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ARTICLE

The interface between the Mental Health Act and Mental Capacity Act: physical health treatment

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SUMMARY

The interface between the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA) can throw up complex issues. This article reviews a Court of Protection case that considered this interface specifically in the context of physical healthcare for a patient detained under the MHA. The court analysis also included consideration of the European Convention on Human Rights, the Mental Health Units (Use of Force) Act 2018 and the concept of residual liberty. The judgment describes principles to be applied when considering whether non-consensual physical health treatment for detained patients could result in a further deprivation of liberty. Discussion of other Court of Protection cases considers the issue of communication during a capacity assessment, the MHA/MCA interface in obstetric cases and what test to apply in determining whether a patient could be detained under the MHA. Such principles and guidance are helpful in clinical practice for healthcare professionals who deal with the MHA/MCA interface.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the interface between the MHA and MCA as it affects treatment for physical disorders of detained patients without the patients' consent
- understand legal aspects when patients receive medical treatment needing chemical or physical restraint
- understand the concept of 'residual liberty' for detained patients.

KEYWORDS

Consent and capacity; human rights; psychiatry and law; deprivation of liberty; physical treatment for detained patients.

This article reviews a 2023 judgment from the family division of the High Court of England and Wales. It involved a 64-year-old woman known to the court as 'HJ' (*Norfolk and Suffolk NHS Foundation Trust v HJ* [2023]). The judgment concentrated on the lawfulness of care being provided to HJ. She had long-standing mental health problems as well as various physical health problems. This case specifically considered the juxtaposition of the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA) in terms of physical healthcare. In doing so the judgment considers various legal elements, including the MHA, MCA and the European Convention on Human Rights (ECHR). It elucidates specific principles and a framework to apply for an assessment as to whether medical treatment provided to someone in lawful detention without that person's consent amounts to a further deprivation of their liberty.

The *Norfolk and Suffolk* case

The case came to court following an application by the Norfolk and Suffolk NHS Foundation Trust to determine whether it was lawful to deprive HJ of her liberty while healthcare professionals administered enemas for constipation. It was subsequently agreed by all parties in the case (HJ being represented by the Official Solicitor, as she was assessed as lacking capacity to engage in legal proceedings) that the trust did not need the determination originally sought. However, the judge was asked by the parties to produce a full judgment owing to the importance of a series of issues concerning the treatment of patients for physical health conditions who are detained under the MHA.

Mental health

The judgment described HJ's long-standing history of bipolar affective disorder being characterised by psychotic symptoms with delusions and hallucinations. Her disorder manifested itself with 'very challenging behaviour', including being verbally and physically aggressive to staff and patients and 'other disinhibited behaviour'. HJ was treated with antipsychotic medication. Owing to poor adherence to the oral formulation this, and other medication, was administered covertly under section 4 of the MCA (best interests) or via a depot injection

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(at times under restraint) and was described as 'challenging for clinical staff'.

At the time of the hearing HJ was detained under section 3 of the MHA, having originally been admitted in June 2020 following a decline in her mental health after a fall. She was awaiting discharge, albeit no arrangements had been finalised for a suitable community placement to include care for both her mental and physical disorders.

Physical health

HJ had various physical health problems, including acute oropharyngeal dysphagia, renal impairment, double incontinence, hypothyroidism and chronic constipation, the latter being the pertinent issue in this case.

It was accepted that HJ's chronic constipation was not a direct consequence of her mental disorder but arose owing to a 'functional bowel disease and slow intestinal transit'. The usual treatment regimen consisted of a combination of diet, exercise, laxatives and enemas as needed, as well as trying to avoid any medication that caused or aggravated constipation. Following specialist gastroenterological advice, a plan was made to increase HJ's laxative doses with a view to reducing the need for enemas (requiring restraint to administer). However, the increased laxative dose caused strong peristaltic contractions and discomfort and needed to be reduced (HJ was also on linaclotide, a drug for constipation refractory to laxatives). The combination of laxatives and regular enemas promoted reasonable control of HJ's bowel habit.

The judgment agreed with the trust that although her poor oral adherence (even when given covertly) might have had an impact on the efficacy of her laxatives, the treating team were fully justified in not increasing the dose of laxatives as recommended by the gastroenterologist as HJ was unable to tolerate higher doses (this being a side-effect of the laxatives and not related to her mental disorder). Hence, enemas were still needed. It was noted that if HJ was not provided with enemas and had no bowel movements it could become 'very painful' in the short term but had the more serious longer-term risk of bowel perforation.

