Practice Guidance

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

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Learning points

- The scope of the Mental Health Act and the Mental Capacity Act.
- The key differences between the two pieces of legislation.
- How to decide which regime to follow in a hospital or community setting when admission and care or treatment might lead to a deprivation of liberty.

Contents

Introduction

The law connecting the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA) is complex and can be difficult to implement in practice, especially in relation to authorising a deprivation of liberty in a hospital setting. More guidance is emerging from case law and other valued sources, such as 39 Essex Chambers. This guide will aim to bring guidance from the law, codes of practice and other sources together, which can be used for quick reference by those involved in decision making in this field.

> **Note**
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> The MHA and MCA both cover England and Wales. The MCA code of practice and Deprivation of Liberty Safeguards codes of practice also cover both countries, but there are separate codes of practice under the MHA for England and Wales. These provide similar guidance on the application of the act, so in this guide references are generally taken from the code of practice for England.

The statutory regimes of the MHA and MCA

As a starting point, it is important to understand the key differences between these two regimes.

The scope of the MHA

To fall within the scope of the MHA, the person has to have a mental disorder within the meaning of the act, which is defined as "any disorder or disability of the mind" (MHA section 1(2)). This excludes dependence on drugs and alcohol and for the purposes of the longer-term treatment powers, will only include people with learning disabilities if their disability is "associated with abnormally aggressive or seriously irresponsible conduct" (MHA section 1(2)).

The MHA is mainly focused on the assessment and treatment of mental disorder in hospital settings, which may be provided under compulsory powers if the person is unable or unwilling to consent, and it is necessary to detain them in hospital to protect them and/or others from harm. It is important to remember that capacity and best interests are not central considerations under the MHA, but rather, when it comes to hospital admission, whether it is necessary to detain the person – this is also known as the 'necessity test'.

In certain circumstances, for example, when the person is objecting to their admission to hospital or resisting treatment for a mental disorder, and their admission to hospital requires use of compulsion, the MHA has to be used to lawfully detain that person, regardless of whether they have or lack capacity to decide to be admitted to hospital. This is, of course, on the basis that they meet the criteria for detention under the MHA. There are also MHA powers that can be used in community settings. These include guardianship (MHA section 7), community treatment orders (MHA section 17A–17G), conditional discharge (MHA section 41) and leave of absence from detention under the MHA (MHA section 17 leave).

The scope of the MCA

The MCA was amended by the MHA 2007 to include the Deprivation of Liberty Safeguards (DoLS). It is important to note that DoLS is part of the MCA (and therefore subject to its principles in section 1, for example) and not a standalone piece of legislation.

To fall within the scope of the MCA, the person has to be assessed as lacking the relevant capacity within the meaning of the act: "For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain." (MCA section 2(1)).

The provisions of the MCA, such as best interests decision making (MCA section 4 and section 5), using restraint and restriction (MCA section 6) and depriving a person of their liberty (MCA sections 4A and 4B and schedule A1 (DoLS) cannot be applied to people who have capacity to make the relevant decision.

There is a two-stage test for capacity, a functional test followed by a diagnostic test (as based on MCA section 2 and section 3), which has to be applied alongside the first three statutory principles of the MCA, that is: the presumption of capacity (MCA section 1(2)); taking all practicable steps to help the person make their own decision (MCA section 1(3)); and that the person must not be treated as unable to make the decision merely because they are making an unwise decision (MCA section 1(4)).

For those assessed as lacking the relevant capacity, any act of care or treatment provided to them must be in their best interests (principle 4 – MCA section 1(5)); and less restrictive alternatives have to be considered first (principle 5 – MCA section 1(6)). If the proposed course of action or decision that has been made in the person's best interests includes an act intended to restrain the person, the decision maker must reasonably believe that the restraint is necessary to prevent harm to the person and is proportionate to the likelihood and seriousness of the harm (under MCA section 6). You should also consider whether the restraint will meet the threshold for a deprivation of liberty, and if so, this will need to be authorised under the DoLS scheme, through a Court of Protection order or under section 4B (in cases where life-sustaining treatment or a vital act is necessary and where a relevant court decision is being sought).

For more information see Inform Adults' knowledge and practice hub on mental capacity and deprivation of liberty.

Key differences between the MHA and MCA

While the MHA is triggered when a person falls within the definition of mental disorder and meets the 'necessity test' as well as the other criteria, the trigger for the MCA is that at the material time, they lack capacity to make a particular decision within the meaning of the MCA. 39 Essex Chambers (2018) summarises the key differences as follows:

1. The MCA relates to a person's functioning – that is their (in)capacity to make a particular decision – whereas the MHA relates to a person's status, as someone diagnosed as having a mental disorder within the meaning of the act and subject to its powers.

2. The MCA requires acts done or decisions made under the act on behalf of people who lack the requisite capacity to be done or made in their best interests. Detention under the MHA, by contrast, contains no equivalent requirement; under its provisions, an individual can (for instance) be detained solely on the basis of the risk that they pose to others.

3 The MCA covers nearly all decision making, whereas the MHA is, to a very large degree, limited to decisions about care in hospital and medical treatment for mental disorder.

