The University of Bolton

LL.B (Hons)

Mental Capacity Act 2005 v Mental Health Act 1983 as amended: Working in Collaboration or Opposition with regard to Capacity and Decision Making for individuals who are under the influence of Alcohol, Illicit Substances or make attempts to end their life.

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Table of Contents

TABLE OF CASES

A Local Authority v A (2010) 1549 EWHC (Fam)

G v E and others (2010) 621 EWCA

GJ v The Foundation Trust, PCT and The Secretary of State for Health [2009] EWHC 2972

HL v the United Kingdom [2004] All ER (d) 39 (Oct)

Richard Rabone (In his own Right & as Personal Representative of the Estate of Melanie Rabone, Deceased), Gillian Rabone (In her own Right) v Pennine Care NHS Trust (2010) 698 EWCA (Civ)

Savage v South Essex Partnership NHS Foundation Trust [2009] 1 All E 1053

TABLE OF STATUTES

Mental Capacity Act 2005

Mental Health Act 1983

Mental Health Act 2007

Suicide Act 1961

INTRODUCTION

The Mental Capacity Act introduced in 2005 and implemented in 2009 may have brought about many changes in the way in which statute is applied to ensure that people, who present a risk to themselves or others, can be managed, particularly when they have been assessed as lacking the capacity to make decisions about their care and/or treatment.

This dissertation will explore the law surrounding the area of capacity, assessment, treatment and detention in the current climate and will also establish the difficulties of applying the law i.e. interpretation of statute and application of correct statute in situations where individuals have or are making unwise decisions[1]. In doing this the dissertation will provide an insight into whether the Mental Health Act (MHA) 1983 and the Mental Capacity Act (MCA) 2005 work in collaboration or opposition in protecting individuals or others including the general public.

Deprivation of Liberty – What does this mean?

People who lack capacity can be deprived of their liberty. Therefore a concern arises as to how or when a person can be legally deprived of their liberty, particularly when capacity is affected by negative lifestyle choices or unwise decisions[2].

Due to the complexity of Deprivation of Liberty (DoL) there does not appear to be a statutory definition. The case HL v the United Kingdom[3] alternatively referred to as '*The Bournewood Case*'[4], established the common law definition when the European Court of Human Rights (ECrtHR) ruled that:

> *'The key factor in the present case is that the healthcare professionals treating and managing the applicant exercised complete and effective control over his care and movements' and that 'the applicant was under continuous supervision and control and was not free to leave'.*

[1] Mental Capacity Act (MCA) 2005 S1 (4)
[2] MCA 2005 S1 (4)
[3] [2004] All ER (d) 39 (Oct)
[4] [1998] 1 All ER 634

The 'Bournewood Case' was a groundbreaking case for the area of protection of individuals when capacity to make decisions impacts on their liberty, and subsequently highlighted the need to protect against arbitrary detention of individuals. This case led to the introduction of The Mental Capacity Act (MCA) 2005, which introduced new DoL safeguards. The MCA was implemented in 2007; however, the safeguards only came into force in April 2009. Prior to this time there was no statutory procedure that could authorize deprivation of an individual's liberty, particularly in the best interest of a person who appeared to lack capacity to make decisions. There were however procedures for detaining individuals in hospital when they were deemed as having a mental illness, for assessment and/or treatment i.e. The Mental Health Act 1983.

The DoL safeguards[5] require:

> '*That a hospital or care home (a 'managing authority'), must seek authorisation from a 'supervisory body' in order to be able to deprive someone who has a mental disorder as defined in statute[6], and who lacks capacity to consent, of their liberty, within the meaning of Article 5 of the European Convention on Human Rights (ECHR)*'.[7]

The aim of the safeguards provided for in the MCA 2005, are to protect vulnerable individuals, who are not detained under the MHA 1983, however their freedom may be restricted because they are unable to consent to care and treatment.

Whilst it is considered as acceptable to deprive somebody of their liberty in sustaining life or carrying out an act if one reasonably believes that, he is preventing a serious deterioration to a person's condition[8], there are

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[5] MCA S42
[6] Mental Health Act (MHA) 1983
[7] Article 5 of Schedule 1 to the Human Rights Act 1998 provides: 'everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: ...(e) the lawful detention ... of persons of unsound mind ... 4 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.'
[8] MCA 2005 S[4B [(3-5)

restrictions in DoL where care and treatment is required. These restrictions and limitations appear to provide for those who are considered to require Mental Health Treatment, in situations where the condition may not be life threatening and there is not a requirement to sustain life, but treatment may be required to improve a condition. The MCA 2005 provides that all reasonable steps have been taken in ascertaining levels of capacity before DoL is applied[9]. The act of DoL must be proportionate to the fact that there is a likelihood of harm and must take into account the seriousness of the harm[10].

According to Richardson, 2010[11] there is much uncertainty surrounding the '*precise factors, which will amount to deprivation of liberty*' as she believes that case law is inconsistent. This suggests that professionals, who are required to apply the MHA 1983 and MCA 2005, are likely to overcompensate in their application when addressing DoL to avoid legal redress.

[9] MCA 2005 S5 (1- 4)
[10] MCA 2005 S6 (3)
[11] Richardson, G. (2010). Mental capacity at the margin: the interface between two Acts. *Medical Law Review* . page 12 of 16. Accessed 12/07/2010 http://login.westlaw.co.uk

AN INTRODUCTION TO THE CURRENT PRACTICE IN MENTAL HEALTH ASSESSMENT OF CAPACITY AND DETENTION TO HOSPITAL

What is capacity in the eyes of the law?