Treatment of constipation

The extent of the constipation treatment plan was described in detail. As well as daily laxatives and medication, HJ needed enemas every 2–3 days. The restraint process to administer enemas usually required five staff. When HJ showed signs of distress suggestive of constipation she was guided or physically escorted to her bed (this could take from 30 s to 5 min), placed in a prone position and rolled onto her left side. Staff positioned themselves either side of the bed for initial reassurance while the need for an enema was explained. HJ 'typically' responded by attempting to pull at staff clothing or grip onto them. Administration of the enema needed four people to hold her arms and legs (to prevent her from hitting, grabbing or kicking out) and one staff member to administer (this typically took 3–5 min). A further member supported her head if needed and monitored her physical state during restraint. HJ would usually be loud and verbally aggressive towards staff and could at times remain agitated/distressed for up to 1 h after.

The interaction of HJ's mental and physical healthcare needs

The judge concurred with the trust's position that HJ's chronic constipation was 'not the primary or even a subsidiary cause of her mental disorder, although there is some evidence that she can present with an improved mental state after she has had an enema'. The judgment noted that although HJ's presenting mental state could, to a degree, be improved or deteriorate depending on her physical condition, for example when in pain or discomfort, it did not mean her mental disorder was caused by her physical health problems. It was therefore agreed that the administration of enemas fell outside the scope of section 63 of the MHA (Treatment not requiring consent) even when applying the expanded scope of ancillary treatments under section 63 for physical disorders that were a clear symptom or manifestation of the underlying mental disorder (e.g. *B v Croydon Health Authority* [1995]).

Capacity to make medical treatment decisions

The position of the trust, following an assessment by a registered mental health nurse, was that HJ lacked capacity to consent to medical treatment, including that for chronic constipation (including enemas). This was further affirmed following an independent assessment by a consultant psychiatrist, who concluded that HJ was unable to understand relevant information as a direct result of her mental disorder and hence she lacked capacity to make decisions about medical treatment. The judge proceeded on the basis that HJ lacked 'capacity to make her own decisions concerning all material aspects of her medical treatment' whether she was detained or not. The judgment noted that although the independent consultant was unable to assess this directly because HJ refused to engage or communicate with him, he was able to refer to 'clear references' in her notes to arrive at a conclusion. This revealed that HJ was 'disinterested in her condition/treatment

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or actively hostile towards those caring for her, which represents a degree of persecutory thinking' and meant she was 'unable to weigh relevant information in the balance to make a decision about treatment options'.

The legal consequences of HJ's lack of capacity

Mental Capacity Act 2005

Pertinent parts of the MCA were reviewed. Section 5 (Acts in connection with care or treatment) defines the circumstances in which a person can provide care or treatment for a person who lacks capacity to consent to care or treatment without incurring personal liability. The judgment opined that section 5 'effectively provides a codified defence of necessity and, in and of itself, does not provide a formal power to anyone to do anything'. The judgment drew on *An* NHS Trust v Y [2018] in that:

> 'Section 5 allows carers, including health professionals, to carry out acts in connection with personal care, health care, or treatment of a person who lacks capacity to consent. It provides a significant degree of protection from liability, provided that the act is done in the reasonable belief that capacity is lacking and that the act is in the patient's best interests. If these conditions are satisfied, no more liability is incurred than would have been incurred if the patient had had capacity to consent and had done so.'

Hence, assuming the clinician is 'neither negligent nor criminal in the way in which they carry out the action', then they will be protected from any form of legal liability.

Section 6 ('Section 5 acts: limitations') (Box 1) was salient in that where any part of the care provided to the patient involves restraint, there are limitations to acts that can lawfully be done to an adult who lacks capacity. It was emphasised in the judgment that the fundamental principle is that, in the absence of proper legal basis for the imposition of any form of restraint, any substantial restraint of a person is highly likely to amount to an assault.

The 'broad effect' of section 6 is that, where such treatment is 'reasonably believed' to be in a person's best interests (section 4), 'restraint short of a deprivation of liberty can lawfully be imposed' on a person 'without any further authorisation where it is reasonably believed by those providing the care that it is necessary to prevent harm and the restraint used is proportionate to the likelihood and seriousness of that harm'. In this case clinicians were satisfied that the administration of enemas under proportionate restraint was in HJ's best interests and was a proportionate approach in seeking to avoid the potentially serious or even life-threatening sequelae of severe constipation. Such an approach, the judgment concluded, was 'lawful' because the clinicians were indeed acting within the terms of section 6.

