RELATIONSHIP BETWEEN THE MENTAL CAPACITY ACT (MCA) AND THE MENTAL HEALTH ACT (MHA)

This is one of a series of resource materials for clinical ethics committees providing explanation and discussion of the sections of the Mental Capacity Act which are particularly relevant to their work.

Introduction
Mental disorder may sometimes be associated with impaired decision making capacity. This incapacity may be temporary during acute periods of illness or more sustained in those with severe and enduring mental health problems. In such circumstances treatment will proceed using the provisions contained in the MCA.

On occasions a person may be so unwell that they may also fulfill the criteria for detention in hospital under the Mental Health Act (MHA) for assessment and treatment of their mental disorder. When this occurs it may be unclear as to the most appropriate legislative route to take (see link for a summary of the MHA http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034)

Case example

<table>
<thead>
<tr>
<th>Box 1</th>
<th>Case example Mrs A</th>
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<tbody>
<tr>
<td>Mrs A is severely depressed and extremely withdrawn. She passively goes along with her husband who brings her to the ward for admission. She makes no attempt to go when her husband leaves but later sits staring at the door asking to go home. She cannot engage in any discussion about the treatment plan. The team thinks she lacks decision making capacity. The team then discusses whether she should be treated under the MCA (as she lacks capacity) or, given that she has not consented to the admission and looks as if she wants to leave, whether the MHA would be more appropriate.</td>
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The differences between the 2 Acts and pointers to the most appropriate course of action will be considered under the following headings.

1. Purpose and scope
2. Principles and policy concerns
3. The role of capacity
4. Role of 3rd parties in decision making
5. Planning ahead for future incapacity
6. Relationship between the 2 Acts
7. Deprivation of liberty
8. Pointers to the use of the MHA rather than MCA
10. Ethical Implications of preferring one legislative route over the other

1. Purpose and scope of the MCA and the MHA

Mental Capacity Act
- The MCA provides a framework for decision making on behalf of people who lack capacity to decide for themselves. This Act only applies to those over 16.
- Decisions can be wide-ranging, simple or complex and include decisions regarding medical treatment for both physical and mental disorder.

Mental Health Act
- Unlike the MCA this Act does not outline the specific principles which underpin its operation although Section 1.1 of the Code of Practice outlines some broad principles which also include promoting autonomy, non discrimination and using the least restrictive interventions compatible with ensuring the safety of the patient and others.

Over the last decade, following some high profile incidents involving mentally disordered individuals, public protection from those suffering from mental disorder has increasingly become a major policy concern.
3. The presence or absence of capacity carries different weight

Mental Capacity Act
The issue of capacity (or more accurately lack of capacity) is central to the operation of this Act. Statutory provisions only come into play if a person lacks capacity for the specific decision in question. If capacity is retained then the common law and professional guidance relating to consent applies. (see resource materials on assessing capacity)

The test of capacity is clearly defined and if a person has capacity for the decision in question then, that decision, however unwise, must be respected.

Mental Health Act
Unlike the MCA capacity is not central to the operation of the Mental Health Act. The issue of capacity only arises in three circumstances under the MHA

- Consent to treatment with Electroconvulsive Therapy (ECT) at any time during a period of detention (s58 MHA, regulation 16 Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983).
- Consent to the continuation of medication after 3 months from the onset of detention (s58 MHA)
- Consent for Psychosurgery or the implantation of hormones (s57)

The test of capacity is not defined within the MHA other than requiring that the person is “capable of understanding” the proposed treatment.

Lady Justice Hale in R (Wilkinson) v Broadmoor Special Hospital Authority and others commented obiter dictum that the test contained in s 58 of the MHA is the same as the common law test of capacity as outlined in Re C/ MB. With the introduction of the MCA the test for capacity would now be that outlined in the MCA.

Despite detention under the MHA, a person may still retain capacity to give or refuse consent to treatment. The Code of Practice relating to the Act acknowledges this when it states:

“A detained patient is not necessarily incapable of giving consent. The patient’s consent should be sought for all proposed treatments which may be lawfully given under the Act.”

Refusal of treatment for a physical disorder by a patient with capacity who is detained under the MHA must be respected. However, the refusal of treatment for the mental disorder for which the patient is detained by a patient who has capacity can be overridden and the patient treated at the discretion of the responsible medical officer (RMO).

