**Mental Health Act, Mental Capacity Act and DOLS implications for CYP and 0-25 Service Practitioners**

**Mental Capacity Act 2005 (MCA)**

The Mental Capacity Act 2005 (MCA) generally applies to people over the age of 16, with two exceptions:

1 The Court of Protection can make decisions about a child’s property or finances (or appoint a deputy to make these decisions) if the child lacks mental capacity\* to make such decisions and is likely to still lack capacity to make financial decisions when they reach the age of 18.

2 The offences of ill treatment or wilful neglect of a person who lacks capacity\* can also apply to victims younger than 16 (Section 44).

\* the person under 16 would have to lack mental capacity as a result of an impairment or disturbance in the functioning of their mind or brain.

**Young people aged 16 - 17 years**

Most of the Mental Capacity Act applies to young people aged 16- 17 years, with some exceptions:

1 Only people aged 18 and over can make a Lasting Power of Attorney

2 Only people aged 18 and over can make an advance decision to refuse

medical treatment.

3 The Court of Protection may only make a statutory will for a person aged 18 and over.

**Statutory Principles of the MCA 2005 (Section 1 of the Act)**

1 A person must be assumed to have capacity unless it is established that they lack capacity.

2 A person is not to be treated as unable to make a decision unless all practicable steps to help him to 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 this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

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

**Presumption of Capacity (1st Principle) and Young People**

A person must be assumed to have capacity unless it is established that they lack capacity. The burden of displacing the presumption lies with the person seeking to demonstrate a lack of mental capacity.

People under 16 years are not automatically presumed to be legally competent to make decisions about their care and treatment, with the burden upon the young person to demonstrate that they are competent to make a particular decision. They may be deemed competent if they have “sufficient intelligence and understanding to understand what is proposed”. (Gillick competence)

Once a person reaches the age of 16, they are presumed in law to be competent to give consent for themselves. This does not apply to all decisions (e.g. organ donation or other non therapeutic procedures), which are covered under The Family Law Reform Act 1969.

If a 16 - 17 year old lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, their mind or brain then the Mental Capacity Act will apply in the same way as it does to those who are 18 and over.

**Mental Health Act 1983 (MHA)**

There is no lower or upper age limit for use of the MHA.

The 2007 amendments to the 1983 Act brought a number of key changes in relation to detention and treatment of people under 18

1 **Admitting young people to suitable environments**

The effect of this change is that hospital managers are placed under a duty to ensure that patients under 18 who are admitted to hospital for assessment or for treatment under the legislation, or who are voluntary patients are in an environment that is suitable for their age (subject to their needs).

There is flexibility in the amendment to allow for patients under 18 years to be placed on adult psychiatric wards where the patient’s needs are better met this way. S140 of the MHA places a duty upon Clinical Commissioning Groups to let Local Social Service Authorities know where services that can admit young people in an emergency are to be found.

2 **Electro-Convulsive Therapy**

Patients aged 18 and over may only be given ECT if they have **mental capacity** and agree, or if they don’t have mental capacity, except in an emergency, the ECT must be authorised by a Second Opinion Approved Doctor (SOAD).

This means that a detained patient can refuse to have ECT, and this can only be overturned if a SOAD agrees that the patient does not have capacity to make the decision, and that giving the ECT treatment would be appropriate. In this case, the SOAD also needs to be sure that there is not a valid advanced decision refusing the use of ECT. If such a advanced decision has been made, then ECT cannot be given, except in an emergency.

Patients under 18, even if they have mental capacity and agree, may only be given ECT with the additional agreement of a SOAD. These rules apply to young people **whether or not they are detained***.* In addition, if a young person isn’t detained, and doesn’t have mental capacity to agree to the treatment, as well as the agreement of the SOAD, another authority to treat (for example, from the court of protection) will be needed.

**3 Consent to Admission of 16 -17 year olds**

The 2007 amendments to Section 131 of the MHA 1983 mean that young people16 - 17 years old with capacity, who do not consent to their informal admission to hospital for the treatment of mental disorder cannot be admitted to hospital for such treatment on the basis of consent from someone with parental responsibility for them.

