

The Mental Capacity Act: applications and interface with the Mental Health Act

Imagine that two people refuse life-saving medical interventions. One is a 50-year-old man with schizophrenia who has delusions that doctors are against him. The other is a 17-year-old woman with a religious conviction that accepting a blood transfusion is sinful. Who decides if these refusals should be accepted or overridden, and how are such vital decisions reached?

Before the Mental Capacity Act 2005, such decisions came under common law (Department for Constitutional Affairs, 2007). In 1989, the Law Commission responded to concerns raised by carers about the prevalence of paternalistic practice in health care and lack of clear legal guidance (Houses of Parliament, Parliamentary Office of Science and Technology, 2011). They set out to develop a new legal framework based on three fundamental concepts: decision-making capacity, best interests and anticipatory decision making (Houses of Parliament, Parliamentary Office of Science and Technology, 2011). The Mental Capacity Act was established in 2005 and with it a new Court of Protection, equivalent in status to the High Court.

The issue of capacity is relevant to all branches of medicine, and the principles of the Mental Capacity Act are fundamental to upholding the values of modern medicine. This article clarifies the legislation and crossover with the Mental Health Act 1983 and puts the Mental Capacity Act into a practical context.

Essentials of the Mental Capacity Act in England and Wales

The Mental Capacity Act applies to everyone over 16 years of age, and states that:

'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain.'

There is a two-stage test of capacity:

CASE STUDY 1

A 20-year-old man (T) with no known psychiatric history was brought into the accident and emergency department having cut his wrists. He was intoxicated with alcohol. He consented to treatment of his injuries but refused to wait to see the psychiatric team and attempted to leave.

Capacity

In this case T was acutely intoxicated and after assessment of his capacity was found unable to adequately weigh the risks and benefits of the decision to leave the accident and

emergency department, and therefore lacked capacity to do so.

Key points

T was likely to regain capacity once he was no longer intoxicated; however, given the potential risks which were associated with allowing him to leave the department, a decision was taken in his best interests to prevent him leaving. This involved asking security to stay with T. He was assessed the next morning by liaison psychiatry once he was sober.

1. Is there an impairment of or disturbance in the functioning of the person's mind or brain?
2. If so, is the impairment or disturbance such that the person lacks the capacity to make a decision in relation to the matter(s) in question? (Department for Constitutional Affairs, 2007).

The impairment may be permanent or temporary and does not necessarily have to be attributable to a recognized medical condition. Acute intoxication, for example, may cause a temporary lack of capacity. If there is no such impairment, the person must be assumed to have capacity (Department for Constitutional Affairs, 2007) (*Case study 1*).

In the second stage of the test, the Mental Capacity Act states that a person is unable to make a decision if he or she is unable:

- To understand the information relevant to the decision
- To retain that information
- To use or weigh that information
- To communicate the decision (Department for Constitutional Affairs, 2007).

If any one of these criteria is not met, the person must be assumed not to have capacity for that decision at that time. However, all practicable steps must be taken to support the person to make his/her own

decision. This overlaps with the Equality Act 2010, and may include steps such as providing a translator or using written or pictorial information aids. Capacity only applies for a specific decision and time and therefore may change; if a decision can be safely postponed until the person regains capacity, this should be considered (Department for Constitutional Affairs, 2007).

A decision that seems unwise to the assessor does not constitute a lack of capacity; it may be influenced by the individual's cultural and religious identity and his/her life experiences, which may well differ from those of the assessor. In the example of a patient refusing a blood transfusion as a result of strong religious beliefs, the information that he/she deems relevant and necessary to adequately weigh the decision will include the spiritual consequences of accepting or declining the transfusion as well as the medical ones. Whether these

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consequences outweigh the potential medical consequences or not must be the individual's decision, not the assessor's. The principles of the Mental Capacity Act are outlined in *Table 1*.