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1 R (Wilkinson) v Broadmoor Special Hospital Authority and others [2001] EWCA 1545.
2 Re MB (An adult: Medical treatment) [1997] 2 FCR 541. Re C (adult: refusal of medical treatment) [1994] 1 All ER 819
4. Role of third parties in decision making

Mental Capacity Act

**Lasting Power of Attorney (LPA)**
The MCA provides for the appointment of an attorney who may be authorised to make healthcare decisions. For the first time in English law, if the statutory provisions are complied with, a third party will be able to consent / refuse medical treatment on behalf of another adult. (see resource materials on decision-making of attorneys and deputies)

**Independent Mental Capacity Advocate (IMCA)**
The MCA contains requires the appointment of an Independent Mental Capacity Advocate (IMCA) where a person who has no one else (other than a paid carer) to help and support them and decisions are being made about serious medical treatment or place of residence. The IMCA is not a decision maker on behalf of the incapacitated person but will contribute to the best interests discussion. In order to do this effectively the IMCA may have access to the records pertinent to the decision in question. (see resource materials on the role of the MCA)

Mental Health Act
The primary decision maker under the MHA is the Responsible Medical Officer (RMO) although certain decisions, under certain circumstances will be subject to external review by the second opinion appointed doctor or by a Mental Health Review Tribunal.

5. Planning ahead for future incapacity
The MCA provides two mechanisms for advance planning:

1. advance decisions to refuse treatment and (see resource materials on advance decision-making)
2. by granting a Lasting Power of Attorney (see resource materials on the role of attorneys).

The new MHA 2007 (which amends the 1983 MHA) states that a valid and applicable advance decision to refuse electroconvulsive therapy (ECT), even if detained under the MHA, will be binding except in an emergency. (Section 27(5)

6. Relationship between the two Acts
Section 28 of the MCA states:
(1) Nothing in this Act authorises anyone-
   (a) to give a patient medical treatment for mental disorder, or
   (b) to consent to a patient's being given medical treatment for mental disorder, if, at the time when it is proposed to treat the patient, his treatment is regulated by Part IV of the Mental Health Act.

(2) "Medical treatment", "mental disorder" and "patient" have the same meaning as in that Act (Mental Health Act).

The MHA will therefore trump the MCA in the treatment of mental disorder.

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5 See Code of Practice (MCA) 10.42 – 10.50
Part IV of the MHA authorises treatment for mental disorder for those detained under the relevant sections of the Act.

Those on short term sections which are for emergency detention of patients until full assessment can be carried out such as s4 or s5(2) or s5(4) are **not** included in part IV. If, in such a situation, the person lacks decision making capacity regarding the proposed treatment then this can, if in their best interests, be given under the MCA.

**Case example**

**Box 2 Case example Mrs B**

Mrs B is admitted informally having made a serious attempt on her life. She becomes distressed and agitated and insists on leaving hospital stating that it is her intention to “do it properly.” The duty doctor is called, believes she is at substantial risk of self harm if she were to leave hospital and therefore detains her on s 5(2) MHA. Whilst waiting for the further assessment to consider detention under s2 or 3 Mrs B starts banging her head against the wall causing a large abrasion to her forehead. Despite restraint by the nursing team she remains agitated, continues to try and harm herself and is unable to engage in discussion about treatment options. The doctor decides that an IM injection of lorazepam needs to be administered. Her distress makes it impossible to discuss this and the team agree that her decision making capacity is currently impaired. It is in her best interests to prevent further harm and, as nursing intervention does not appear to be sufficient, treatment with lorazepam is in her best interests. The injection is therefore given under the MCA.

### 7. Deprivation of liberty under the two Acts

The MCA allows **restriction** of liberty / restraint as long as certain conditions are fulfilled (S 6 [http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_2#pt1-pb2-l1g6](http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_2#pt1-pb2-l1g6)). The **Act** distinguishes between restriction of liberty or restraint and deprivation of liberty. The Mental Health Act 2007 amends the MCA to include a section on deprivation of liberty. Except in emergency situations a person should not be deprived of their liberty without the authority of the court.

Where the line between restriction and deprivation of liberty should be drawn can be difficult to determine and will depend on the facts of the particular case. The European Court of Human Rights has held that the difference was **“one of degree or intensity, not one of nature or**
The MCA code of practice considers this question and advises that the decision will depend on specific factors in an individual case including:

- the type of care being provided
- how long the situation lasts
- its effects, or
- the way in a particular situation came about.