4 The MCA specifically excludes from its ambit anyone giving a patient medical treatment for a mental disorder, or consenting to a patient being given medical treatment for a mental disorder, if the patient is, at the relevant time, detained and subject to the compulsory treatment provisions of part 4 MHA.

39 Essex Chambers (2018) also provides this very useful table summarising the key differences between the MHA and MCA:

	Mental Health Act 1983	**Mental Capacity Act 2005**
Who	The non-compliant capacitated and non-compliant incapacitated. Inability or unwillingness of the patient who suffers from a mental disorder to consent to the relevant care and treatment.	The compliant incapacitated and the non-compliant incapacitated. Person who lacks capacity to make a relevant decision.
Purpose	Compulsory care in hospital and medical treatment given to patient for mental disorder.	All decision making.
Trigger	"Necessity test": when it is necessary to protect patient or others from harm that patient receive care and treatment for mental disorder.	"Best interests test": acts done or decisions made under the MCA on behalf of persons who lack capacity must be done in their best interests.

There are of course areas that overlap and this is where the interface between the MHA and MCA needs to be considered.

The hospital setting

Photo: Karen Roach/Fotolia

In hospital settings there are circumstances where the MCA can be applied, even though the person is detained under the MHA, such as for physical health treatment or decisions around finances or future accommodation. There are also circumstances where only one or the other piece of legislation can be applied, for example, if a person not subject to the MHA is being deprived of their liberty and this needs to be authorised. In these cases, the decision maker will have to decide which regime applies.

Circumstances where both the MHA and MCA can be applied in a hospital setting

In cases where a person is detained in hospital under the MHA, but needs treatment for a physical health problem, in certain cases the MCA (and even DoLS) could potentially be applied alongside the MHA. The MHA code of practice for England provides the most up-to-date guidance relevant to this area, which can be found in chapter 13:

"The [MHA] regulates medical treatment of mental disorder for individuals who are liable to be detained under the [MHA]. This may include treatment of physical conditions that is intended to alleviate or prevent a worsening of symptoms or a manifestation of the mental disorder (eg a clozapine blood test) or where the treatment is otherwise part of, or ancillary to, treatment for mental disorder."

In other words, if a person is detained under the MHA, and needs physical health treatment that is related to their mental health problem, then this treatment can be given under the

MHA. Another example would be if a person has self-harmed and needs medical attention. But if the need for treatment for a physical health problem is unrelated to their mental health problem, and the person lacks capacity to make their own decision in relation to this matter, then treatment could potentially be given under the MCA:

"Where individuals liable to be detained under the Act [MHA] have a physical condition unrelated to their mental disorder, consent to treat this physical condition must be sought from the individual. If the individual does not have the capacity to consent, treatment can be provided under the MCA as long as it is in their best interests."

For example, if a person detained under MHA section 3 (detention for treatment) needs cancer treatment and they lack capacity to make their own decision, then this treatment could be provided in their best interests. Other decisions unrelated to medical treatment, but related to their care, such as where the person should be discharged to, could also be made in the person's best interests under the MCA while the person is still subject to the MHA.

One point worth highlighting here is that the best interests principle does not operate when the person has previously made an applicable advance decision to refuse medical treatment (MCA, code of practice 5.4). Also note that where there is a lasting power of attorney or a court appointed deputy, the attorney or deputy will be the best interests decision maker for decisions within the scope of their authority (MCA, code of practice 5.8).

A further example of a clear overlap between the MHA and MCA in a hospital setting is where a person detained under the MHA is placed on section 17 (leave of absence from hospital) and transferred to a general hospital for physical health treatment. If their admission and treatment for the physical disorder amounts to a deprivation of their liberty, then a DoLS authorisation should be sought (or a Court of Protection order in cases where they fall outside the scope of DoLS).

This was confirmed in the case of *A Hospital NHS Trust v CD and a Mental Health Foundation Trust* [2015] EWCOP 74, where a woman with paranoid schizophrenia detained under MHA section 3 needed to be transferred to a general hospital for a hysterectomy because of a large ovarian growth. The judge found that it would be lawful to place her on section 17 leave of absence from hospital and then use DoLS or a Court of Protection order to deprive her of liberty in the general hospital for this physical health treatment.

Case study

Sarah, 25, has been detained under the MHA in an eating disorder unit. She needs a blood test because there are concerns that her potassium levels are too low due to a recent increase in purging behaviours. However, she is refusing to have this blood test. This would be an example of where the physical health treatment (blood test and possible treatment for low potassium levels) can be carried out under the compulsory

powers of the MHA, as the purging behaviours (which are causing the need for the physical health treatment) are directly related to her mental health problem (eating disorder).

But if the blood test reveals another physical health problem which is unrelated to her eating disorder, such as leukaemia, then Sarah's consent will need to be sought for treatment. If she has capacity to consent, but is refusing treatment, then this treatment cannot be given to her. If she lacks capacity to make her own decision, then the decision maker will need to consider if this treatment would be in her best interests and if so, this treatment could be given under the MCA. If she needs to be transferred to a general hospital for this treatment, then she could be granted section 17 leave and the relevant hospital will need to consider whether a DoLS authorisation should be requested.