Mental capacity in Northern Ireland

The Mental Capacity Act (Northern Ireland) 2016 is an example of fusion legislation (Lynch et al, 2017). It covers health and social care; there is no separate Mental Health Act. Before this, decisions for people lacking capacity were taken under common law (Lynch et al, 2017). The Bamford review of mental health and learning disability (Department of Health, 2007) recommended that this was not compatible with the essential principles of autonomy, justice, benefit and least harm. It recommended that:

'there should be a single comprehensive legislative framework for the reform of mental health legislation and the introduction of capacity'.
(Department of Health, 2007)

The essential principles of the Mental Capacity Act (Northern Ireland) and the diagnostic and functional aspects of the test of capacity are in line with those of the Mental Capacity Act in England and Wales.

Mental Capacity in Scotland

The Adults with Incapacity Act 2000 was one of the first pieces of legislation to be passed by the Scottish Parliament (Scottish Government, 2008). It applies to those over 16 years of age who lack capacity to act on or make decisions as a result of mental disorder or inability to communicate because of physical disability (Scottish Government, 2008).

When an individual has no welfare attorney or guardian appointed, a doctor is authorised to provide medical treatment. If there is disagreement a second medical opinion must be sought. Capacity is assumed until proved otherwise.

As can be seen, the general principles of capacity are fairly consistent across the UK, despite differences in legal structure in the different countries.

The interface between the Mental Capacity and Mental Health Acts

Outside of Northern Ireland where the Mental Health Act and Mental Capacity Act are combined, the crossover between these pieces of legislation and when each should be applied can be complex, particularly regarding patients with mental illness in a physical health setting and vice versa.

In general, the Mental Health Act is applied when treatment is specifically for a mental illness, and the Mental Capacity Act is applied when the decision pertains to treatment for physical illness, even if the individual has a mental illness (Ministry of Justice, 2008) (*Case study 2*). If an individual is detained under the Mental Health Act and requires treatment for a physical illness, his/her capacity must be

assessed under the Mental Capacity Act for treatment to be given (Brindle and Branton, 2010). Treatment for physical illnesses or injuries can only be given under the Mental Health Act if it is a direct consequence of the mental illness (for example malnutrition resulting from severe depression) (Brindle and Branton, 2010).

Where there is high risk of harm to him-/herself or others without treatment of a mental disorder in hospital, an individual may be detained under the Mental Health Act and, in a sense, this 'trumps' the Mental Capacity Act (Brindle and Branton, 2010). However, someone should not be admitted to hospital informally for treatment of a mental disorder if the person lacks capacity to consent to this. Although this may appear less restrictive, in practice the individual is unofficially detained as he/she is not allowed to leave, but will not have access to legal rights built into the Mental Health Act, such as the right to a tribunal and aftercare.

Table 1. Principles of the Mental Capacity Act

A person must be assumed to have capacity unless proved otherwise
All practicable steps must be taken to aid the individual before a decision can be reached
A person cannot be said to not have capacity because they are making an unwise decision
A decision made under this Act on behalf of an individual must be made in their best interests
Regard must be had for the least restrictive option possible

From Ministry of Justice (2008)

CASE STUDY 2

A 32-year-old woman (S) with schizophrenia was brought into hospital in labour. Her partner informed staff that recently S had been 'acting strangely', responding to unseen stimuli and not making sense. Complications arose that necessitated an emergency caesarean. The obstetrician attempted to explain that there was a potential risk of death to the baby and S without the operation, but she was felt to be unable to engage in the conversation.

Capacity

Although the obstetric team felt she lacked capacity to consent to the operation, owing to the high risks involved, advice was sought from the psychiatry team. On assessment S was found to be actively psychotic with symptoms of formal thought disorder and auditory

hallucinations. This was likely complicated by severe pain.

Owing to the impairment of mind at that time, namely psychosis, it was felt that S was unable to weigh the potential risks of having or refusing the surgery and therefore lacked capacity to make this decision.

Key points

It is likely that S would regain capacity to make this decision with treatment, but because of the emergency nature of the situation it would have been inappropriate to wait for her to regain capacity. She therefore underwent an emergency caesarean section under general anaesthetic in her best interests. Following this she was detained under the Mental Health Act for treatment of psychosis.

