The role of the Deputy

with regard to the

interaction of Mental Health Act 1983 and Mental Capacity Act 2005

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MENTAL CAPACITY ACT 2005 ("MCA") v MENTAL HEALTH ACT 1983 ("MHA")

- MCA applies if you lack mental capacity to make a decision that needs to be made

"a disturbance or impairment in the functioning of mind or brain" which results in person not understanding the necessary information, unable to retain the information to make a decision, not able to use or weigh the information or unable to communicate a decision.

Provides how decisions should be made in the best interests of a person who lacks the capacity.

- MHA applies if you have a mental disorder

"Organic " - physical change in brain which affect its functioning (e.g. dementia, acquired brain injury)

"Functional" - alteration in brain function appears to be associated with changes in way information is signalled around the brain (e.g. depression or schizophrenia).

Gives powers to others to make decisions about a person's mental health treatment in circumstances where the person may be a risk to themselves and/or other people. Includes conditions and procedure for being sectioned and sets out rights if a person is sectioned.

- Multiple interfaces between MHA and MCA:

- Welfare
- Medical treatment
- Finances
- Deprivation of Liberty

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Relationship between MCA and MHA – medical treatment and detention

- Use MHA to detain and treat somebody who lacks capacity to consent to treatment (rather than MCA) if:

- Not possible to give care/treatment without depriving liberty

- Person needs treatment that cannot be given under MCA. E.g. advance decision refusing treatment

- Restraint required in way not allowed under MCA

- Not possible to assess or treat person safely or effectively without treatment being compulsory (e.g. person expected to regain capacity to consent, but might then refuse to consent)

- Person lacks capacity to decide on some elements of treatment, and they/someone else might suffer harm as a result

- Consider if can use MCA instead to achieve aims safely & effectively instead

- Compulsory treatment under MHA not an option if:

- mental disorder does not justify detention in hospital; or
- treatment for physical illness or disability required only

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- MCA applies to people subject to MHA in the same way with 4 exceptions:

- If someone is detained under MHA, decision makers cannot normally reply on the MCA to give treatment for mental disorder or make decisions about treatment on that person's behalf;

- If somebody can be treated for their mental disorder without their consent because they are detained under the MHA, healthcare staff can treat them even if it goes against an advance decision to refuse that treatment;

- If a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live; and

- Independent Mental Capacity Advocates do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA.

- Healthcare staff cannot give psychosurgery (i.e. neurosurgery for mental disorder) to a person who lacks capacity to agree to it. This applies whether or not the person is otherwise subject to MHA.

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Case scenario: Deciding whether to use MHA or MCA

Mrs Carter is in her 80's and has dementia. Somebody finds her wandering in the street, very confused and angry. A neighbour takes her home and calls her doctor. At home, it looks like she has been deliberately smashing things. There are cuts on her hands and arms, but she won't let the doctor touch them, and she hasn't been taking her medication.

Her doctor wants to admit her to hospital for assessment. Mrs Carter gets angry and says that they'll never keep her in hospital. So the doctor thinks that it might be necessary to use the MHA. He arranges for an approved social worker to visit. The social worker discovers that Mrs Carter was expecting her son this morning, but he has not turned up. They find out that he has been delayed, but could not call because Mrs Carter's telephone has become unplugged.

When she is told that her son is on his way, Mrs Carter brightens up. She lets the doctor treat her cuts – which the doctor thinks it is in her best interests to do as soon as possible.

When Mrs Carter's son arrives, the social worker explains the doctor is very worried, especially that Mrs Carter is not taking her medication. The son explains that he will help his mother take it in future. It is agreed that the MCA will allow him to do that. The social worker arranges to return a week later and calls the doctor to say that she thinks Mrs Carter can get the care she needs without being detained under the MHA. The doctor agrees.

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Case Scenario: Deciding on whether to follow an advance decision to refuse treatment

Miss Khan gets depression from time to time and has old physical injuries that cause her pain. She does not like the side effects of medication, and manages her health through diet and exercise. She knows that healthcare staff might doubt her decision-making capacity when she is depressed. So she makes an advance decision to refuse all medication for her physical pain and depression.

A year later, she gets major depression and is detained under the MHA. Her GP (family doctor) tells her responsible medical officer (RMO) at the hospital about her advance decision. But Miss Khan's condition gets so bad that she will not discuss treatment. So the RMO decides to prescribe medication for her depression, despite her advance decision. This is possible because Miss Khan is detained under the MHA.

The RMO also believes that Miss Khan now lacks capacity to consent to medication for her physical pain. He assesses the validity of the advance decision to refuse medication for the physical pain. Her GP says that Miss Khan seemed perfectly well when she made the decision and seemed to understand what it meant. In the GP's view, Miss Khan had the capacity to make the advance decision. The RMO decides that the advance decision is valid and applicable, and does not prescribe medication for Miss Khan's pain – even though he thinks it would be in her best interests. When Miss Khan's conditions improves, the consultant will be able to discuss whether she would like to change her mind about treatment for her physical pain.

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Scenario: Using the MCA to treat a patient who is detained under the MHA

- Mr Peters is detained in hospital under section 3 of the MHA and is receiving treatment under Part 4 of the MHA. Mr Peters has paranoid schizophrenia, delusions, hallucinations and thought disorder. He refuses all medical treatment. Mr Peters has recently developed blood in his urine and staff persuaded him to have an ultrasound scan. The scan revealed suspected renal carcinoma.
- His consultant believes that he needs a CT scan and treatment for the carcinoma. But Mr Peters refuses a general anaesthetic and other medical procedures. The consultant assesses Mr Peters as lacking capacity to consent to treatment under the MCA's test of capacity. The MHA is not relevant here, because the CT scan is not part of Mr Peters' treatment for mental disorder.
- Under section 5 of the MCA, doctors can provide treatment without consent. But they must follow the principals of the Act and believe that treatment is in Mr Peters' best interests.