A further consideration here is whether Sarah has ever made a valid and applicable advance decision to refuse the proposed treatment, in which case the best interests principle would not apply. It would be the same as Sarah having capacity to consent and refusing the treatment – you cannot override a capacitated person's refusal of treatment for a physical health problem (which is unrelated to a mental health problem), nor can you override a valid and applicable advance decision by using the MCA best interests principle (or DoLS). If there is a deputy or lasting power of attorney (LPA) for health and welfare decisions, then their consent would need to be sought if Sarah lacks capacity to consent in her own right and the decision falls within the scope of the attorney/deputy's authority.

Circumstances where the MHA will not be available in a hospital setting

Leading on from the point above, the MHA code of practice for England specifies that the act will not be applicable in the following cases:

"If the individual is deprived of their liberty and the need for physical treatment is the only reason why the person needs to be detained in hospital, then the patient is not within the scope of the Mental Health Act (as the purpose of the deprivation of liberty is not to treat mental disorder) and a DoLS authorisation or a Court of Protection order should be sought."

The general principle here is that if the incapacitated person only needs treatment for a physical health problem, and they will be deprived of their liberty in hospital to receive this treatment, then a DoLS authorisation should be sought (even if the person is objecting), as the MHA won't be available.

However, the DoLS authorisation in itself will not 'authorise' the care or treatment; any necessary care or treatment should be provided in accordance with the MCA (MHA code of practice for England, 13.41). Therefore, decision makers will have to apply the principles of

the MCA and ensure that the care and treatment is, when given, in the person's best interests, taking into consideration the less restrictive principle. Advance decisions again need to be followed, as well as valid and applicable decisions made by an LPA or deputy. If the person who lacks the relevant capacity is not eligible for DoLS, eg hospital patients aged 16 or 17, then the case will have to be referred to the Court of Protection to authorise a deprivation of liberty.

Case study

Peter, 92, has dementia. He has been admitted to an acute hospital setting with a chest infection. He has been assessed as lacking capacity to give valid consent to his admission. He is very confused and disorientated and doesn't understand that he is in hospital or that he needs treatment for this chest infection. He is resistive to all care interventions and has made several attempts to leave the ward, saying that he needs to get back home because he is the main carer for his wife (who is sadly no longer alive). Due to his persistent attempts to leave, he is placed under one-to-one supervision and a DoLS authorisation is requested by the ward manager.

A DoLS referral for Peter is the correct course of action, even though he is in hospital with a mental disorder, objecting to care/treatment and refusing to stay on the ward. This is because he only needs to be kept (or deprived of his liberty) in hospital for treatment of a physical health problem (chest infection). He doesn't need to be detained for treatment of his mental disorder (dementia), so the MHA is not applicable.

In some cases it might be more difficult to determine whether an incapacitated person needs to be kept in hospital for physical health or mental health treatment, and whether DoLS or the MHA should be used to authorise their detention, especially when they are receiving treatment for both problems. For example, if Peter was being given medication for both his chest infection and dementia and he was objecting to taking this medication, necessitating the need to give it covertly, then the decision maker would, of course, need to consider whether he is within the scope of the MHA.

The key question to ask is: "What is the primary purpose of the admission and care/treatment?" If it is to treat the chest infection and there would be no need to keep Peter in hospital once he has recovered from this infection, despite the fact that he has dementia, then DoLS will be applicable.

But if it becomes clear that the treatment for the chest infection is secondary to the treatment he needs because of his dementia, and he is objecting to his admission to hospital and/or this care and treatment, then he may well be ineligible for DoLS and detention under the MHA should be considered instead, as discussed in more detail below.

Circumstances where the MHA must be applied (and the MCA/DoLS won't be available)

First of all, it is important to point out that "a person who lacks capacity to consent to being accommodated in a hospital for care and/or treatment for mental disorder and who is likely to be deprived of their liberty should never be informally admitted to hospital (whether they are content to be admitted or not)". (MHA code of practice for England, 13.52)

So, if an incapacitated person needs to be detained in hospital for treatment of their mental illness, either the MHA or DoLS should be used to authorise this deprivation of their liberty. There are certain cases where the MHA has to be applied to authorise a deprivation of liberty in a hospital setting, because the person will be ineligible for DoLS. This guide will examine these cases first, before looking at when there is a choice between the two regimes.

Both the MHA and DoLS codes of practice set out similar guidelines. As stated in the DoLS code of practice (4.14): an individual is not eligible for a deprivation of liberty authorisation if they are detained as a hospital inpatient under the MHA.

This point is straightforward – a person cannot be detained under both the MHA and DoLS at the same time in a hospital setting (also see MHA code of practice for England, 13.49). But, note that a person on MHA section 17 leave is not considered 'detained' under the MHA and can therefore be kept under DoLS in a general hospital setting for physical health treatment (as pointed out earlier).

The DoLS code of practice (4.45) says: "If the proposed authorisation relates to deprivation of liberty in a hospital wholly or partly for the purpose of treatment of a mental disorder, then the relevant person will not be eligible if:

- they object to being admitted to hospital, or to some or all of the treatment they will receive there for a mental disorder, and
- they meet the criteria for an application for admission under section 2 or section 3 of the MHA (unless an attorney or deputy, acting within their powers, had consented to the things to which the person is objecting)."