A person is considered to lack capacity in the eyes of the law if they are '*at the material time… unable to make a decision himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain*,'[12] irrespective of whether the disturbance is temporary or permanent[13]. A person cannot be considered as lacking capacity purely because of their age or appearance[14]. Nor should an aspect of their behaviour lead others to make unjustified assumptions about his capacity.[15]

In making a decision a person is required to understand the information that is relevant, to be able to retain the information given to them, to weigh the information as part of the decision-making process and communicate his decision[16]. However, the fact that a person is unable to retain the information for a lengthy period solely should not be regarded as the inability to make a decision[17], and it may be considered as unrealistic to require an individual to have the ability to foresee the consequences of an action[18] in light of an unwise decision that has been made.

According to Keywood, 2010[19], there is an immediate conflict between capacity and social care refusal. She identifies that service users are empowered to take responsibility whilst at the same time services are required to implement safeguards to protect service users from exploitation due to their vulnerability. Questions may subsequently be asked in how the conflict may be administered to ensure that actions in application of the statutes are considered as lawful.

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[12] MCA 2005 Part I S2 (1)
[13] MCA 2005 Part I S2 (2)
[14] MCA 2005 Part I S2 (3)(a)
[15] MCA 2005 Part I S2 (3)(b)
[16] MCA 2005 Part I S3 (1)(a-d)
[17] MCA 2005 Part I S3 (3)
[18] A Local Authority v A (2010) 1549 EWHC (Fam)
[19] Keywood, K. (2010). Case Comment: Vulnerable adults, mental capacity and social care refusal. *Medical Law Review* . Accessed 12/07/2010 http://login.westlaw.co.uk

How is application for assessment and detention made and who is responsible for the application?

It is common for people admitted to inpatient psychiatric wards to lack the capacity to make decisions relating to their treatment, particularly if the individual is suffering from illness such as mania, schizophrenia or having been detained using the MHA 1983[20].

Scott, 2009[21], suggests that the MCA 2005 now stands alongside the MHA 1983, which is not considered as a capacity based statute. He further suggests that the MCA 2005 is a more appropriate statute to apply when there is a need to committ and treat patients where capacity appears to be an issue ensuring that the law is correctly applied. Subsequently this would imply that the consequence of correct application of statute would be that the aims of the safeguards will be realized and also resulting in compliance with the ECHR[22].

If a person requires admission to hospital for Assessment and/or Treatment; who was unwilling to be admitted informally; who are perceived as posing a risk to themselves and others, assessment may be made using the Mental Health Act (MHA) 1983. The MHA 1983 requires that application of the Act is only to be for mentally disordered[23] individuals as defined within the statute. The MHA 1983[24], has changed the definition of mental disorder to '*any disorder or disability of the mind*,' subsequently broadening the scope of the application of the statute, to a wider classification of individuals. By broadening the definition within the amended statute it was felt that there

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[20] Maudsley Hospital London. (2009). People admmitted to psychiatric hospitals commonly lack the mental capacity to make treatment decisions - Evidence based mental health. *British Medical Journal* – A study carried out by the Maudsley Hospital London between February 2006 and June 2007. 350 people that were consecutvely admitted to hospital were used in the research. 338 people where assessed with regard to capacity and 60% was the prevalence of those considered to be incapacitated to make decisions regarding treatment. 200 people were assessed using the McArthur Competence Assessment Tool and 138 were assessed by psychiatric trainees only without the tool being used.

[21] Maudsley Hospital London. (2009). People admmitted to psychiatric hospitals commonly lack the mental capacity to make treatment decisions - Evidence based mental health. *British Medical Journal* .

[22] Art 8

[23] MHA 1983 Part I S1 (1)

[24] Part I S1 (2)

would be a substantial decrease in the use of compulsory powers so long as there was a '*well defined criteria in application*'[25].

The Statute[26] has also now included specific exclusions of those patients who present with '*dependence on alcohol and drugs*' as these are not in themselves considered as a '*disorder or disability of the mind*,' unless they are coupled with a concurrent mental disorder.[27]

One of the roles employed within Mental Health services currently is Accident and Emergency (A+E) Liaison. This role predominantly tends to be carried out by a Qualified Mental Health Nurse (QMHN). One of the responsibilities of the QMHN is to assess people who attend A+E that present with high-risk behaviours, such as wanting to commit suicide or have carried out acts to deliberately self-harm themselves. Those individuals who are presenting with behaviour that would suggest that they are experiencing a relapse from diagnosed mental illness[28], requiring treatment may also be assessed.

During the interview it may become apparent that the individual being assessed would benefit from treatment in hospital. In the first instance the individual would be offered admission on an informal basis, meaning that they have given their consent to the admission and then further provide '*informed consent*' for subsequent treatment if this is required.

If the patient is posing a risk to themselves and/or others[29], they are considered as having a '*disorder or disability of the mind*'[30], and if it is felt that hospital admission would benefit the individual for further assessment and/or treatment, but they will not consent to admission to hospital, the MHA 1983 Section 2 or 3 may be applied for compulsory detention if criteria of the statute are met.

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[25] Department of Health. (1999). *Reform of the Mental health Act 1983.* London: DoH. Page 3
[26] MHA 1983 Part I S1
[27] MHA 1983 Part I S1 [(3)
[28] Identified within American Psychiatric Association. (1994). *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington.
[29] MHA 1983 Part I S3 (2)(c)
[30] MHA 1983 Part I S1 (2)

If the QMHN feels the risks are high and the patient attempts to abscond from A+E without an assessment being carried out, a request may be made for an approved medical practitioner[31] to attend and assess the individual resulting in a MHA application being made to detain the individual concerned[32]. In circumstances where the person is successful in absconding a request may be made for the police to carry out a welfare check on the individual.