The judgment noted that if matters had stopped at this point there would have been no recourse for a court hearing as the 'legal approvals needed under these procedures of the MCA do not require court oversight', i.e. a routine clinical application of the MCA. However,

> 'the Trust was concerned that the process of administering enemas was depriving HJ of her liberty and rightly observed that, if that was the position, it was not possible for a standard authorisation to be made to provide lawful authority for that deprivation of liberty because HJ, as a detained patient under the MHA in hospital, was ineligible to be subject to a standard authorisation or deprived of her liberty pursuant to sections 4A(3) and section 16(2) MCA: see the ineligibility categories in Schedule 1A of the MCA'.

Hence the case came to court on the basis that the court would need to consider and approve HJ's

BOX 1 Section 6 of the Mental Capacity Act 2005 – 'Section 5 acts: limitations'

Section 6 states that:

(1) If D does an act that is intended to restrain P, it is not an act to which section 5 applies unless two further conditions are satisfied.

(2) The first condition is that D reasonably believes that it is necessary to do the act in order to prevent harm to P.

(3) The second is that the act is a proportionate response to—

  (a) the likelihood of P's suffering harm, and

  (b) the seriousness of that harm.

(4) For the purposes of this section D restrains P if he—

  (a) uses, or threatens to use, force to secure the doing of an act which P resists, or

  (b) restricts P's liberty of movement, whether or not P resists.

(5) This section was repealed in 2009.

(6) Section 5 does not authorise a person to do an act which conflicts with a decision made, within the scope of his authority and in accordance with this Part, by—

  (a) a donee of a lasting power of attorney granted by P, or

  (b) a deputy appointed for P by the court.

(7) But nothing in subsection (6) stops a person—

  (a) providing life-sustaining treatment, or

  (b) doing any act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition, while a decision as respects any relevant issue is sought from the court. (From: www.legislation.gov.uk/ukpga/2005/9/section/6)

deprivation of liberty as there was 'no other mechanism to do so'.

Prior to the case the judge raised concerns with the parties that, because HJ was lawfully detained under the MHA, he was 'not satisfied that the process of administering enemas necessarily resulted in a further deprivation of her liberty' and invited the parties to reconsider as to 'which side of the line this case fell'. On reflection the parties involved reversed their original positions and agreed that the process of administering enemas did not further deprive HJ of her liberty. As the case had come to court the judge was, however, invited to explain why this position was correct in law.

Article 5 ECHR – the right to liberty and security

The judgment analysed the effect of Article 5 of the ECHR in relation to the original proposal that HJ was deprived of her liberty in relation to physical treatment. Article 5 provides that no one shall be deprived of their liberty except in the cases that it describes and in accordance with a procedure prescribed by law. These include the lawful detention of persons of unsound mind: Article 5(1)(e). The primary purpose of Article 5 is to prevent the arbitrary detention of a person by a state body but 'Article 5(1)(e) is not in principle concerned with suitable treatment or conditions' (*Ashingdane v United Kingdom* (1985)). The European Court of Human Rights, however, determined that this general restriction did not mean that a person's Article 5 rights cannot be breached once that person was lawfully detained (*Munjaz v United Kingdom* [2012]). Mr Munjaz was detained under sections 47/49 of the MHA in Ashworth Special Hospital. He challenged the lawfulness of the hospital's policy on seclusion as he was regularly placed in seclusion for extended periods of time. He argued such periods amounted to a breach of his Article 5 rights.

Prior to the European Court case, the House of Lords (the forerunner of the UK Supreme Court) considered the Article 5 question in terms of whether the hospital seclusion policy lawfully permitted 'a patient to be deprived of any residual liberty to which he is properly entitled' (*Munjaz, R v Ashworth Hospital Authority* [2005]). The concept of residual liberty means that detained people, such as those under the MHA, still retain civil liberties such as ECHR rights. The House of Lords judgment observed 'a person who was held by a state body in circumstances where that person was deprived of their liberty on a primary basis and where that deprivation of liberty satisfied the requirements of Article 5 ECHR, nonetheless, retained a measure of "residual liberty"'. It was considered that if that residual liberty was to be taken away, then a person 'could suffer a deprivation of liberty which would have to be justified'. The European Court of Human Rights had confirmed that a detained person was indeed capable of being subjected to a further deprivation of liberty but that 'whether or not there has been a further deprivation of liberty in respect of a person who is already lawfully detained must depend on the circumstances of case' (*Munjaz v United Kingdom* [2012]), i.e. it was a question of fact and degree as to whether a change in detention conditions that further curtailed a detained person's liberty amounted to a further deprivation of liberty: 'The question of justification or otherwise of that further deprivation of liberty would only arise if the line was crossed so that a further deprivation of liberty was established'.