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Does the MHA affect the duties of attorneys and deputies?

- In general no but two exceptions:

1. Cannot consent on a patient's behalf for treatment under Part 4 MHA. (Part 4 allows doctors to give patients who are liable to be detained treatment for mental health disorder without consent)
2. They will not be able to take decisions:
   - about where a person subject to guardianship should live, or
   - that conflict with decisions that a guardian has a legal right to make.

- If subject to MHA, can still create LPA (if have capacity) and Court of Protection can still appoint a deputy.
- In certain cases, people subject to the MHA may be required to meet specific conditions such as live in a particular place, maintain contact with health services, avoid a particular area. Attorney/Deputy make a contravening decision, patient will be taken to have gone against the condition. Could mean patient is recalled to hospital.
- Attorney/Deputy can exercise patients' rights under MHA on their behalf, if they have the relevant authority. Some personal welfare attorney/deputies may be able to apply to the Mental Health Review Tribunal (MHRT) for the patient's discharge from detention, guardianship or after-care under supervision.
- MHA gives rights to *"nearest relative"* e.g. object to an application for admission for treatment, apply for the patient to be admitted to hospital or guardianship. Attorney/Deputy may not exercise these rights, unless also nearest relative.
- Good practice for clinicians and others involved in assessment to find out if there is an attorney/deputy and so they should be made aware.

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Role of Deputy in relation to Finances and Welfare

- Two types of Deputy: (1) **Property and Financial Affairs** and (2) **Health and Welfare**

- PFA / OPG Deputy Standards :

- *identify and secure all benefits including public funding (inc. s117 MHA)*
- *seek recovery of any money owned to the client (recover care funding inc. s117 MHA)*
- *consider accommodation needs*
- *ensure any level of care (including supplementary therapies or treatments) is relevant to the client, good value for money and appropriate to level of funds*
- *arrange for client to receive personal allowance, relevant to their needs*
- *safeguarding – deputy should know how to make a referral to the relevant authority*
- *OPG annual report asks deputy if reviewed care plan*

- HW / OPG Deputy Standards (Standard 5) :

- *carry out health review/assessment at least once a year*
- *notify all involved in client's network of deputy order (clinicians, care provider)*

Similar duties on attorney under Lasting Powers of Attorney

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MCA or MHA? – Deprivation of Liberty

- Deprivation of Liberty is not the same as being detained under the MHA.

- An individual does not need to have treatment for a mental health problem in order to be deprived of their liberty. You can be deprived of your liberty to keep you safe, or for treatment of other health problems.

- If a person already detained under MHA, the health professional cannot at the same time apply DoLS procedure under MCA.

- Number of cases where the Supreme Court has confirmed the position surrounding discharge from hospital subject to conditions that give rise to a DoL, even where the individual concerned as consented to those conditions:

Secretary of State for Justice v MM [2018] UKSC 60 – The MHA cannot be used to impose conditions amounting to a DoL on a person who has been conditionally discharged from care homes and hospitals, even if the person has consented. The relevant DoL scheme under the MCA must be followed.

Welsh Ministers v PJ [2018] UKSC 66 – Clinician did not have power to impose conditions in a community treatment order

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Mental Capacity (Amendment) Act 2019

- The Mental Capacity (Amendment) Act 2019 (MCAA 2019) received Royal Assent on 16 May 2019.
- Broadly implements the Law Commission's recommendations for a new scheme (the Liberty Protection Safeguards) to replace the current Deprivation of Liberty Safeguards regime with a simpler, more streamlined administrative process for authorising a deprivation of liberty.
- LPS requires that prior to authorising the arrangements, the responsible body must be satisfied that the three authorisation conditions are met, namely that the:

- the person lacks capacity to consent to the arrangements
- the person has a mental disorder
- arrangements are necessary to prevent harm to the person and are proportionate in relation to the likelihood and seriousness of harm to the person

- The Act applies to England and Wales, and will come into force on a date to be appointed, currently expected to be in Spring 2020

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Independent Review of the Mental Health Act 1983

- Modernising the Mental Health Act: Increasing choice, reducing compulsion report of 6 December 2018
- Main finding that detention under MHA 1982 was *"too often experienced as awful"* and undignified (particularly those from black and ethnic minority groups).
- Report describes move toward a *"rights based Mental Health Act".*
- Does not recommend that MHA and MCA are "fused" together but does recommend that MHA and MCA are updated with "essential reforms" or new legislation.
- MHA should be prefaced with fundamental principles and a purpose, which enshrines concepts including choice and autonomy, that its powers be used in the least restrictive way, and a focus on the person as an individual (which is a feature of current MCA).
- Report also recommends that section 17 Children Act be amended to clarify that a child admitted to a mental health facility is a "child in need" so that parents can request services from local authorities.
- Achieve harmonisation by "cross ticketing" judges of the COP and the Mental Health Tribunal to hear cases where a person is subject to both the MHA 1983 and the MCA 2005, and by ensuring recognition in both regimes of advance decision making, and the position of those who hold powers of attorney and of deputies.

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