Going back to the case of Peter, this would be applicable if he was primarily kept in hospital to be given care and treatment for his mental disorder – dementia – and he was objecting to this.

This is by far the point that causes the most confusion among professionals, as it all hinges on whether the person is objecting or not, and views on what should be considered an objection differ. For example, if a person is trying to leave the ward because they don't understand where they are, does it mean that they are objecting to being there, or that they are just confused and not truly objecting? Similarly, if a person is not trying to leave, but is resistant to elements of their care, such as personal care, should they be seen as objecting?

And what if the person no longer needs 'active treatment for a mental disorder', but is awaiting discharge and is objecting to being on the ward, should they be detained under the MHA?

These are all real dilemmas for decision makers. The MHA code of practice for England (13.51) provides the following guidance:

"Whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects, the reasonableness of that objection is not the issue. In many cases the patient will be perfectly able to state their objection. In other cases the relevant person will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained.

"In deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision makers should err on the side of caution and, where in doubt, take the position that a patient is objecting."

Similar guidance is provided in the MHA code of practice for Wales (13.35-13.38).

Ultimately decision makers will have to come to a conclusion on whether the person is objecting or not. The bottom line is that if a person needs to be detained in hospital (any hospital) for assessment or treatment of a mental disorder, and they are objecting to admission or to any part of their care and treatment for their mental disorder, then they should be detained under the MHA, as long as they meet its criteria for detention.

For the purpose of the MHA, treatment for a mental disorder includes nursing care (MHA code of practice for England, 23.2) and any other "medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations" (MHA code of practice for England, 23.3).

Individuals who are presenting with signs and symptoms of dementia or have a confirmed diagnosis of dementia will fall within the MHA's definition of mental disorder (MHA code of practice for England, 14.120).

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Therefore any nursing care given to inpatients with dementia, such as personal care, should be classed as treatment for a mental disorder. And as the guidance above clearly states, if a person is objecting to their admission or to any part of their treatment for a mental disorder, decision makers should err on the side of caution and, where in doubt, take the position that a patient is objecting.

The DoLS code of practice (4.48) also says: “Even where a person does not object and a deprivation of liberty authorisation is possible, it should not be assumed that such an authorisation is invariably the correct course. There may be other factors that suggest that the Mental Health Act 1983 should be used (for example, where it is thought likely that the person will recover relevant capacity and will then refuse to consent to treatment, or where it is important for the hospital managers to have a formal power to retake a person who goes absent without leave). Further guidance on this is given in the Mental Health Act 1983 code of practice.”

One last area to highlight where the MHA should be applied as opposed to DoLS is set out in the DoLS code of practice (4.50 and 4.51): “If the proposed authorisation relates to deprivation of liberty in a hospital wholly or partly for the purpose of treatment of mental disorder, then the person will also not be eligible if they are:

- currently on leave of absence [section 17 leave] from detention under the Mental Health Act 1983,

- subject to supervised community treatment, or
- subject to conditional discharge,

in which case powers of recall under the Mental Health Act 1983 should be used.

"People on leave of absence from detention under the Mental Health Act 1983 or subject to supervised community treatment or conditional discharge are, however, eligible for the deprivation of liberty safeguards if they require treatment in hospital for a physical disorder."

Case study

John, 38, has mild learning disabilities and paranoid schizophrenia. He has had numerous admissions to hospital under section 3 of the MHA. After his most recent admission he was placed on a community treatment order which provided for him to live in a residential care setting. He had capacity to consent to these arrangements. He has now been living in this care home for the last four months and seems to be responding well to this type of care and support.

When John's mental health is stable, he functions well and consents to all his care and treatment, which includes a fortnightly depot injection (anti-psychotic). But when he experiences psychotic symptoms, he struggles to understand why he needs this treatment and will often refuse his depot injection. Over the last six weeks he has been recalled to hospital on two occasions due to refusing this treatment. But on both occasions he was only given his depot injection, kept overnight for observation and discharged the following morning, as there was no need to detain him further.

The last time this happened was just over a week ago. John's care co-ordinator has visited him twice since he has been back at the care home and is concerned because he is still displaying psychotic symptoms, which have been getting worse. His responsible clinician suspects that his medication needs to be increased and wants to admit him to hospital. John agrees to be admitted as an informal patient (he has capacity to consent at this point).

But over the next week in hospital John deteriorates rapidly and becomes very delusional and confused. He is assessed as lacking capacity to consent to remaining in hospital, but because he remains compliant with treatment, he is not detained under the MHA. Instead, the hospital requests a DoLS authorisation.

In this case, John would not be eligible for DoLS, because he is subject to a community treatment order and the power of recall under this order has to be used if he needs to be detained in hospital for treatment of his mental disorder without his valid consent (even though he is not objecting). His responsible clinician will therefore have to

> formally recall him to hospital and revoke the community treatment order, which will leave him detained under section 3 of the MHA again.

Circumstances where decision makers have a choice between the MHA and MCA

There are cases where decision makers have a choice between the MHA and MCA in authorising a deprivation of liberty in hospital. This would mainly be in the case of the 'compliant incapacitated psychiatric inpatient' as clarified in *AM v South London & Maudsley NHS Foundation Trust & Secretary of State for Health* [2013] UKUT 0365 (AAC).