The *Norfolk and Suffolk* judgment drew on ECHR case law, which elucidated three principles as criteria for determining whether a detention was arbitrary (*Saadi v United Kingdom* (2008)):

(a) detention infected by bad faith or deception on the part of the authorities is arbitrary
(b) detention which is not in furtherance of one of the purposes permitted by Article 5(1) is arbitrary
(c) detention in an inappropriate place and in inappropriate conditions is arbitrary.

Article 8 ECHR – the right to private life

The parties were not able to agree whether the engagement of HJ's rights under Article 8 of the ECHR imposed additional procedural duties on the trust which should be included within a court order, including a duty to conduct regular reviews of the treatment regime. The judgment readily accepted that HJ's Article 8 rights were engaged in relation to decisions about the need for treatment with enemas and the concomitant use of restraint to achieve this. It was noted that Article 8 contained both procedural and substantive obligations (*R (TB) v The Combined Court at Stafford* [2006]). In this case the procedural element related to the process or framework to be in place to monitor treatment decisions (as part of this process, the person's involvement and views in the decision-making process being paramount to ensure fairness and respect of the person's Article 8 interests).

The process of administering enemas took HJ's views into account as required by the best interests decision-making process under section 4 of the MCA, 'albeit they are not decisive'. Furthermore, it was noted that the section 4 and section 6 MCA decision-making process was a 'process mandated by statute' and if followed satisfied the 'requirements of fairness and properly respects a patient's article 8 rights'. There were additional procedural

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BOX 2 The Mental Health Units (Use of Force) Act 2018 and its application in HJ's case

In summary, this Act requires the following:

(a) Each mental health unit should have a 'responsible person' (section 2) who must be a permanent member of staff within the organisation and be a member of the organisation or trust board. The role may be undertaken by, for example, the Chief Nursing Officer or Medical Director, and may be delegated to a relevant person if they are of an appropriate level of seniority (section 10).

(b) The responsible person must:

(i) publish and keep under review a policy regarding the use of force on patients by staff who work in the mental health units run by that organisation or trust (section 3)

(ii) publish information about the use of force (section 4)

(iii) provide training for staff in the appropriate use of force (section 5).

The trust described how it was complying with the terms of this Act. The judgment concluded that the way in which restraint was applied to HJ was consistent with the trust's policy and furthermore the recording of the use of restraint followed ('if not exceeds') the 2018 Act requirements (*Norfolk and Suffolk NHS Foundation Trust v HJ* [2023]).

obligations imposed by the Mental Health Units (Use of Force) Act 2018 (see below) because restraint applied to HJ was undertaken within a mental health unit. The judgment concluded:

> 'the requirements on the Trust to continue to comply with the best interests decision making processes under section 4 MCA, the need to ensure that any level of restraint is justified under section 6 MCA and the additional procedural requirements imposed on the Trust by a combination of the MHA framework and the 2018 Act provide an entirely adequate procedural framework to protect HJ's article 8 rights'.

Hence it was not necessary to supplement the Article 8 provisions with a further court order.

Mental Health Units (Use of Force) Act 2018

As noted above, the judgment observed that there were additional procedural obligations imposed by the Mental Health Units (Use of Force) Act 2018 because any restraint applied to HJ took place within a mental health unit. This Act is concerned with 'the oversight and management of the appropriate use of force in relation to people in mental health units' and is accompanied by statutory guidance (Department of Health & Social Care 2021). The Act applies to all patients being assessed or treated for a mental disorder in a mental health unit and applies to both NHS and independent hospitals. It equally applies to MHA detained patients and informal or voluntary patients. Box 2 summarises the key features of this Act and how it was applied in HJ's case.

Conclusion of the court

The judgment, in 'pulling the threads of the reasoning' of the case law considered, found principles to apply as to whether medical treatment provided to a detained patient amounted to a further deprivation of liberty (Box 3). In applying these principles, the judgment noted

> 'it must follow that, save in exceptional circumstances, any proper and lawful exercise of clinical judgment by clinicians in administering medical treatment to a detained person will not amount to a deprivation of the person's residual liberty because there is no element of arbitrariness in the actions of the clinical staff'.

