from detention under the MHA. Paragraph 12(3) of Schedule A1 to the MCA says, in effect, that when deciding whether the qualifying requirements for an authorisation are met, it is the circumstances which are expected to apply at the time the authorisation is expected to come into effect which are to be considered. The main effect of Cases B, C and D is that a person who is subject to compulsory measures under the MHA which fall short of actual detention cannot be deprived of their liberty under the MCA if that would conflict with a requirement imposed on them under the MHA. So, a person who is on leave of absence from detention in hospital under the MHA can, in general, be the subject of an MCA DOLS authorisation – but not if (for example) that authorisation envisages them living in one care home when it is a condition of

their leave of absence that they live in a different care home. Cases B and C also, in effect, prevent people being made the subject of a MCA DOLS authorisation detaining them in a hospital for the purpose of mental health treatment where the same could be achieved by recalling them to hospital from leave of absence, supervised community treatment or conditional discharge under the MHA (as the case may be). Case E concerns people who are “within the scope” of the MHA, but not so far actually liable to be detained under it. In broad terms (and subject to certain caveats), it means that the MCA cannot be used to deprive someone of their liberty in a hospital for the purposes of mental health treatment if they are objecting to that course of action and they could instead be detained under the MHA.

It is important to note that case E only applies to detention in hospital, and only where the purpose of the proposed deprivation of liberty is treatment for mental disorder within the meaning of the MHA. It is not relevant to deprivation of liberty in other settings (eg care homes) or for other purposes (eg treatment for physical health problems, or for substance dependence by itself separately from treatment for mental disorder with the meaning of the MHA).

The Government’s policy intention was that people who lack capacity to consent to being admitted to hospital, but who are clearly objecting to it, should generally be treated like people who have capacity and are refusing to consent to mental health treatment. If it is considered necessary to detain them in hospital, and they would have been detained under the MHA if they had the capacity to refuse treatment, then as a matter of policy it was thought right that the MHA should be used in preference to the MCA. It was specifically in the context of the interpretation of Case E that Mr Justice Charles talked in J about the MHA having “primacy”. Outside that context, the Department does not understand him to have been making a more general statement about the relationship between the two Acts. Indeed, as set out above, the Department does not think it would actually be possible to say, in general, which has primacy over the other.

14. The key point from this document is that a patient may move from detention in hospital under the MHA to a community placement under the MCA without offending the letter or spirit of the legislation.
15. However, this does not offer a solution to the problem that arises where the RC and/or AMHP are not willing to make the application under the MHA. In my experience, the only solution, after talking has failed, is judicial review of the RC and/or AMHP who are refusing to recommend and/or make the application for detention, although no case in my experience has progressed much further beyond the grant of permission and so the law has not been tested by the Court.
16. It also the case, as set out in the commentary on the case in the Thirty Nine Essex Court of Protection Cases Online, that in some cases difficult questions may arise as to which arrangement – the hospital with specialist support, or the community with significant behavioural restrictions – is the more restrictive.
17. One illustration of a problem of this type is afforded by the case of *Secretary of State for Justice v RB* [2011] EWCA Civ 1608, [2012] 1 WLR 2043. In that case the Secretary of State challenged a decision of the Mental Health Tribunal to discharge RB upon conditions as to his residence, supervision and compliance with medication and professional directions. It was held that the arrangements would amount to a deprivation of his liberty and therefore the decision was outside the powers of the Tribunal. RB did have capacity to consent to these conditions, but they still amounted to a deprivation. Ironically, given the Department of Health's position in DN, had he been found to lack capacity, it is possible that he might lawfully have been discharged into a deprivation of liberty regime under a Standard Authorisation with similar provisions.

Guardianship and the Mental Capacity Act 2005

18. In the case of *C v Blackburn with Darwen Borough Council and A Teaching Care Trust* [2011] EWHC 3321 (Fam), [2012] MHLR 202 Peter Jackson J considered the position of C, who was subject to guardianship as well as a SA. He found that C was a Case D person (if that is not too confusing) and he was not ineligible since the

requirement of the guardianship and the SA was that he should reside at a particular place (and it was only if he were required to reside in two different places by each scheme that a difficulty would arise).

19. Peter Jackson J also made this further, unquestionably correct, observation about guardianship – the power to require a patient to reside at a particular place does not amount to a power to deprive him of his liberty there (whether by preventing him from leaving or otherwise (para. 30)). Accordingly, it may be appropriate in some cases for a patient to be subject to both guardianship and a SA (or declaration of the Court).

20. He went on to consider Charles J’s proposition that in general the MHA has primacy over the MCA, and said this:

35. In my view, there are good reasons why the provisions of the MHA should prevail where they apply. It is a self-contained system with inbuilt checks and balances and it is well understood by professionals working in the field. It is cheaper than the Court of Protection.

...

37. On the other hand, it is not in my view appropriate for genuinely contested issues about the place of residence of a resisting incapacitated person to be determined either under the guardianship regime or by means of a standard authorisation under the DOLS regime. Substantial decisions of that kind ought properly to be made by the Court of Protection, using its power to make welfare decisions under s16 MCA.

...

38. However, a decision about the existence of jurisdiction does not depend on the balance of advantage and disadvantage. Tempting though it is to find that the court can override the effects of guardianship (no doubt expressing it to be in exceptional circumstances) by making an order that conflicts with the guardian’s requirement about place of residence, the effect of s.8 is inescapable. The words “to the exclusion of any other person” are

synonymous with “exclusively”. I cannot accept that Parliament intended to differentiate between a person and an authority in the manner that Ms Hewson suggests. If the distinction is drawn between an individual and an authority, her reading means that the guardian (who could well be an individual) is protected from interference from private individuals but not from public bodies. These would not be limited to the court, but include bodies such as local authorities and health trusts. This cannot be right. The clear intention of the section is to make the three specified decisions the exclusive responsibility of the guardian. That power can only be removed by the discharge of the guardianship under s.72 or by means of judicial review, to the extent that it is available.

21. However, Peter Jackson J went on, at paragraph 44, to invite the local authority “to consider its position as a guardian” and left the welfare application alive with liberty to restore.

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15.10.12

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