Where there is deprivation of liberty and the person also fulfils criteria for detention under the MHA then use of the MHA should be considered if there is no less restrictive way that the care and treatment for the mental disorder can be given. **Unlike the MCA the MHA contains procedures to ensure compliance with rights under Article 5 of the European Convention on Human Rights (right to liberty and security).**

There will, however, be a small group of incapacitated individuals who will need to be deprived of their liberty in their best interests but who do not necessarily meet criteria for detention under the MHA. These may include those with head injury, learning disability or dementia. Provisions for such individuals are now covered by amendment to the MCA in the Mental Health Act 2007.

### 9. Pointers to the use of the MHA rather than MCA

- If there is deprivation of liberty and the criteria for detention under the MHA are present.
- To over-ride an Advance Decision to refuse treatment for mental disorder (with the exception of ECT when the new MHA 2007 comes into operation)
- to over-ride an attorney who is refusing consent to treatment for mental disorder
- If the person is resisting treatment for mental disorder and restraint is required regularly or for a prolonged period of time

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6 *HL v UK* (Application no. 45508/99 5th October 2004 para 89)
10. Potential areas of conflict between the 2 Acts

*Case example:*

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<tr>
<th>Box 3</th>
<th>Advance decisions</th>
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<td>Mr B suffers schizophrenia and has previously been admitted to hospital and treated successfully with antipsychotic drugs. Between episodes he makes a good recovery and decides to make an advance refusal of treatment with all antipsychotics as he considers the side effects of this type of treatment unacceptable. Mr B becomes unwell again and passively co-operates with admission to hospital. He is extremely frightened by auditory hallucinations stating that he is going to be executed. He refuses oral antipsychotics believing these drugs will kill him. It is the view of the psychiatric team that Mr B lacks capacity to decide about treatment. The consultant thinks treatment should be given by injection. The team is aware that Mr B has made an advance decision to refuse treatment with all antipsychotic drugs.</td>
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If, in the above case, the person was dealt with under the MCA the advance refusal of antipsychotic drugs, if valid and applicable would be binding.

This advance decision could, however, be circumvented by detaining the person under the MHA. Using the provisions contained in Part IV (s 63 MHA 1983) depot antipsychotic medication could be given despite the advance decision to refuse this form of treatment.

**Lasting Power of Attorney (LPA)**
As outlined above, it is now possible for a third party to make treatment decisions on behalf of an incapacitated adult but the MHA can trump this with regard to treatment for mental but not physical disorder.
11. Ethical Implications of preferring one legislative route over the other

The above examples illustrate the tension between the two Acts. In some instances there will be a clear legal route that should be chosen, for example, when a severely mentally disordered person is being deprived of their liberty. In other situations the most appropriate route may be less clear cut and it is important to recognise that there may be different consequences of choosing one legislative route over the other.

**Respect for autonomy**

- the statutory route that is chosen will determine whether or not autonomy must be respected (despite the current incapacity) via the mechanisms of a valid and applicable advance decision

- Under the MCA, third parties such as an attorney acting under a Lasting Power of Attorney (LPA) or a court appointed deputy may, if certain conditions are met, give or refuse consent to the proposed treatment on behalf of the incapacitated person and such decisions will be binding on the healthcare professional. This mechanism is less directly autonomy promoting than advance decisions as the attorney is required to act in the persons best interests, not as a substitute decision maker.
Issues of distributive justice

- Section 117 MHA imposes a duty to provide after-care following a period of detention under certain sections of the MHA. The court has held that such services be provided free of charge. (*R v Manchester City Council Ex p. Stenett* [2002] UKHL 34.) This includes payment for residential accommodation. This may lead to the situation whereby patients with essentially the same needs will be treated differently depending on which legislative route is used. In the above judgement their Lordships considered the issue of a person with severe dementia requiring residential accommodation and the different financial implications of being admitted to hospital under the MHA or not.

Protection of rights and freedoms

- Safeguards available to patients vary between the two statutes. In particular s58 MHA requires that, in the absence of capacity, treatment decisions are reviewed by a Second Opinion Appointed Doctor.

- In the MCA there is no in-built review of treatment decisions (and therefore protection from arbitrary decision making) although the Court of Protection may be called upon to decide if there is major disagreement amongst those considering the best course of action.

- Article 5 rights are protected under the MHA as there are mechanisms to review detention although in many instances referral for review of detention is not automatic and must be requested by the detained individual.