The MHA code of practice for England has now incorporated guidance from this case law, which is set out in chapter 13 as: "If an individual:

a) is suffering from a mental disorder (within the meaning of the Act [MHA];
b) needs to be assessed and/or treated in a hospital setting for that disorder or for physical conditions related to that disorder (and meets the criteria for an application for admission under sections 2 or 3 of the Act [MHA]);
c) has a care treatment package that may or will amount to a deprivation of liberty;
d) lacks capacity to consent to being accommodated in the relevant hospital for the purpose of treatment, and;
e) does not object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder.

Then in principle a DoLS authorisation (or potentially a Court of Protection order) and detention under the Act [MHA] would both be available (subject to the assessments required for a DoLS authorisation, including the eligibility assessment). This is the one situation where the option of using either the Act [MHA] or DoLS exists. It is important to note that a person cannot be detained under the Act [MHA] at the same time as being subject to a DoLS authorisation or a Court of Protection order."

For those individuals who satisfy all the criteria in (a) to (e) above, decision makers should consider which regime is the most appropriate, taking into account further guidance from the *AM v SLAM* [2013] case law, which can be summarised from the MHA code of practice as:

- The choice of using the MHA or MCA (including DoLS) should never be based on the decision maker's general preference for one regime or the other, or because they are more familiar with one of these regimes (MCA, code of practice 13.58).
- The key consideration should be which regime would be less restrictive for that person, balanced against any potential benefits associated with the other regime. It is important to note that one regime is not generally less restrictive than the other, as both regimes are based on the need to impose as few restrictions on the person's liberty and autonomy as possible (MCA, code of practice 13.58). Therefore, the

decision maker will need to consider the person's individual circumstances – what may be a less restrictive regime for one person, may not necessarily be the less restrictive regime for another.

- Both regimes provide appropriate procedural safeguards to protect the person's rights during their detention. Therefore, decision makers should not view one regime as generally offering better safeguards than the other. However, the nature of the safeguards under each regime is different and the decision maker must consider which safeguards are more likely to best protect the interests of the person, depending on their individual circumstances (MCA, code of practice 13.59).
- Where detention under the MHA and a DoLS authorisation or Court of Protection order are available, the MHA code of practice does not aim to prescribe to the decision maker which one to choose, but rather to consider the unique circumstances of each case in light of the above guidance and clearly record the reasons for their final decision as to which regime would be most appropriate in each individual case (MHA code of practice for England, 13.61).

Case study

Irene, 63, has had bipolar mood disorder for most of her adult life. She is well known to mental health services and has had numerous hospital admissions under section 3 of the MHA. She has always strongly objected to admissions and treatment for her mood disorder, especially mood stabilising medication. Over recent years her mood has been more stable, but she has been deteriorating cognitively and those involved in her care suspect that this might be the onset of dementia. No formal testing has taken place though as she won't agree to it, stating that it is "just old age" and that she doesn't want "another label".

More recently, Irene's family have been growing increasingly concerned as she appears to be self-neglecting. They also report that she is not eating properly, which is a concern as she is diabetic. She has been prescribed medication to control her diabetes, but it is not clear if she has been taking this or any of her mood stabilisers. Neighbours have also found her wandering around at night in a confused state; often crying and saying that she's looking for her mother (who is no longer alive). Social services start to visit more frequently and offer support at home. Most of the time, Irene has capacity and refuses all support, saying that she can manage on her own. But on some occasions she presents with severe confusion and fluctuating moods, crying for help and agreeing to a support package at home. Unfortunately, as soon as she regains capacity, she again refuses all support.

Then Irene is admitted to a general hospital after being found collapsed in the road. She initially appears very confused and disorientated and tests are carried out for underlying infections. But all tests come back negative and she is now presenting with rapid fluctuations in her mood. Due to her presentation and history of bipolar mood disorder, she needs to be transferred to a psychiatric hospital for further assessment

of her mental health. She is assessed as lacking capacity to consent to this admission but is fully compliant and makes no attempts to leave. She will, however, be deprived of her liberty and the hospital now needs to seek authorisation for this.

This is an example of where either the MHA or DoLS frameworks could be used to authorise the deprivation of liberty. Irene is a 'compliant incapacitated psychiatric inpatient' and satisfies all the criteria in (a) to (e) set out earlier. The decision makers therefore need to consider the guidance in the MHA code of practice to establish which regime would be the most appropriate for her. They may want to ask these questions:

- Which regime would be less restrictive for Irene, balanced against any potential benefits associated with the other regime?

Note that one regime is not less restrictive than the other. Both regimes will authorise a deprivation of liberty, but it might be less restrictive in Irene's case to be placed on MHA section 2 (28-day assessment period), rather than under a DoLS authorisation, which may have a longer timeframe. On the other hand, if detention under MHA section 3 is considered, then this would be for a period of up to six months before it would need to be formally renewed, whereas a DoLS authorisation could be set for a shorter time, with conditions attached to minimise any restrictions that are in place. So, what would be less restrictive for Irene will depend on her individual circumstances.

