

The Mental Capacity Act 2005, the Mental Health Act 1983, and the Common Law¹

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This paper considers what has come to be known as the ‘interface’ between the Mental Capacity Act 2005 and the Mental Health Act 1983. Sections 5 and 6 of the 2005 Act provide a general defence to acts of care and treatment which may involve restraint and restriction of liberty of a mentally incapacitated person. Because authority is conferred by way of a defence, there are no procedural safeguards comparable to those available under the Mental Health Act 1983 in relation to care and treatment decisions taken under the Mental Capacity Act. Sections 5 and 6 apply to any person. The defence confers powers to make decisions concerning care and treatment. Powers similar to those available under section 5 may be expressly conferred on the donee of a lasting power of attorney³ or a deputy appointed by the Court of Protection.⁴

Until the 2005 Act comes into force in 2007, practitioners will have to be aware of the interface between powers to admit to institutional care and treat without consent under common law and those which exist under the Mental Health Act 1983. In simple terms, the interface question is ‘When may the common law or, after 2007, the 2005 Act, be used to admit to institutional care and treat without consent, and when will use of the Mental Health Act be required?’ The 1981 decision in *X v United Kingdom*⁵ prompted significant changes to the Mental Health (Amendment) Bill then introduced. As the Mental Capacity Bill reached its final Parliamentary stages, the decision in *HL v United Kingdom*⁶ prompted a major rethink of the interrelationship between mental health and mental capacity legislation. The solution was to remove deprivations of liberty from the scope of the Mental Capacity Act completely, and to leave the interface question to be dealt with under mental health or other health legislation. This article argues that there are two decisions of the European Court which need to be considered in determining how to bridge what has become the “Bournemouth gap”: *HL v United Kingdom* and *Storck v Germany*⁷. These will

1 This is an amended version of a paper given at Sweet and Maxwell’s Mental Capacity Act Conference, 30 September 2005, Kingsway Hall Hotel, London

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3 Mental Capacity Act s 9(1)(a) which provides for donees to take decisions concerning personal welfare, which could include consenting to or refusing treatment.

4 *Ibid.*, s 16(1)(a). Both donees and deputies may restrain an incapacitated person subject to the conditions in s 11 (donees) and in s 20(7)–(13) (deputies). In the case of deputies, authority to restrain must be expressly conferred by the court.

5 (1981) 4 E.H.R.R. 188

6 E.Ct.HR Judgment 5th October 2004

7 E.Ct.HR Judgment 16th June 2005

require that the State must provide effective supervisory mechanisms to ensure that mentally incapacitated people are not deprived of their liberty (Article 5) and do not have their right of bodily integrity interfered with (Article 8) without lawful authority.

The Section 5 defence in respect of care and treatment acts done in the best interests of a mentally incapacitated person

Section 5 aims to codify, and as Richard Jones points out,⁸ 'to clarify' the common law doctrine of necessity in relation to mentally incapacitated adults. Originally captioned 'The general authority to treat', this section is now titled 'Acts in connection with care and treatment.' The section provides a defence to anyone (not necessarily a health or social care professional), doing an act in connection with the care and treatment of a person ("P") who is reasonably believed to lack capacity in relation to the matter. The person, referred to in the section as "D", will have a defence to proceedings based on the absence of consent to the act⁹, provided the following three conditions are met:

- (1) D takes reasonable steps to establish whether P lacks capacity in relation to the matter;
- (2) D reasonably believes that P lacks capacity in relation to the matter
- (3) D reasonably believes that it will be in P's best interests for the act to be done

The section does not provide a defence if the act is carried out negligently, or if a criminal offence is committed. If there is a valid advance decision refusing the proposed care or treatment intervention, it may not be given.¹⁰ A further limitation is contained in s 6(6) which provides that a decision made either by a court appointed deputy or by the donee of a lasting power of attorney acting within the scope of their authority will take priority over any decision which might be made under section 5.