If restraint was 'imposed' to enable treatment for a physical health problem for someone who lacks capacity to consent, then section 6 of the MCA outlines the tests for lawfulness of any restraint. Hence, if section 6 conditions are satisfied, then the 'usual consequence' will be no breach of a patient's Article 5 rights. The judgment noted that in such circumstances this was partly due to the trust owing a

BOX 3 Principles to apply as to whether medical treatment provided to a detained patient amounted to a further deprivation of liberty

The judgment in HJ's case stated:

(a) the starting point should be that it will only be in exceptional cases […] where something that happens to a person who has already been lawfully deprived of their liberty will amount to a further deprivation of that person's residual liberty;

(b) article 5 will only arise in an exceptional case because the usual position is that '*Article 5(1)(e) is not in principle concerned with suitable treatment or conditions*' […]; and

(c) the acid test for the engagement of article 5 in any case involving an alleged deprivation of residual liberty is whether there is an unacceptable element of arbitrariness in the actions which are taken by a state body and which are said to deprive a person of their residual liberty […]. (*Norfolk and Suffolk NHS Foundation Trust v HJ* [2023])

'common law duty of care to HJ' – this duty meant that while HJ was detained, staff were required to provide her with 'appropriate medical treatment to meet her physical and psychological needs'. The 'carefully thought-out' constipation treatment plan was tailored to HJ's medical needs. Hence it was not arbitrary and it was designed to meet her medical needs in a 'lawful and proportionate manner'. The judgment was clear that the medical treatment provided by staff did not amount to 'the type of exceptional circumstances' that could lead to a 'further deprivation of HJ's residual liberty'. HJ could not be deprived of her liberty 'as a result of the actions of Trust staff' who were performing their duty of care that they were required to take.

The judgment was satisfied that the MCA provided a sufficient framework 'for governing the lawfulness of the actions of the trust and [its] clinical staff'. In light of this and the above conclusions the judge made a declaration under section 15 of the MCA (Power to make declarations) that the trust was acting lawfully in administering enemas to HJ in accordance with the treatment plans and protocols described.

Discussion

An MCA capacity newsletter sagely noted the importance of this case where constipation and associated risks were formally addressed as this was a 'too often ignored' capacity issue in general but 'perhaps especially – in the context of those learning disabilities' (39 Essex Chambers 2023a). The newsletter observed the emphasis placed on the Mental Health Units (Use of Force) Act 2018, this being the first time it had appeared in any judgment. It was initially introduced to respond to use of force in response to challenging behaviours (more in terms of risk to self and others). But the breadth of the Act's definition of force had 'rightly' meant its provisions, designed to secure greater accountability and transparency, should also apply to clinical situations involving physical care when people are detained in mental health units. The newsletter posed the question as to why equivalent provisions should not apply in relation to those subject to deprivations of liberty in other settings which are, to all intents and purposes, identical.

A conundrum, as in the *Norfolk and Suffolk* case, is when a patient does not or cannot communicate with clinicians during the capacity assessment process, i.e. section 3(1)(d) of the MCA. This communication element was the key issue in a Court of Protection case in early 2023 (*Nottingham University Hospitals NHS Trust v RL* [2023]). This involved a 30-year-old man presenting with severe malnutrition in an acute hospital. The court was asked to urgently authorise the need for a nasogastric tube for treatment of both the person's physical and mental health (he was 'virtually stuporous and mute' owing to a severe depressive episode). The judgment found that the patient was not engaging in communication by any means attempted and 'simply has made it impossible for anyone to know what his wishes are because he will not express them himself'. On evidence accrued over time as to his capacity to consent to malnutrition treatment, the patient was assessed to have been able to understand and retain relevant information but unable to weigh it or communicate his decision. Ruck Keene (2023a) observed that this dilemma regarding what 'communication' means for the purposes of section 3(1)(d) had been 'curiously under-considered by the courts'. He stressed the need to distinguish between a situation where a person is unwilling to take part in a capacity assessment and one where they are unable to take part. He further drew on guidance for carrying out and recording capacity assessments (39 Essex Chambers 2023b) in observing that the 'communication' limb of section 3 had broadened to cover situations where a person is 'unable to express a stable – or, here – any preference', having originally been intended to only cover a narrow category of cases, such as locked-in syndrome.

Around the time of the *Norfolk and Suffolk* case two other Court of Protection cases considered capacity decisions for obstetric treatment and care for detained pregnant MHA patients. This obstetric clinical scenario is very much an example of the MHA/MCA interface concerning medical treatment issues. Box 4 describes salient features from these and other Court of Protection cases to elucidate the complexities considered at this interface. Although this topic is ripe for a separate article of its own, the cases provide scenarios that may be applicable to other MCA/MHA cases and medical treatment issues, for example anticipatory/prospective authorisation of deprivation of liberty, the potential use of restraint under best interests, the use of covert medication and that a formal diagnosis is not required to satisfy section 2(1) of the MCA capacity assessment.