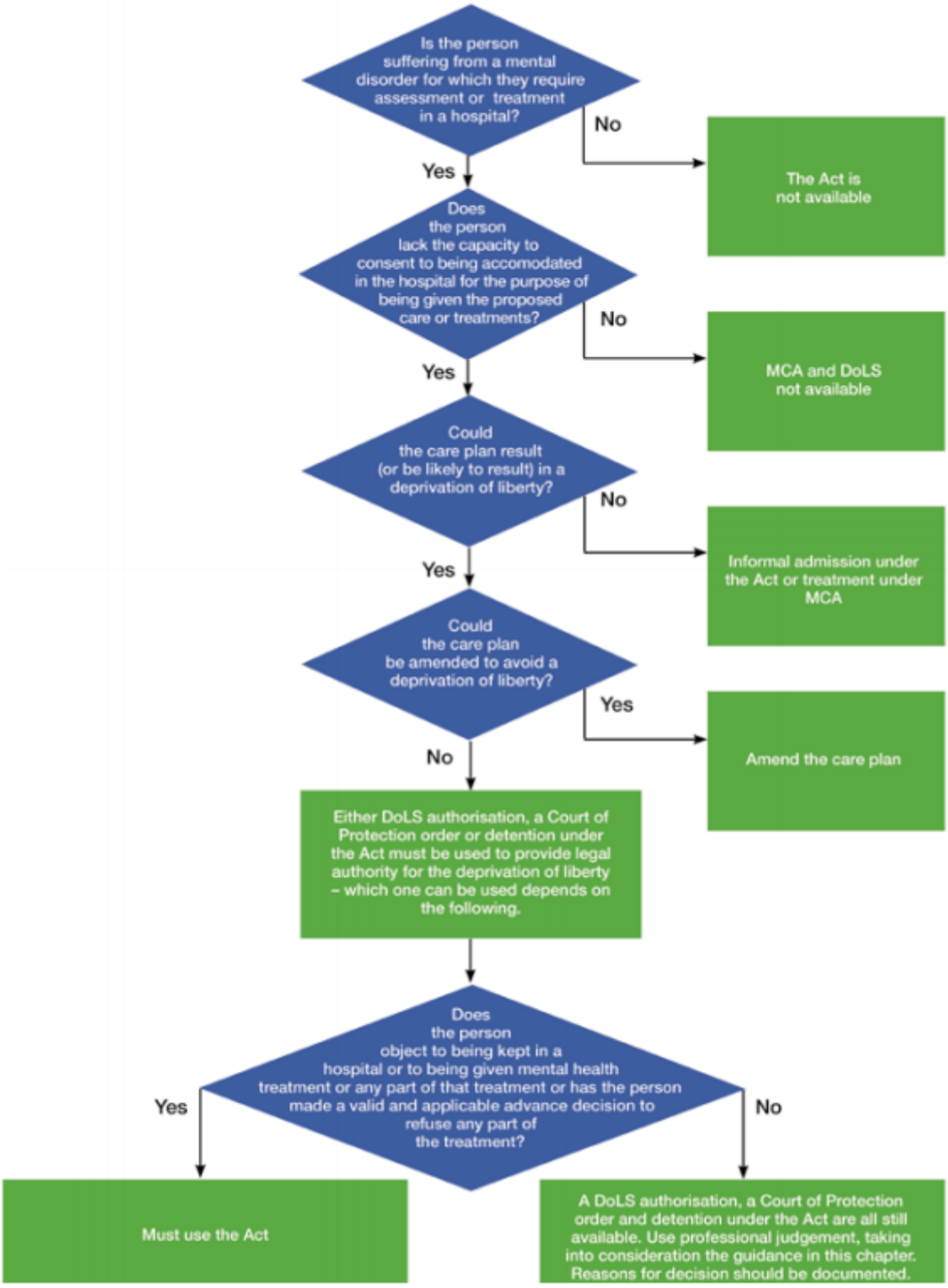
- Which safeguards are more likely to best protect Irene's interests?

It is again important to remember that both regimes provide appropriate safeguards to protect Irene's rights during detention. We should therefore not view one regime as generally offering better safeguards than the other. In Irene's case, automatic consideration of her case by a mental health tribunal (which she would be entitled to if detained under the MHA) might be more beneficial. On the other hand, a DoLS authorisation with a shorter timeframe and conditions or further recommendations attached could also ensure that her detention is brought to an end as soon as possible (by, for example, recommending a care package at home).

There are other factors that decision makers in Irene's case should consider when deciding between the MHA and DoLS. Her history suggests that she may regain capacity and then refuse to consent to treatment. As pointed out earlier, the DoLS code of practice (4.48) advises that the MHA could be used in such cases, even if the person is not objecting. Or if she was at risk of absconding, then it could be important for the hospital managers to have formal powers to bring her back to hospital, which they would have if she was detained under the MHA. Lastly, if she was presenting as a risk to others, then the MHA might be more appropriate as use of the DoLS is very firmly focused on risk of harm to the person (see discussion below).