For the purpose of application of the MCA 2005 when capacity of an individual is in question and the person does not have a '*disorder or disability of the mind*' as defined by statute[33], the assessor must be a Medical Practitioner with a minimum qualification of 3 years post registration, and must have completed the Deprivation of Liberty Safeguards Mental Health Assessors training programme[34].

There may be also situations when people are brought to a place of safety (A+E) by the police[35] when they have been found to be in a public place appearing to be suffering from a '*mental disorder and to be in immediate need of care or control*'[36]. The police, as with the assessments carried out by the QMHN, will need to apply the requirements of the statute to either further detain the person under a more appropriate section of the MHA or rescind the S136[37].

On occasions, due to the number of professionals required in the application of the MHA 1983, assessments can take several hours to co-ordinate. Consequently decisions have been made by Professionals to apply the MCA 2005 in holding a person in hospital until such a time as they can be assessed using the most appropriate statute, using the rationale that detention is '*in the patients best interest*'. It is the author's experience that the police are the professionals that are more likely to use this practice, particularly at times where time constraints have been placed upon them from the senior

[31] MHA 1983 Part II S12
[32] MHA 1983 as amended 2007 Part II
[33] MHA 1983 Part I S1 (2)
[34] http://www.bma.org.uk/ethics/consent_and_capacity/mentalhealth0309.jsp
[35] MHA 1983 as amended 2007 Part X S136 (2)
[36] MHA 1983 as amended 2007 Part X S136 (1)
[37] MHA 1983 as amended 2007 Part X S136 (2)

professionals within the police force. This would seem to support the argument that the MCA 2005 is a more appropriate statute to apply where capacity is concerned and individuals pose a risk to themselves or others.

More recently the author has experienced practice whereby the police have transported an individual to a place of safety under *MCA 2005* quoting *Section 5*[38], rather than applying the MHA 1983[39], again due to the time constraints placed upon them. This seems to suggest that the argument proposed by Keywood, 2010[40], that '*professionals are reluctant to query capacity*' is not necessarily supported in circumstances where professionals such as the police are required to make decisions in the immediacy of their practice, with the desired outcome that the decisions made will have limited impact on their working time. One of the main concerns with this practice is that when an individual has been '*delivered*' to A+E there are no powers to prevent them leaving again, as there would have been if the person had been brought to A+E under the provision of the MHA 1983[41]. In the longer term this practice may impact upon the time constraints of the police when a welfare check is requested and the individual has left and is considered to be at risk to themselves and/or others, particularly if the individual avoids going to their normal place of residence.

This raises fundamental questions in how the principles[42] within the MCA 2005 are applied as was illustrated in the a recent case of *GJ v The Foundation Trust, PCT and The Secretary of State for Health* [43], in which it was stated obiter that '*it would be unlawful for anyone to proceed on the basis that they can pick and choose between the two statutory regimes as they think fit…rendering one regime preferable to the other*'[44]. More specifically giving the rationale for application of the MCA 2005 of time constraints of professionals i.e. police, nurses, medics etc as oppose to the protection of the

[38](7)(b)
[39] MHA 1983 S136
[40] Keywood, K. (2010). Case Comment: Vulnerable adults, mental capacity and social care refusal. *Medical Law Review* . Page 3
[41] S136
[42] MCA 2005 Part I S1 (4 & 5)
[43] [2009] EWHC 2972
[44] GJ v The Foundation Trust, PCT and The Secretary of State for Health [2009] EWHC 2972 as per Charles J Para 59

needs of the individual being assessed. This argument seems to suggest that there is a potential currently for professionals to be acting unlawfully in their practice.

In the protection of individual's human rights a holistic assessment of capacity should be carried out encompassing many factors, rather than just the here and now.

Biomedical Ethics – Best Interest arguments

The MCA 2005 requires that an individual's best interest be considered when a person is deemed to lack capacity[45]. This would suggest that even though a person lacks capacity the scope for consideration of other factors goes far deeper than just an assessment of whether or not they can make a decision, based on their understanding.

The person that makes the assessment should take into consideration all the factors as required by the statute. It has been suggested further by *Beauchamp & Childress, 2001*[46], that those factors should include historical information, such as what the person would have wanted to happen prior to their capacity being affected, when they were able to make autonomous decisions i.e. their personal preferences, values and morals. *Donnelly, 2009*[47] suggests that the assessor should also consider whether or not the person lacking capacity is likely to regain capacity.[48]

Donnelly[49] further implies that Autonomy is the essential principle within Advance Directives whereby a patient is provided with the opportunity to provide prior wishes regarding their future care and treatment when their capacity may be affected. These wishes include not only the right to refuse certain treatments but also the agreement to accept certain treatments for example Electro-Convulsive Therapy (ECT).

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[45] MCA 2005 S4

[46] Beauchamp, T., & Childress, J. (2001). *Principles of Biomedical Ethics* (5 ed.). Oxford: OUP. Page 102

[47] Donnelly, M. (2009). Best interests, patient participation and the Mental Capacity Act 2005. *Medical Law Review* : Accessed 12/07/2010 http://login.westlaw.co.uk

[48] Autonomy is a fundamental principle identified under *Article 8 of the ECHR*.