The draft Code of Practice at Para 5.5 gives examples of acts in connection with care and treatment, and states that as far as medical treatment is concerned, this includes diagnosis, treatment, taking of blood or body samples, and nursing care.

Restraint

Section 6 sets a number of limitations on the scope of section 5 acts. Section 5 may only be used by D to justify an act intended to restrain P if two conditions are met. The first is that D reasonably believes that the act is necessary to prevent harm to P. The second is that the act is a proportionate response both to the likelihood of P suffering harm, and the seriousness of that harm. Restraint means the use or threat of force to secure the doing of an act which P resists, or the placing of any restriction of P's liberty of movement, whether or not P resists. The Draft Code of Practice tells us that 'Restraint may take many forms. It may be both verbal and physical and may vary from shouting threats at someone, to holding them down, to locking them in a room.'¹¹ Examples are given of needing to restrain a man with dementia by holding him still whilst necessary diagnostic tests are done.

8 *Mental Capacity Act Manual*, Richard Jones (Sweet & Maxwell) (2005) 9–26

9 *Mental Capacity Act* s 5(2).

10 *Ibid.*, s 5(4).

11 *Mental Capacity Act Draft Code of Practice*, para. 5.28.

How does this apply to psychiatric treatment? The Draft Code clearly sees restraint as including ‘chemical restraint, for example giving someone a large amount of sleeping pills in order to sedate them and thereby restrict their liberty of movement.’¹² The Act precludes giving treatment for mental disorder under any of its provisions, ‘if at the time when it is proposed to treat the patient, his treatment is regulated by Part IV of the 1983 Act.’¹³ In other words, the Mental Capacity Act will not apply if the patient is already liable to be detained under one of the longer term detention powers in the Mental Health Act.

Section 6(5), inserted to take account of *HL v United Kingdom*, provides that D does more than merely restrain P if he deprives P of his liberty within the meaning of Article 5, whether or not D is a public authority. The Government’s interim advice¹⁴ is that health and social services should avoid interventions of a degree and intensity which are likely to amount to deprivations of liberty, which currently require the authority of detention the Mental Health Act 1983. The Government has undertaken a consultation on the consequences of *HL v United Kingdom*, suggesting that a new form of protective care be introduced as an alternative to compulsion for compliant mentally incapacitated patients who are deprived of their liberty¹⁵.

Section 28 Mental Health Act Matters

Section 28 provides that nothing in this Act authorises anyone –

- (a) to give a patient treatment for mental disorder, or
- (b) to consent to a patient’s being given medical treatment for mental disorder

if at the time his treatment is regulated by Part IV of the Mental Health Act 1983.

As Richard Jones puts it, ‘The effect of this section is that the consent to treatment provisions in Part IV of the 1983 Act will “trump” the provisions of the 2005 Act.’ Jones states that “The 1983 Act should be invoked in respect of a mentally incapacitated person who needs to be hospitalised for treatment for mental disorder in two circumstances (assuming the criteria for compulsion are met):

1. Where there is a deprivation of liberty; and
2. Where it is considered that the provisions of a valid and applicable advance decision refusing a particular treatment for the patient’s mental disorder should be overridden.”

In *HL v United Kingdom* the Strasbourg Court held that factors to be taken into account in determining whether there has been a deprivation of liberty include the type, duration, effects and manner of implementation of the measure in question. ‘The distinction between a deprivation of, and restriction upon, liberty’, said the court, ‘is merely one of degree or intensity and not one of nature or substance.’

The key factor is whether those with care of the patient exercise complete and effective control over his care and movements. This includes strict control over: assessment, treatment, contacts, (including with carers), movement, and residence. A person can still be deprived of his liberty

12 *Id.*

13 *Mental Capacity Act s. 28.*

14 *Advice on the Decision of the European Court of Human Rights in the case of HL v UK (the*

‘Bournewood’ Case) [Gateway Reference 4269] 10th December 2004

15 *Chapter 5 ‘Bournewood’ Consultation Department of Health (March 2005)*

without ever having tried to leave, it is enough that there is an intention to prevent them from leaving should they attempt to do so. Similarly, it is 'not determinative' whether the ward is locked or lockable. It is the intention to prevent the patient leaving which counts. Applying these tests the Court held that HL had been deprived of his liberty.