This means that where a young person aged 16 or 17, who has the capacity to make a decision on their health care, decides that they do not want to consent to treatment for mental disorder, they can’t be admitted to hospital for that treatment unless they meet the conditions to be detained under the MHA, even if a person with parental responsibility is prepared to consent.

It also means that where a young person aged 16 or 17, who has the capacity to make a decision on their health care, consents to being admitted to hospital for treatment of a mental disorder they should be treated as an informal patient, even if a person with parental responsibility is refusing consent.

**Guiding principles of the MHA (from the MHA Code of Practice)**

**Purpose principle**

1.2 Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

**Least restriction principle**

1.3 People taking action without a patient’s consent must attempt to keep to a minimum the restrictions they impose on the patient’s liberty, having regard to the purpose for which the restrictions are imposed.

**Respect principle**

1.4 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient’s views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

**Participation principle**

1.5 Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient’s welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

**Effectiveness, efficiency and equity principle**

1.6 People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

**Deprivation of Liberty (DoL) and the Deprivation of Liberty Safeguards (DoLS)**

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act and came in to force in April 2009. They provide a range of safeguards to protect people 18 years and over who have a mental disorder and lack capacity to consent to their accommodation for care or treatment in a hospital or registered care home.

In March 2014 the Supreme Court provided a judgement (P v Chester West & Chester Council P & Q v Surrey CC {2014} UKSC 19) which included the following “acid test” for a Deprivation of Liberty (DoL):

**The person is under continuous supervision and control**

AND

**the person is not free to leave**

AND

**they lack mental capacity to consent to the accommodation for their care or treatment arrangements.**

Factors that are no longer considered relevant include:

- **objection to the care or placement**

**- the purpose of the care or placement**

**- the relative normality of the care arrangements.**

There are a range of care and treatment settings that are not covered by the DoLS, for example:

1 Supported living arrangements

2 Extra Care Housing

3 Private dwellings

In addition, the DoLS only apply to people 18 years or older, so people below this age are not protected by the DoLS.

As a result, for people in care settings other than hospitals or registered care homes and for those under 18 years old, any DoL (see Acid Test for DoL above) has to be authorised by the Court of Protection. There is a positive obligation on local authorities to apply to the court under these circumstances.

The full case transcript of some useful case law in relation to this (Re Daniel X) can be found here:

<http://www.bailii.org/ew/cases/EWFC/OJ/2016/B31.html>

With a summary from 39 Essex St. chambers here:

<http://www.39essex.com/cop_cases/re-daniel-x/>

Further support or advice in relation to the Deprivation of Liberty Safeguards can be provided by the DoLS Team.

Tel: 01454 865 824 Email: DoLSteam@southglos.gov.uk

Further support or advice in relation to making applications to the Court of Protection to authorise a Deprivation of Liberty not covered by the DoLS can be provided by the legal team.

Tel: 01454 863 401 Email: LegalSupport@southglos.gov.uk

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**Summary**

**MHA**

* no upper or lower age limit
* young people must be admitted to suitable environments
* there are particular rules around the use of ECT for 16-17 year olds, with MCA crossovers.
* parental responsibility can not override capacitated consent or refusal of treatment for a mental disorder
* principles of the MHA are guidance

**MCA**

* generally applies to people over 16 years (with a couple of exceptions) – notably the s44 offence relating to ill treatment and wilful neglect
* a person has to be 18 years to be able to make a lasting power of attorney or an advance decision to refuse treatment
* the MCA principles are statutory not guidance
* people under16 years are not automatically presumed to have capacity
* the MCA applies to a person 16 years or over if they lack mental capacity as a result of an impairment or disturbance in the functioning of their mind or brain (stage 1 of the test for capacity)

**DOLS**

* applies to people18 years and over
* protects people who may be having their article 5 rights (Human Rights Act 1998) breached
* applies to people in care homes and hospitals
* the Court of Protection can authorise a DOLS in other settings using the same assessment criteria

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