[49] Donnelly, M. (2009). Best interests, patient participation and the Mental Capacity Act 2005. *Medical Law Review* : Accessed 12/07/2010 http://login.westlaw.co.uk

It would be reasonable to assume that the above procedures should be simple to integrate into a mental health system, particularly since the introduction of Advance Directives. In Mental Health, individuals will have periods of time in which they have full insight into their illness, particularly during periods where they have recovered. At these times they will have the capacity to make decisions about their treatment options about times in the future where their insight may reduce during periods of relapse.

Morrissey, 2010[50], appears to support the reasonable assumption, that people with mental health problems traditionally were not given the opportunity to be involved in decisions about their treatment, particularly when they have been in a crisis as this has been the point at which their capacity has been affected. She goes on further to say that the significance of prior autonomy is paramount in mental health practice where an individual's level of insight fluctuates and the treatment they receive when they are unwell may be invasive.

Morrissey's view was reinforced with the introduction of the MHA 2007 whereby there are specific provisions made for '*respect for a patients past and present wishes and feelings*'[51]. The MCA 2005 permits an individual to make an advance decision whereby they can refuse treatment[52]. Having said this whilst there seems to be legislative cover for advance decisions the statutes[53] conflict at times where public safety is involved as this appears to outweigh the autonomy of individuals[54] as previously identified by Keywood, 2010.

This consequently raises questions about individuals who present in situations where capacity issues may be considerably short term due to such things as substance induced psychosis or capacity issues. The associated risk behaviour that they present with, that may impact on their own safety or that

[50] Morrissey, F. (2010). Advanced directives in mental health care: hearing the voice of the mentally ill. *Medico-Legal Journal of Ireland* : Accesses 12/07/2010 http://login.westlaw.co.uk
[51] MHA 2007 S8 (2B) (A)
[52] MCA 2005 S24 and S25
[53] MCA 2005 and MHA 2007
[54] MHA 2007 S8 (2B) (h and i)

of others, may be only present for a short period of time i.e. hours and minutes. There are also those who have been assessed as maintaining capacity and have made a conscious decision that they no longer want to live.

Consequently it is possible therefore that statutes may be applied incorrectly and factors considered weighed inappropriately.

The Impact of legislation on those who make unwise decisions with specific regard to

Behaviour and/or psychosis induced by: Alcohol Use / Illicit substance Use or Attempts to take own life

Alcohol and substance use are major factors within the field of mental health practice.[55] If there were a concurrent diagnosed mental illness this would be considered as a dual diagnosis. Where there is a dual diagnosis there would be a need to identify that illness is primary and which is secondary, meaning which illness presented first.

According to *Rassool, 2002*[56]*,* individuals who experience either substance use or alcohol use may present as also having cognitive impairment, which is likely to affect their ability to give '*informed consent*'. Informed consent has been defined as 'the voluntary and continuing permission of the patient to receive a particular treatment, based on adequate knowledge of the purpose; nature; likely effects and risks of that treatment; including the likelihood of its success and any alternative to it.'[57].

Alcohol

Alcohol use is a widely recognized form of social activity, and statistics (Appendix I – Table 1)[58] suggest that adults regularly consume more than the recommended daily units of alcohol. Studies[59] have also shown that alcohol use is more prevalent in men than in women, and is responsible for a large proportion of health care problems. 80% of men and 60% of women in developed countries drink alcohol at some time in their lives[60].

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[55] See Mueser, K., Noordsy, D., Drake, R., & Fox, L. (2003). *Integrated Treatment for Dual Diagnosis: A Guide to Effective Practice.* New York: The Guildford Press; Rassool, H. (2002). *Dual Diagnosis: Substance Misuse and Psychiatric Disorders.* Blackwell Publishing Company; Rosenthal, R. (2003). *Dual Diagnosis: Key Readings in Addiction Psuchiatry.* New York: Brunner-Routledge.

[56] Rassool, H. (2002). *Dual Diagnosis: Substance Misuse and Psychiatric Disorders.* Blackwell Publishing Company. Pages 39 – 40

[57] Department of Health. (1993). *Code of Practice of the Mental Health Act 1983.* London. Para 15.12 (now Superseded by Department of Health. (2008). *Revised Code of Practice of the Mental Health Act 1983.* London.)

[58] General Household Survey 2004, Office for National Statistics (ONS)

[59] Schuckit, M. (2009). Alocohol use disorders. *The Lancet , 373*, 492 - 501.

[60] Teeson, M. (2006). Substance use, dependance and treatment seeking in the United States of America and Australia: A cross national comparison. *Drug Alcohol Depend , 81*, 149 - 155.

Further studies have attempted to identify whether or not alcohol use affects mental health resulting in possible diagnosis of mental illness[61]. Findings[62] have suggested that hazardous and dependent drinking were not associated with the onset of depression and anxiety at follow up, however binge drinking, at least on a monthly basis, was associated with an increase in anxiety and depression. Anxiety and depression were used as the main diagnostic tools as identified that individuals with significant psychiatric problems tend to display symptoms of both and subsequently may result in more than one psychiatric diagnosis i.e. Dual Diagnosis.

This would seem to suggest that alcohol use therefore is unlikely to result in what may be considered as a concurrent mental disorder[63], and therefore it may possible to argue that it would be unlawful to apply the MHA 1983 in transporting individuals to a place of safety[64] or detaining individuals for assessment and/or treatment[65].