There is a plethora of Court of Protection judgments on medical treatment being authorised under a deprivation of liberty. Key sections of the MCA utilised by the courts for such decisions include:

- section 4 – best interests
- section 4a – restriction on deprivation of liberty
- section 15 – power to make declarations
- section 16 – powers to make decisions and appoint deputies: general
- section 47 – general powers and effect of orders etc.

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- section 48 – interim orders and directions
- section 49 – power to call for reports.

A recent case involving a person in a care home, who was resisting assessment and treatment for chronic bilateral venous leg ulcers, provided an overview of how the MCA can be utilised by courts in depriving someone of their liberty for medical treatment (*Barnet Enfield and Haringey Mental Health NHS Trust v Mr K* [2023]). The judgment is an excellent example of how detailed treatment plans need to be regarding issues such as chemical and physical restraint and transportation of patients when medical treatment is authorised under a Deprivation of Liberty order. Another complex case involving a patient detained under section 3 of the MHA also provided an excellent exposition of a best interests decision and detailed treatment plans (*East Suffolk and North Essex NHS Foundation Trust v DL* [2023]). The patient was diagnosed with a mild intellectual disability, complex post-traumatic stress disorder, a dissociative disorder and emotionally unstable personality disorder. She needed rehydrating and refeeding because she had been restricting her intake of nutrition and hydration. The court declared it was lawful and in her best interests to implement an 'escalation plan' that included deep sedation to enable parenteral nutrition in an intensive care unit (nasogastric feeding having been ruled out owing to the patient's mental state).

Another recent Court of Protection case (*Manchester University Hospitals NHS Foundation Trust v JS* [2023]) looked at the juxtaposition of the MHA/MCA in the context of what test is to be applied by decision makers in determining whether a person

BOX 4 The interface between the Mental Heath Act (MHA) and the Mental Capacity Act (MCA) in obstetric cases

- *North Middlesex University Hospital NHS Trust v MB* [2023] – this case contemplated the complexities of a detained patient being transferred to another hospital to receive obstetric care potentially under an anticipatory or prospective authorisation of deprivation of liberty (were she to be assessed as lacking the capacity around the time of labour at a future time).
- *Gloucestershire Hospitals NHS Foundation Trust v Joanna* [2023] – this case considered similar complex obstetric capacity and treatment decisions of a detained patient. This included the potential concurrent use of the MCA under a best interests approach to include the potential use of restraint for a planned Caesarean section.
- *North Bristol NHS Trust v R* [2023] – although not detained under the MHA (she had been previously) the patient was pregnant while serving a prison sentence. The patient was assessed as lacking MCA capacity to decide whether her baby should be delivered pre-term by means of an elective Caesarean section. The court made section 15 MCA declarations that it was lawful and in her best interests for her to have an elective Caesarean section in accordance with a detailed care plan. The judgment also confirmed that a formal diagnosis, in order for the terms of section 2(1) of the MCA to be satisfied, was *not* required in order to reach a conclusion that a person lacks capacity to make a decision. This case was described as a 'masterclass' in the principles to apply in assessing capacity (39 Essex Chambers 2023c).
- *H, Re (An Adult; Termination)* [2023] – this involved a woman diagnosed with schizoaffective disorder detained under section 3 of the MHA. Following her detention, it was discovered that she was pregnant. The court concluded that although she was requesting a termination, she lacked capacity to make this decision owing to her ongoing psychotic symptoms. The court concluded, however, that it was in her best interests to have the termination carried out by a medical procedure (with a back-up option of a surgical procedure) and also considered the potential use of covert medication and proportional restraint as part of her care plan for this. The court made orders under section 16 of the MCA to this effect.
- *Guys and St Thomas' NHS Foundation Trust v R* [2020] – this involved a detained patient who was 39 weeks and 6 days into her pregnancy. She was assessed as being able to make decisions about her ante-natal and obstetric care. However, it was assessed that she was at substantial risk of deterioration in her mental health whereby she would likely lose capacity during labour, which would increase her obstetric risks, resulting in an emergency Caesarean section and fears she may resist this. The court made section 15 MCA declarations, including that should the patient lack capacity to make obstetric care decisions it was lawful for the trust to deliver care and treatment in accordance with proposed care plans. If this amounted to a deprivation of liberty, this would be authorised as such, 'providing always that any measures used to facilitate or provide the arrangements shall be the minimum necessary to protect the safety of the Respondent and those involved in her transfer and treatment; and that all reasonable and proportionate steps are taken to minimise distress to the Respondent and to maintain her dignity'. This case also considered an advance directive to refuse treatment (ADRT: sections 24–26 of the MCA). Although not assessed as being valid in this case, an ADRT of course potentially adds another layer of legal discourse in similar cases.
- *NHS Trust & Ors v FG* [2014] – this judgment produced guidance that is still relevant for Court of Protection applications regarding obstetric capacity issues involving pregnant women who have mental health problems (including detained patients).