Since the decision in *HL v United Kingdom*¹⁶, the European Court of Human Rights has delivered a further important ruling in *Storck v Germany*¹⁷ which contains important statements not only about the right to protection against arbitrary detention under Article 5 and but also concerning the right to physical integrity as an aspect of respect for private life under Article 8. The applicant had been admitted at age 15 to a children and young person's unit and spent seven months there in 1974–5. From July 1977 to April 1979 she was placed in a locked ward at a private psychiatric clinic (Dr Heine's Clinic), without any judicial order, as required by German law. She was brought back in March 1979 by police after she escaped. The private clinic was not entitled under German law to receive detained patients.

The Court held that there was a positive obligation for the state to take measures to protect the right to liberty under Article 5 and the right to personal integrity under Article 8 against infringements by private persons, and that both Article 5 and Article 8 had been infringed. The Court stated, at para 143, that 'Insofar as the applicant argued that she had been medically treated against her will while detained, the court reiterates that even a minor interference with the physical integrity of an individual must be regarded as an interference with the right of respect for private life if it is carried out against the individual's will.'

This statement suggests that the crucial factor in identifying a breach of Article 8 is the fact that the intervention is carried out against the individual's will, in other words that there is some resistance. However, in *HL v United Kingdom* the Strasbourg Court refused to treat compliant incapacitated patients as on a par with capable patients who were consenting. Reaffirming the importance of the right to liberty, the Court stated that:

'The right to liberty in a democratic society is too important for a person to lose the benefit of Convention protection simply because they have given themselves up to detention, especially when they are not capable of consenting to, or disagreeing with, the proposed action'.¹⁸

The Court emphatically rejected the argument that a compliant incapacitated patient should be treated on the same basis as a capable consenting patient in relation to deprivations of liberty under Article 5. The same principle must apply to interferences with physical integrity. It is too important to be lost simply because a person has given themselves up to the intervention, especially if they lack capacity to consent.

This, it is submitted, requires a gloss on Richard Jones' statement that sections 5 and 6

'[P]rovide authority for treating P's mental disorder in a hospital setting as an informal patient, even if P's liberty was restricted, as long as P is not being deprived of his or her liberty in that hospital. The use of restraint which results in P being deprived of his or her liberty would constitute a violation of rights under Article 5'.¹⁹

16 Judgment 5th October 2005

17 Judgment of 16 June 2005.

18 *HL v United Kingdom* Judgment of 5 October 2004,

para. 90.

19 R.M. Jones, *Mental Capacity Act Manual*, 9–29. 2005 Sweet & Maxwell

The gloss is to the effect that if the person lacks capacity and the decision-maker is assuming complete control over treatment to the extent that they are making decisions about the administration of strong psychotropic medication or even ECT to a patient, then that is assuming complete control over treatment and would be a factor tipping the balance firmly towards there being a deprivation of liberty requiring use of the Mental Health Act 1983 or at the very least use of protective care provisions such as those proposed to fill the so-called *Bournewood Gap*²⁰. In *Storck*, the Court found a breach of the positive obligation under Article 8(1) because at the relevant time there was a lack of effective state control over private institutions offering protection of individuals against infringements of their personal integrity.

Where there are procedural safeguards under the Mental Health Act governing the administration of medicines and ECT, the giving of these treatments to incapacitated adults who do not resist without equivalent safeguards may well breach Article 8. So the question arises whether ECT could be given under ss.5 and 6 to an informal incapacitated patient who was not subject to control of a level of intensity to amount to a deprivation of liberty. It is submitted that the very decision to assume sufficient control of treatment to give ECT, a not inconsiderable intervention, without the consent of an incapacitated patient, would tip the balance in favour of there being a deprivation of liberty requiring use of the Mental Health Act in order to ensure effective protection of Article 5 and Article 8 rights.