Summary of what to consider in the hospital setting

The MHA codes of practice for England and Wales provide a useful flowchart which summarises what decision makers need to consider when deciding whether the MHA (referred to as "the Act" below) and/or MCA is available to be used in hospital settings. The below is taken from the code for England:



The community setting

As mentioned earlier, there are MHA powers that can be used in community settings, which include guardianship (MHA section 7), community treatment orders (CTOs) (MHA sections 17A-17G), conditional discharge (MHA section 41 and section 72, which is only available for certain forensic patients, that is those who entered MHA detention from the criminal justice system and are considered to pose a high level of risk) and leave of absence from detention under the MHA (MHA section 17 leave). However, none of these powers can be used to authorise a deprivation of the person's liberty. Where the person is subject to one of these MHA powers and lacks capacity to consent to their care and treatment regime in a hospital or care home – and which amounts to a deprivation of that person's liberty – authorisation under DoLS must be sought. In other settings, such as private homes and supported living, authorisation from the Court of Protection must be sought.

Authorisation under DoLS can be granted alongside the orders mentioned above, as long as the person meets the "qualifying requirements" for DoLS and the DoLS authorisation is not in accordance with a requirement imposed by the MHA community power.

An example would be where a DoLS authorisation has been requested to keep a person in care home A, but the person's guardian (under the MHA guardianship) has made the decision that they should live in care home B. Therefore, a DoLS authorisation cannot be granted to deprive the person of their liberty in care home A, as this would not be in accordance with the guardian's decision. But authorisation could be granted for care home B, as this would be in accordance with the guardian's decision.

As the DoLS code of practice explains (4.41-4.44): "A person is not eligible for a deprivation of liberty authorisation if:

– the authorisation, if given, would be inconsistent with an obligation placed on them under the Mental Health Act 1983, such as a requirement to live somewhere else. This will only affect people who are on leave of absence from detention [section 17 leave] under the Mental Health Act 1983 or who are subject to guardianship, supervised community treatment or conditional discharge.

– where the proposed authorisation relates to a care home, or to deprivation of liberty in a hospital for non-mental health treatment, the eligibility assessment will simply be a matter of checking that authorisation would not be inconsistent with an obligation placed on the person under the Mental Health Act 1983.

– when a person is subject to guardianship under the Mental Health Act 1983, their guardian can decide where they are to live, but cannot authorise deprivation of liberty and cannot require them to live somewhere where they are deprived of liberty unless that deprivation of liberty is authorised.

– occasionally, a person who is subject to guardianship and who lacks capacity to make the relevant decisions may need specific care or treatment in a care home or hospital that cannot be delivered without deprivation of liberty.

This may be in a care home in which they are already living or in which the guardian thinks they ought to live, or it may be in a hospital where they need to be for physical health care. It may also apply if they need to be in hospital for mental health care. The process for obtaining a deprivation of liberty authorisation and the criteria to be applied are the same as for any other person."

The following case law supports this further:

- In *GW v Gloucestershire CC* [2016] UKUT 499 it was confirmed that guardianship does not allow a deprivation of liberty and if the care plan is amounting to this, then authorisation under DoLS or a court order needs to be sought.
- In *A Hospital NHS Trust v CD and a Mental Health Foundation Trust* [2015] EWCOP 74, (mentioned earlier) the judge found that it would be lawful to place a person on section 17 leave and then use DoLS to detain them in a general hospital for physical health treatment.
- In *MM v Secretary of State for Justice* [2018] UKSC 60 and *Welsh Ministers v PJ* [2018] UKSC 66, the Supreme Court confirmed that the MHA does not permit a mental health tribunal or the Secretary of State to order a conditional discharge of a restricted patient subject to conditions which amount to a deprivation of liberty, or a responsible clinician to impose conditions in a CTO which have the effect of depriving a patient of liberty.

DoLS and managing 'risk to others' in community settings

One last area to address is whether DoLS can be used to manage risk to others in the community. This is a complex question and there are conflicting views from case law.

The best advice to practitioners is that they should be very cautious about relying on DoLS where the real risk is risk of harm to others and that further legal advice should always be sought in such cases. If the risk of harm to others is only subsidiary, then it is likely that DoLS could be used. However, DoLS is very firmly focused on risk of harm to the person, and in *P v a Local Authority* [2015], the DoLS authorisation was discharged largely because the real risk wasn't of harm to the person, but of harm to others. On the other hand, cases such as *N v A Local Authority* [2016] EWCOP 47 indicate that, to some degree, factors relating to harm to others can be relevant.

Further advice to local authorities is that if the reason for depriving someone of their liberty is risk of harm to others, then they should seriously consider taking the matter to the Court of Protection, rather than risk taking responsibility for what may be a flawed DoLS authorisation.

Ruck Keene (2016) supports this point and further advises that: "It is, of course, the case that there have been a number of judgments in which, exercising powers under section 16 MCA

2005, judges have held that a deprivation of liberty for what on any view are public protection purposes is nonetheless in a person's best interests (see in particular *Y County Council v ZZ* [2012] EWCOP B34).

"For my part, I have always been deeply uncomfortable with this approach to best interests, but I cannot deny that they exist. However, my reading of the judgment in the current case is that any supervisory body considering authorising a deprivation of liberty on public protection grounds would be very well-advised seeking the authority of the Court of Protection under section 16 MCA 2005 rather than seeking to rely upon DoLS."