Having said this alcohol detoxification may pose an issue; it is possible for a person to suffer from Delirium Tremens (DT's)[66] in which they present with symptoms of psychosis such as various forms of hallucinations, without immediate insight during the detoxification process. The DT's usually resolve within a period of hours to days (up to a period of 2-4 weeks) depending on the level of intoxification[67]. Therefore during this period there is a potential for a person's capacity to be questioned. A problem arises when somebody is intoxicated, however does not exceed the level where they may present with DT's upon detoxification, as it is likely that capacity may only be affected for a matter of hours rather than days. The MHA 1983 does not exclude disorders

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[61] Haynes, J. (2005). Alcohol Consumption as a risk factor for anxiety and depression. Results from the longitudinal follow-up of the National Psychiatric Morbidity Survey. *British Journal of Psychiatry , 187*, 544 - 551.
[62] Ibid
[63] South London and Maudsley NHS Foundation Trust. (2010). *The Maze: A Practical Guide to the Mental Health Act 1983 (Amended 2007).* London.
[64] MHA 1983 as amended 2007 Part X S136 (2)
[65] MHA 1983 Part II S2 or S3
[66] American Psychiatric Association. (1994). *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington. Pages 129 - 133
[67] Ibid

of these kinds[68] therefore in these situations it is possible that application would be lawful.

An assessing practitioner records the alcohol readings. A Breathalyzer unit is used in which the individual is required to breathe into a machine, using a tube for several seconds. The Breathalyzer reads the amounts of alcohol per litre of breath. A reasonable assessment may be made of those individuals that blow a reading of the drink drive limit or below i.e. 0.35mg/L. Individuals who blow above this level are considered as intoxicated and therefore cannot be assessed until their level has reduced. The alcohol levels tend to reduce at a rate of 0.1mg/L each hour after final consumption.

In the circumstances where the individual's alcohol levels are excessive, they may be offered admission to a medical ward until such a time that their alcohol levels are within appropriate limits for assessment. If the person refuses and tries to leave hospital problems may arise as the police may be called to perform welfare checks as previously identified. Any other measure to try to prevent the individual from leaving could possibly be perceived as a '*De Facto*' detention[69].

Could therefore the MCA 2005 be applied to deprive an individual of their liberty when their capacity is impaired due to alcohol or substance use?

There are few cases, in which this has been explored within case law, and these, have been with regard to entering a contractual relationship. It was held in *Gore v Gibson*[70] that a contract is not binding on a person that is so intoxicated that he does not know the consequences of his actions. Having said this, upon the intoxicated person sobering up the contract may then be considered binding[71], subsequently making the contract voidable not void.

In terms of assessment under the MCA 2005 for incapacity, it is therefore reasonable to assume that an individual may only be considered as lacking

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[68] See Department of Health. (2008). *Revised Code of Practice of the Mental Health Act 1983.* London. Para 3.11

[69] See Fennell, 1998

[70] (1845) 13 M & W 621; 153 ER 260

[71] Matthews v Baxter (1873) LR 8 Ex 132

capacity whilst intoxicated. And capacity would resume at the point that the individual is no longer intoxicated unless there is an underlying condition that may affect capacity. It is possible therefore that if an individual's alcohol reading was 0.55mg/L at the hospital, they abscond and it takes the police 2 hours to establish the whereabouts of the person, their alcohol level may be within appropriate levels and it is likely that they will have the capacity to make decisions regarding their care and treatment.

Illicit Substance Use

There are approximately 400,000 major drug users in the UK and it has been reported that there are only half of those who receive treatment[72]. It is likely that people with psychiatric disorders are more likely to also use substances than those that do not have a psychiatric disorder[73] as illustrated in Appendix II – Table 1.1[74]. It has also been suggested that the psychiatric diagnosis would be primary to the substance use in dual diagnosis[75]. This suggests that unlike alcohol there is on the balance of probability likely to be a concurrent mental disorder with substance users.

This subsequently means that where an assessment is needed it may be more appropriate that the MHA 1983 S2 or S3 is used, however only if there is a concurrent mental disorder identified, for example drug induced psychosis[76]. However in both alcohol and illicit substance use the associated disorder may last only for a short time period, rendering the MCA 2005 as a more appropriate statute to detain an individual in maintaining their safety.

Attempts to take on Life

The ECHR[77] underpins the ethical and moral principles of inviolability of human life[78]. In the wider arena where there has been a long-standing illness

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[72] http://lcjb.cjsonline.gov.uk/West%20Mercia/2522.html
[73] Mueser, K., Noordsy, D., Drake, R., & Fox, L. (2003). *Integrated Treatment for Dual Diagnosis: A Guide to Effective Practice.* New York: The Guildford Press. Page 4-5
[74] Mueser, K., Noordsy, D., Drake, R., & Fox, L. (2003). *Integrated Treatment for Dual Diagnosis: A Guide to Effective Practice.* New York: The Guildford Press. Page 5
[75] See Rosenthal, 2003, chapter 3
[76] American Psychiatric Association. (1994). *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington. Page 310 - 315
[77] European Convention of Human Rights Art 8(1)

or medical condition, there should be a balance between a person's autonomous decision to refuse life sustaining treatment and the government's interest in preserving life.

The MCA 2005[79] provides for appointment of Lasting Powers of Attorney, whom in theoretical terms are proxy decision makers for the individual. The decisions that they make concern individuals specified personal welfare[80] and specified property and affairs[81]. It is possible to assume that enforcement of documents such as advance directives would be included in this power given to them. There has been academic opinion that would seem to suggest that this is not necessarily the case[82]. Where there are longer term illness decisions to be made about preservation of life, *Samanta, 2009*[83], suggests that it is likely that a court in assessing the proxy decision made by Lasting Power of Attorney against the Medical expertise, are likely to decide in the favour of the expertise of medics.

Questions may be raised therefore in the situation where there are decisions to be made in the absence of advance directives, whereby an individual attempts to take their own life.