Conclusion: The Scope of the Positive Obligation under Article 8 and its relationship to Deprivation of Liberty

It is important to bear in mind the statement of the scope of the positive obligation under Article 8, as outlined in of the judgment in *Storck*:

The Court ... considers that on account of its obligation to secure to its citizens the right to physical and moral integrity, *the state remained under a duty to exercise supervision and control over private psychiatric institutions.* (emphasis added) [The court noted that in the sphere of interferences with a person's physical integrity, German law provided for strong penal sanctions and for liability in tort and went on to say that]. Just as in cases of deprivation of liberty, the Court finds that such retrospective measures alone are not sufficient to provide appropriate protection of the physical integrity of individuals in such a vulnerable position as the applicant. The above findings as to the lack of effective state control over private psychiatric institutions at the relevant time are equally applicable as far as the protection of individuals against infringements of their persona integrity is concerned. The Court therefore concludes that the respondent state failed to comply with its positive obligation to protect the applicant against interferences with her private life as guaranteed by Article 8(1).²¹

Once there is a breach of Article 8(1), then there comes the question of whether the intervention may be justified under Article 8(2). In that context the court noted that it was 'undisputed that the detention of a mentally insane person for the purpose of medical treatment required a court order *if the person did not, or was unable to, consent to his detention and treatment*' (emphasis added) and that since there was no court order, the interference was not in accordance with law.

²⁰ Section 58 (3) (6) Mental Health Act 1983

²¹ *Storck v Germany*, Judgment of 26 June 2005, para 150.

Applying this to the interface question, a mentally incapacitated, non-resisting person detained under the Mental Health Act 1983 is entitled to a second opinion before they are given ECT at any time or medicines for more than three months²². These procedures will probably amount to effective supervision and control and therefore discharge the positive obligation under Article 8(1), which applies to both public and private institutions. What if the same mentally incapacitated, non-resisting person is in a hospital informally because the hospital consider that they are not subjecting him to a level of control which amounts to deprivation of liberty? If it is proposed to give him ECT, it has been argued above that this will tip the balance and make it a deprivation of liberty engaging Article 5 and an interference with personal integrity engaging Article 8. If that person is given ECT under common law, there will be no control or supervision, only potential retrospective liability, which was held not to be enough in *Storck*.

If ECT is made a 'serious treatment' for the purposes of Section 37 of the Mental Capacity Act 2005 and there is nobody other than a paid carer to consult in determining what would be in P's best interests, there would be a requirement on the relevant NHS body to appoint and consult an Independent Mental Capacity Advocate (IMCA), and the submissions made by the IMCA must be taken into account in deciding whether to provide the treatment. Section 37 does not apply to any treatment regulated by Part IV of the Mental Health Act. Treatment is only regulated by Part IV if the patient is detained or liable to be detained. As I have argued the giving of ECT to a mentally incapacitated person should tip the balance of control towards deprivation of liberty.

An equally interesting issue is the position regarding medication. ECT is viewed as a sufficiently controversial treatment to engage a higher level of safeguard than medicine under section 58 of the Mental Health Act 1983. Medicine given without consent might have a similar effect, depending on its nature and its propensity to control behaviour. This raises issues in relation to strong sedative medication, high dose neuroleptics, polypharmacy, and the administration of covert medication. We might question whether there is effective enough control and supervision of these treatments of informal patients to discharge the positive obligation under Article 8, and whether the use of such interventions might mean that a person is being deprived of his or her liberty.

The Government has estimated in its consultation on Bournemouth that there may be as many as 50,000 "Bournemouth" patients in residential care who might be undergoing deprivation of liberty²³. Any new protective care provisions will not only have to ensure that there is effective review of deprivation of liberty, but that there is also adequate protection of the right of bodily integrity under Article 8.

22 Section 58 (3) (b) Mental Health Act 1983

23 Paragraph 3.4. "Bournemouth" Consultation Department of Health (March 2005)