MCQ answers
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BOX 5 Key learning points

- Under section 63 of the Mental Health Act (MHA) (Treatment not requiring consent), treatment for physical disorders can occur without consent where there is a clear causal connection in that the physical disorder is a symptom or manifestation of the mental disorder (for a review of section 63 case law see Curtice & James, 2015).
- For a detained patient where the physical disorder is not the primary or even subsidiary cause of a mental disorder, i.e. is totally unrelated, section 63 does not apply.
- For a detained patient where section 63 does not apply for physical health treatment, and they are unable to consent, then the Mental Capacity Act (MCA) framework applies. The pertinent sections of the MCA that apply are sections 4 (Best interests), 5 (Acts in connection with care or treatment) and 6 (Section 5 acts: limitations).
- For a detained patient under the MHA, European case law has shown that it is possible for such a patient who is unable to consent to medical treatment for physical disorders to receive treatment under a Deprivation of Liberty order, albeit this will only likely be in exceptional cases.
- The European Court of Human Rights has affirmed that detained patients still have residual liberties in the form of other civil liberties, such as other ECHR rights, that can be infringed.

'could' be detained under the MHA. The judgment put forward a 'useful structure' of key questions to aid practitioners and judges 'navigate these choppy waters':

- Is the person a 'mental health patient'?
- Is the person an 'objecting mental health patient'?
- Could the person be detained under section 3 of the MHA? (The judgment mentioned only section 3, but section 2 could also be an option).

Conclusion

The MHA/MCA interface, with its complexities and nuances, is a common scenario for clinicians. Ruck Keene regards the MHA/MCA interface as 'a notoriously awful area' (Ruck Keene 2023b) but has provided a very helpful webinar exploring this area for healthcare professionals (Ruck Keene 2023c). The *Norfolk & Suffolk* case considered this specifically in the context of physical healthcare for detained patients. It provides a framework of principles to apply as to whether medical treatment provided to a detained patient amounts to a further deprivation of liberty. This and other key learning points emanating from this case are described in Box 5.

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None.

References

39 Essex Chambers (2023a) Restraint, physical health and the detained patient: the rights in play. *Mental Capacity Report: Health, Welfare and Deprivation of Liberty*, **2023**(133): 21–6 (https://www.39essex.com/sites/default/files/2023-07/Mental%20Capacity%20Report%20July%202023%20HWDOL.pdf).

39 Essex Chambers (2023b) *Carrying Out and Recording Capacity Assessments (March 2023)*. 39 Essex Chambers (https://www.39essex.com/sites/default/files/2023-03/Mental%20Capacity%20Guidance%20Note%20Capacity%20Assessment%20March%202023.pdf).

39 Essex Chambers (2023c) *Mental Capacity Case: North Bristol NHS Trust v R (31 January 2023)*. 39 Essex Chambers (https://www.39essex.com/information-hub/case/north-bristol-nhs-trust-v-r). Accessed 5 Sep 2023.

Curtice M, James L (2015) Faith, ethics and Section 63 of the Mental Health Act 1983. *Psychiatric Bulletin*, **40**: 77–81.

Department of Health & Social Care (2021) *Mental Health Units (Use of Force) Act 2018: Statutory Guidance for NHS Organisations in England, and Police Forces in England and Wales*. Department of Health & Social Care.

Ruck Keene A (2023a) What should happen where it appears impossible to engage the person? A high-stakes question for the Court of Protection. *Mental Capacity Law and Policy*, 19 Jun (https://www.mentalcapacitylawandpolicy.org.uk/what-should-happen-where-it-appears-impossible-to-engage-the-person-a-high-stakes-question-for-the-court-of-protection/). Accessed 5 Sep 2023.

Ruck Keene A (2023b) The MHA/MCA interface revisited – Theis J rolls up her sleeves. *Mental Capacity Law and Policy*, 10 Aug (https://www.mentalcapacitylawandpolicy.org.uk/the-mha-mca-interface-revisited-theis-j-rolls-up-her-sleeves/). Accessed 5 Sep 2023.