Prior to 1961[84] it was considered a crime to committ suicide. Whilst there are provisions within the Suicide Act 1961 preventing others in assisting or encouraging suicide of another, there does not appear to be provision in the statute to consider the acts of omission in preventing another from committing suicide. On the other hand it is possible however for the court to make a

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[78] See Samanta, J. (2009). Lasting powers of attorney for healthcare under the Mental Capacity Act 2005: enhanced prospective self-determination for future incapacity or a simulacrum. *Medical Law Review* . Page 7 of 26

[79] MCA 2005 Part 1 S9

[80] MCA 2005 Part 1 S9 (1)(a)

[81] MCA 2005 Part 1 S9 (1)(b)

[82] Samanta, J. (2009). Lasting powers of attorney for healthcare under the Mental Capacity Act 2005: enhanced prospective self-determination for future incapacity or a simulacrum. *Medical Law Review* .

[83] Samanta, J. (2009). Lasting powers of attorney for healthcare under the Mental Capacity Act 2005: enhanced prospective self-determination for future incapacity or a simulacrum. *Medical Law Review* . Page 19 of 26

[84] Implementation of the amended Suicide Act 1961

declaration under MCA 2005 S15 (2) where a professional omits to act in such a situation where an individual is deemed to lack capacity[85].

The ECHR[86] imposes an obligation on operational medical authorities to do everything that is reasonably expected of them to prevent a detained patient from committing suicide, however the same obligations are not required for informal patients[87]. A possible rationalle for this was stated obiter by Baker J[88] in identifying that patients who are not detained may be considered as lower risk of suicide, and the obligations of the ECHR art 2, are general obligations therefore practices for informal patients as oppose to detained patients may differ. There is a possibility that where a qualified practitioner has made a mistake in the assessment there may be vicarious liability, which in theory could be dealt with under domestic law.

Subsequently questions may be raised regarding the duty of care to members of the public who are not within an institutional setting, whether detained or informal; when they make a decision to end their life. It is possible that professions such as the Police may hold a duty of care in these situations and may therefore be required to apply statute in administering the duty of care.

Much of the case law relates solely to the duty of care of officers when the individual commits suicide whilst in custody, and subsequently the duty of care arises from the obligations under the *ECHR Art 2*. However as previously identified, individuals who are suicidal may be found by the police in a public place, not whilst they are already in detention. The police have a tendency to offer to take these individuals to a place of safety for Care and Treatment. If the individual refuses then the officers make a decision as to whether or not the person can be detained and transported under statute[89].

[85] G v E and others (2010) 621 EWCA para 64 as per Baker J
[86] ECHR Art 2
[87] Savage v South Essex Partnership NHS Foundation Trust [2009] 1 All ER 1053 as per Jackson LJ Para 62
[88] Savage v South Essex Partnership NHS Foundation Trust [2009] 1 All ER 1053 Para 50
[89] Either MHA 1983 S136 or MCA 2005 S5

In applying the MCA 2005 there should be an appropriate assessment of the individuals capacity[90]. Application of the MHA 1983 requires the the person is suffering from a '*mental disorder and to be in immediate need of care or control*'[91]. In theory the individual who has capacity; does not have a mental disorder; is not posing a risk to others; should be within their right to make an autonomous decision to end their life, however in practice this is not the case as already identified services have a duty of care to preserve life.

Between April 1996 and March 2000 there were reported to be 20,927 suicides[92] in the England and Wales. These figures included verdicts of suicide, open verdict and deaths from undetermined cause. It has been acknowledged that the preventable suicides were those of individuals who suffer from a mental disorder and the less preventable ones were those who use alcohol and/or illicit substances[93]. It has been highlighted that the highest rates of suicide are amongst those who suffer from Affective Disorder, and people who use alcohol and illicit substances, whilst still reported as having committed suicide are amongst the lowest rates (APPENDIX III – Table 1.2)[94]. Despite this it is the authors experience that when individuals are detained and transported to A+E the rationale regularly provided by the professionals concerned, is that the '*person has been found in unsafe circumstances e.g. carrying a knife, and because they are under the influence of alcohol or illicit substances they are going to kill themselves*.' This appears to contradict what the statistics suggest.

[90] MCA 2005 S5
[91] MHA 1983 S136
[92] Department of Health. (2001). *Safety First: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* London: DoH. Page 16 - 96
[93] Department of Health. (2001). *Safety First: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* London: DoH. Page 37
[94] Department of Health. (2001). *Safety First: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* London: DoH. Page 19

CONCLUSION – PROTECTION OF INDIVIDUALS

The fact that alcohol, substances and attempts on own life are possible factors that need to be considered in both assessment under the MHA 1983 and MCA 2005 poses a problem within the current mental health practice. Quite often the individuals that present with suicidal thoughts or those that have deliberately self-harmed (DSH), may also be under the influence of alcohol and/or illicit substances, and their behaviour may be as a consequence of life style choices or them making unwise decisions. If an individual is under the influence of alcohol or illicit substances, an objective assessment cannot be carried out until these substances are out of the patients system, so that the assessment provides a true reflection of the reasons for the behaviour presented.

As previously identified dependence on alcohol and drugs alone are not provided for in the MHA 1983, as they are not considered as a '*disorder or disability of the mind'*[95]. Therefore it is likely that unless there is a concurrent mental illness, application of the MHA 1983 in these circumstances may be considered as unlawful on the one hand, and lawful on the other, dependent on the nature and extent of the substance of choice and the extent and effect of its usage.