Practicalities

Unlike the process for detention under the Mental Health Act, there is no statutory paperwork needed for the Mental Capacity Act. It is sufficient to document clearly in the notes why the individual does or does not have capacity for a specific decision, using the two-stage test above. It is good practice when documenting this to show that due regard was given to the individual's best interests and the least restrictive option.

Under the Mental Capacity Act there is an obligation to consult with carers and family, particularly in the event of a decision needing to be taken in someone's best interests (Ministry of Justice, 2008). All best interest decisions should involve the individual and his/her family as much as possible and consider the least restrictive option. Where the individual does not have family or friends, an independent mental capacity advocate can be appointed to advocate for him/her (Department for Constitutional Affairs, 2007). Neither family nor an independent mental capacity advocate can make decisions on behalf of the individual, unless they hold lasting power of attorney. This enables a person to give someone authority to make decisions on his/her behalf should he/she lose capacity in the future (Department for Constitutional Affairs, 2007). Under the Mental Capacity Act an individual may have an advance directive regarding specific treatments. To be legally binding the individual must have had capacity at the time of making the directive, and the directive must clearly state the circumstances that the refusal refers to (Department for Constitutional Affairs, 2007).

The Mental Capacity Act was amended in 2009 to include the deprivation of liberty safeguards (Brindle and Branton, 2010). This followed the 'Bournewood case' (House of Lords, 2014; Mental Health Law Online, 2018) and was intended to protect vulnerable individuals from being detained arbitrarily. If someone is being deprived of his/her liberty without a legal framework to justify this, this directly contravenes Article 5 of the Human Rights Act – 'everyone has the right to liberty and security of person' (Brindle and Branton, 2010).

Deprivation of liberty safeguards apply to everyone over 18 years of age who has a mental disorder or disability of the

mind, who lacks capacity to give consent to continuous supervision and control in a care home or hospital (Brindle and Branton, 2010). The safeguards cannot be applied when an individual meets criteria to be detained under the Mental Health Act and therefore are typically used in cases of dementia, learning disability, and neurological conditions (Brindle and Branton, 2010).

In the often seen but complicated case of an elderly patient presenting with confusion affecting his/her capacity, the most appropriate legislative structure for treatment depends largely on the cause of the confusion. If acute and felt to be attributable to delirium then it is appropriate to use the Mental Capacity Act as the confusion is the result of a medical condition and likely to abate in time. However, if the confusion has a more chronic basis and capacity is therefore unlikely to return, for example in a patient who has dementia, it is more appropriate to use deprivation of liberty safeguards.

Conclusions

Although the wellbeing of patients is paramount, preserving the autonomy of the individual is also vital. This is an intrinsic principle of the Mental Capacity Act, and by considering each principle of the Act when supporting a patient to make a decision, this balance can be maintained.

The interface between the Mental Capacity Act and Mental Health Act can be complex, particularly when treating patients with both mental and physical illnesses. In circumstances where decisions must be taken in the patient's best interests, decisions should be made by a multidisciplinary team, involving the patient and his/her relatives as much as possible. **BJHM**

Conflict of interest: none.

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KEY POINTS

- Mental capacity is only applicable to a specific decision at the time it is tested and may fluctuate over time.
- A person must be assumed to have capacity unless proven otherwise; making an unwise decision does not in itself indicate a lack of capacity.
- All practicable steps must be taken to support the person to make a decision, for example by ensuring there is no language barrier and he/she has adequate information.
- When making a decision in someone's best interests, thought should always be given to the least restrictive option.
- Treatment for a physical condition cannot be given under the Mental Health Act unless the condition is a direct consequence of mental illness.
- If any health-care professional becomes concerned that a patient is being deprived of his/her liberty without a legal framework in place, the clinician should consider making an urgent deprivation of liberty safeguards referral and discuss this with the multidisciplinary team.

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