Case study

Robert, 49, has early onset dementia. He is presenting with severe cognitive impairment and as a result, he is no longer able to make his own decisions around accommodation, care and treatment. But he is physically fit and still very active. He is also experiencing psychotic episodes, usually associated with auditory hallucinations and paranoia. During these episodes he believes that people are talking about him and plotting to kill him, which triggers verbal and physical aggression towards others.

For the last year he has been living in a long-stay continuing healthcare (CHC) setting (registered as a hospital). He was placed there from an acute psychiatric ward, where he was detained for eight months under the MHA (section 3). Before this he was living at home, but his family could no longer manage his aggressive behaviour; there were reports that he caused serious physical harm to his wife and two teenage children. The police had also attended incidents where he wandered out and harmed or threatened to harm members of the public.

Robert has remained subject to compulsory detention under section 3 the MHA while living in the CHC setting, mainly due to the risk that he poses to others. He needs support with all daily living activities, such as maintaining his personal care, meal preparation and medication management. He is supervised on a one-to-one basis during the day, which increases to two-to-one when he is more agitated and aggressive, or when he needs to be escorted out. He is only taken out if absolutely necessary, such as when he has a hospital appointment, as he has been known to abscond. He is, however, fully compliant with all care and treatment and never tries to leave. The difficulty in his case has always been the risk of harm to others.

But over recent months Robert has been settling and the incidents of verbal and physical aggression towards others have become less frequent. The aggressive outbursts, often managed through physical restraint and sedative medication, used to be a daily occurrence. But his behaviour charts indicate that these outbursts have now reduced to one or two incidents a month. Staff are also now able to predict when these episodes will happen and are managing to de-escalate it through distraction and reassurance, without needing to use any physical or chemical restraint. There are in

fact no recorded incidents of physical restraint in the last eight weeks and the last time he was given sedative medication was six weeks ago.

He no longer needs one-to-one support during the day (this has been reduced to 15-minute checks). More recently, he has been accessing the community as well; still escorted by two members of staff, but without any incidents of aggression or absconding. Staff attribute these improvements to him becoming more familiar with his surroundings and other residents, which has lessened the episodes of paranoia.

Robert's current section 3 order is due to expire in 10 days. His responsible clinician (RC) doesn't think it is necessary to detain him under the MHA any further, as he remains fully compliant with all care/treatment and is no longer such a high risk to others. Therefore, a DoLS authorisation has been requested.

The best interests assessor and mental health assessor carry out a joint visit to assess Robert under DoLS. They are concerned about his history of risk of harm to others and argue that if it wasn't for this risk, he wouldn't need to be detained in the CHC setting in the first instance; he could be moved, for example, to a care home. They argue that the MHA is available (as it is a hospital setting) and that the RC should consider detaining him further under section 3 of the MHA instead.

The RC's counterargument is that a move to a care home would just unsettle Robert and also put him at risk of harm. The RC explains that Robert still becomes paranoid in unfamiliar settings, which triggers the aggressive behaviour. So, if he was moved to a care home (an unfamiliar setting), he is likely to become paranoid and physically aggressive, necessitating the need for more physical and chemical restraint, which could cause harm/injuries to him. Increased episodes of aggression are also likely to lead to a breakdown of the placement, as care home staff may not be able deal with such challenging behaviours. This may lead to further admissions to acute psychiatric settings under the MHA and instead of having any therapeutic value, the RC argues that any such admissions would cause a rapid deterioration in his mental health; reminding the assessors that unfamiliar settings are the main trigger for his paranoia and aggression. It is the familiarity with his current surroundings that has led to him to becoming more stable and settled and moving Robert would be detrimental to his overall wellbeing. The purpose of keeping him there is mainly to ensure that he remains well and stable and to prevent risk of harm to him, as opposed to managing risk of harm to others.

This is a good example of where one might argue that the risk of harm to others is now only subsidiary and that DoLS could be used to authorise the deprivation of Robert's liberty. But it is also a good example of where further advice should be sought. If the risk of harm he posed to others far outweighed the risk of harm to self, then the MHA should be used instead (as was the case when he first moved to the CHC setting).

> If Robert was in a community setting, such as a residential placement, then the MHA would of course not be available to authorise the deprivation of his liberty. But if the main risk was of harm he posed to others, this is where an application to the Court of Protection should be considered. As Alex Ruck Keene reminds us above: "Any supervisory body considering authorising a deprivation of liberty on public protection grounds would be very well-advised seeking the authority of the Court of Protection under section 16 MCA 2005 rather than seeking to rely upon DoLS."

Conclusion

The interface between the MHA and MCA (including DoLS) can be a complicated field to navigate your way around. This guide provides an overview of what to consider, but each case will be different and will not necessarily 'fit' into the categories outlined above.

Some cases may fall on the borderline between the MHA and MCA. However, decision makers have to think carefully about what regime to pursue and in more complex cases this may be a difficult task to undertake.
If in doubt, it is essential to seek further advice from your manager, organisation or legal team to avoid arbitrary and unlawful decision making. And always record the factors you weighed up in your decision making and your reasons for deciding one way or the other. It is not always about making the 'right' or 'wrong' decisions, but about making evidence-based decisions, in line with the law and accepted guidance, which can be defended at a later stage if necessary.

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