With regard to the MCA 2005 the principles clearly state that an assessor cannot assume that an individual is incapacitated on the basis that they made unwise decisions[96]. Consequently it is possible that that alcohol and substance use if they are considered as a lifestyle choice rather than self-medicating a mental disorder could be considered as an unwise decision.

The MCA 2005[97] clearly identifies that the MHA 1983 is supreme when there is a need for an individual to provide consent to receive treatment or actually receive treatment for a mental disorder. Subsequently transportation of an individual by the police could be considered as inappropriate application of

[95] MHA 1983 Part I S1 (2)
[96] MCA 2005 S1 Part I S1 (4)
[97] MCA 2005 S28

statute, particularly where MCA 2005[98] is referred to as authority. It is possible that application of the MHA 1983[99] may have been more appropriate. This would particularly apply in situations where Mental Health professionals request a welfare check by the police, on individual's known to services.

In conclusion it would seem that there is clear evidence to suggest that since the introduction of the MCA 2005 there are changes in the application of statute in ascertaining assessment and treatment of individuals, particularly where substance use impacts on a person's decision-making capacity regarding care and treatment. The NHS Information Centre, Community and Mental Health Teams, 2010[100], report that whilst there was only a 3.5% actual increase in detentions to hospital, there was over a 40% increase since 2008/2009 where the police used a place of safety at a hospital, and a comparable increase in those individuals whereby further detention was not required (Appendix IV – Table 1.3 and Table 1.4 and Table 1.5)[101].

In addressing attempts to take one's own life with specific regard to making an unwise decision[102], it would seem that this is a grey area. In the current law the application of the MHA1983, MCA 2005 and the Suicide Act 1961 may not apply as previously stated above, suggesting that this area alone may be a potential for law reform. The individual wishing to take his or her own life may not have a '*disorder or disability of the mind'*[103]*;* lack capacity or be assisted in any way to complete the act of suicide. It is possible that duty of care by professionals may be applied in application of the ECHR and Law of Tort, where there is a potential need to prevent an individual from taking their own life.

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[98] S5
[99] S136
[100] The NHS Information Centre, Community and Mental Health Teams. (2010). *Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2009/10.* The Health and Social Care Information Centre.
[101] The NHS Information Centre, Community and Mental Health Teams. (2010). *Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2009/10.* The Health and Social Care Information Centre. Page 7, 8 and 11
[102] MCA 2005 Part I S1 (4)
[103] MHA 1983 Part I S1 (2)

With regard to practice, the MCA 2005 is considered as '*new*' due to it's relatively recent implementation. There is still research[104] being carried out to explore the impact that the statute has had in regard to practice and specific diagnosis of mental illness.

The MHA 1983 has been implemented for several years, and application of this depends on the interpretation of certain sections. It has been clear in practice experienced by the author that on many an occasion professionals applying the two statutes i.e. the police, do so on a cascaded verbal information, rather than formal training. This in itself poses a potential problem for the police if they inappropriately interpet statute in their practice, particularly given the fact that the MCA 2005 holds with it a potential for criminal liability[105].

Due to the relatively recent introduction of the MCA 2005 the author is of the opinion that interpretation and application of the statute by the Police, Nurses and Medical Professionals will improve, as further training is provided to them, and research and reviews are carried out on the impact of implementation. Furthermore there may be a potential in the future to consolidate the two statutes making it easier to apply when an individual may lack capacity and/or suffer from an disorder or disability of the mind.

[104] For example see the ADE Project on Mental Capacity and Bipolar Disorder - The University of Nottingham.
[105] MCA 2005 S5 (3)

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APPENDICES

APPENDIX I – Table 1 (Adults[1] drinking more than recommended daily levels, by gender and socio-economic classification[2], 2004)

England Percentages

	All adults	Men	Women
Drank more than 3/4 Units			
Managerial and professional	**32**	**40**	**24**
Large employers and higher managerial	35	42	27
Higher professional	31	36	24
Lower managerial and professional	32	41	24
Intermediate	**30**	**41**	**21**
Intermediate	31	43	23
Small employers/own account	30	39	19
Routine and manual	**28**	**37**	**20**
Lower supervisory and technical	31	38	23
Semi-routine	27	37	19
Routine	27	36	19
All adults[3]	**30**	**39**	**22**
Drank more than 6/8 units			
Managerial and professional	**15**	**22**	**9**
Large employers and higher managerial	16	24	9
Higher professional	13	18	8
Lower managerial and professional	16	24	9
Intermediate	**15**	**23**	**9**
Intermediate	15	24	9
Small employers/own account	16	23	8
Routine and manual	**15**	**22**	**10**
Lower supervisory and technical	16	23	10
Semi-routine	16	22	11
Routine	14	20	9
All adults[3]	**15**	**22**	**9**
Weighted bases (000's)			
Managerial and professional	*13,957*	*6,721*	*7,234*
Intermediate	*6,576*	*3,076*	*3,500*
Routine and manual	*13,458*	*6,203*	*7,254*
All adults[3]	*34,908*	*16,372*	*18,536*
Un-weighted bases			
Managerial and professional	*5,143*	*2,450*	*2,693*
Intermediate	*2,280*	*1,053*	*1,227*
Routine and manual	*4,669*	*2,129*	*2,540*
All adults[3]	*12,387*	*5,748*	*6,639*

1. Aged 16 and over.
2. Based on the current or last job of the household reference person

APPENDIX II – Table 1.1 Lifetime Prevalence (%) and Odds Ratio of Substance Use Disorders for Various DSM III Psychiatric Disorders