Ruck Keene A (2023c) *Updated MCA/MHA interface shedinar. Mental Capacity Law and Policy*, 15 Aug (https://www.mentalcapacitylawandpolicy.org.uk/updated-mca-mha-interface-shedinar/). Accessed 5 Sep 2023.

Cases*

An NHS Trust & Ors v Y & Anor (Rev 1) [2018] UKSC 46.

Ashingdane v United Kingdom (1985) 7 EHRR 528.

Barnet Enfield And Haringey Mental Health NHS Trust & Anor v Mr K & Ors [2023] EWCOP 35.

B v Croydon Health Authority [1995] Fam 133.

East Suffolk and North Essex NHS Foundation Trust v DL & Anor [2023] EWCOP 47.

Gloucestershire Hospitals NHS Foundation Trust & Anor v Joanna [2023] EWCOP 21.

Guys and St Thomas' NHS Foundation Trust (GSTT) & Anor v R [2020] EWCOP 4.

H, Re (An Adult; Termination) [2023] EWCOP 183.

Manchester University Hospitals NHS Foundation Trust v JS & Anor (Schedule 1A Mental Capacity Act 2005) [2023] EWCOP 33.

Munjaz, R (on the application of) v Ashworth Hospital Authority [2005] UKHL 58.

Munjaz v the United Kingdom [2012] ECHR 1704.

NHS Trust & Ors v FG (Rev 1) [2014] EWCOP 30.

Norfolk and Suffolk NHS Foundation Trust v HJ [2023] EWFC 92.

North Bristol NHS Trust v R [2023] EWCOP 5.

North Middlesex University Hospital NHS Trust & Anor v MB [2023] EWCOP 23.

Nottingham University Hospitals NHS Trust & Anor v RL & Ors [2023] EWCOP 22.

R (TB) v The Combined Court at Stafford [2006] EWHC 1645 (Admin).

Saadi v United Kingdom (2008) 47 EHRR 17.

*These cases can be accessed for free at: www.bailii.org

MCQs

Select the single best option for each question stem

1 The concept of residual liberty means that:
- a detained people do not retain civil liberties.
- b detained people still retain civil liberties but only in certain specified situations.
- c detained people still retain only specific civil liberties.
- d detained people still retain civil liberties
- e detained people still retain civil liberties but only applies to those in prison.

2 Regarding restraint and section 6 of the MCA:
- a a person (D) restrains another person (P) if he/she restricts P's liberty of movement, only if P resists
- b a person (D) restrains another person (P) only if he/she uses force to secure the doing of an act that P resists
- c if a person (D) does an act that is intended to restrain another person (P) the first condition is that D vaguely believes that it is necessary to do the act in order to prevent harm to P
- d if a person (D) does an act that is intended to restrain another person (P) the second condition is that the act is a proportionate response only to the likelihood of P's suffering harm
- e if a person (D) does an act that is intended to restrain another person (P) the second condition is that the act is a proportionate response to (a) the likelihood of P's suffering harm and (b) the seriousness of that harm.

3 From the *Norfolk and Suffolk NHS Foundation Trust v HJ* [2023] judgment, the three principles to apply as to whether medical treatment provided to a detained patient amounted to a further deprivation of liberty include:
- a Article 5 of the ECHR always applies to suitable treatment or conditions of care
- b Article 5 of the ECHR is not influenced by whether a decision to deprive someone of their liberty is arbitrary
- c the starting point should be that it will only be in exceptional cases where something that happens to a person who has already been lawfully deprived of their liberty will amount to a further deprivation of that person's residual liberty
- d the effects of Article 8 of the ECHR on a patient's case
- e how the Mental Health Units (Use of Force) Act 2018 can affect a detained patient.

4 Regarding section 63 of the MHA (Treatment not requiring consent):
- a it allows medical treatment for a physical disorder where the physical disorder is a clear symptom or manifestation of the mental disorder
- b it allows medical treatment for a physical disorder that is totally unrelated to the mental disorder
- c it can be used for informal patients
- d where it does apply, medical treatment for a physical disorder cannot then be given for a detained MHA patient under the MCA
- e it can only be used for detained patients who lack capacity to consent to treatment.

5 Regarding physical health treatment for a person deprived of their liberty:
- a Deprivation of Liberty orders do not allow authorisation for transportation to another hospital as part of the care plan
- b case law has shown it can be lawful and in a person's best interests to have an elective Caesarean section
- c Deprivation of Liberty orders do not allow for authorisation of chemical or physical restraint
- d anticipatory or prospective authorisations of deprivation of liberty for medical treatment cannot be made
- e Deprivation of Liberty orders do not allow authorisation of restraint for medical treatment.