	Any substance abuse or dependence		Any alcohol diagnosis		Any drug diagnosis	
Group	%	OR	%	OR	%	OR
General population	16.7	—	13.5	—	6.1	—
Schizophrenia	47.0	4.6	33.7	3.3	27.5	6.2
Any mood disorder	32.0	2.6	21.8	1.9	19.4	4.7
Any bipolar disorder	56.1	6.6	43.6	5.1	33.6	8.3
Major depression	27.2	1.9	16.5	1.3	18.0	3.8
Dysthymia	31.4	2.4	20.9	1.7	18.9	3.9
Any anxiety disorder	23.7	1.7	17.9	1.5	11.9	2.5
Obsessive–compulsive disorder	32.8	2.5	24.0	2.1	18.4	3.7
Phobia	22.9	1.6	17.3	1.4	11.2	2.2
Panic disorder	35.8	2.9	28.7	2.6	16.7	3.2

Note. An odds ratio (OR) is the ratio of the odds of having a substance use disorder in the psychiatric diagnostic group to the odds of the disorder in the remaining population. The data are from the National Institute of Mental Health Epidemiologic Catchment Area (ECA) study (Regier et al., 1990).

APPENDIX III – Table 1.2 Suicides in contact with services in the 12 months before death (England and Wales)

	Total sample (n=4859) Number	% (95% CI)
Demographic features		
Age: median (range)	41 (13-95)	
Male	3198	66% (64-67)
Ethnic minority	282	6% (5-7)
Not currently married	3405	71% (70-73)
Unemployed/long-term sick	2765	58% (58-60)
Living alone	2006	43% (41-44)
Priority groups		
In-patients	754	16% (15-16)
Post-discharge patients	1100	27% (25-28)
CPA	2243	41% (45-48)
Missed contact	1133	28% (27-30)
Non-compliance	929	22% (21-24)
Diagnostic features		
Primary diagnosis		
Schizophrenia & other delusional	960	20% (19-21)
Affective disorder (bipolar & dep.)	2036	42% (41-44)
Alcohol dependence	439	9% (8-10)
Drug dependence	216	4% (4-5)
Personality disorder	505	11% (10-11)
Any secondary diagnosis	2460	52% (51-54)
Duration of history (under 12 months)	1000	21% (20-23)
Over 5 previous admissions	712	16% (15-17)
Last admission was a re-admission	478	17% (15-18)
Behavioural features		
History of self-harm	3077	64% (63-66)
History of violence	920	19% (18-21)
History of alcohol misuse	1899	40% (38-41)
History of drug misuse	1348	28% (27-30)
Contact with services		
Last contact within 7 days of death	2308	48% (47-50)
Symptoms at last contact	2990	64% (63-65)
Requested contact but not taken place	161	4% (4-5)
Estimate of immediate risk: low or none	3950	85% (84-86)
Estimate of long-term risk: low or none	763	57% 54-60)
Out of contact	1153	29% (27-30)
Suicide thought to be preventable	876	21% (19-22)

APPENDIX IV –

Table 1.3 All formal detentions under the Mental Health Act in NHS and independent hospitals, by year

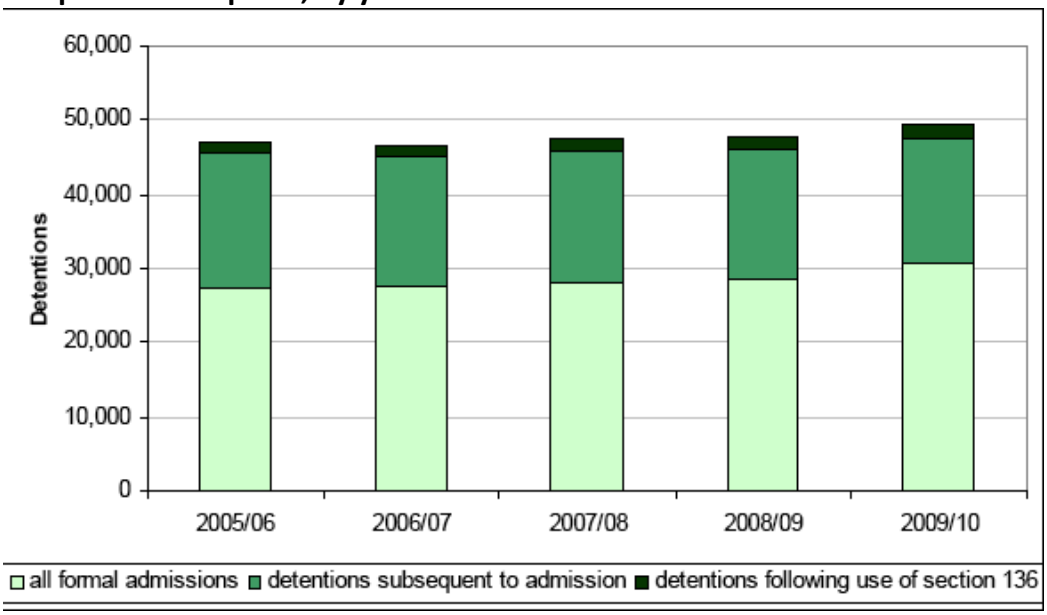

Table 1.4 All detentions under the Mental Health Act, all facilities, by year

	2005/06	2006/07	2007/08	2008/09	2009/10
Total detentions	**47,365**	**46,539**	**47,610**	**47,725**	**49,417**
all formal admissions	27,353	27,716	28,085	28,673	30,774
detentions subsequent to admission	18,523	17,242	17,505	17,299	16,721
detentions following use of section 136	1,489	1,581	2,020	1,753	1,922

Table 1.5 Uses of sections 135 and 136 – place of safety, 2005/06 – 2009/10