Managing the overlap between mental and physical health

Abstract

The interface between the Mental Capacity Act 2005 and the Mental Health Act 1983 can be complex, particularly in patients with co-existing mental and physical illnesses. The management of these patients requires the involvement of patients, relatives and multidisciplinary teams. This article presents four illustrative patient cases, all of whom suffered from co-existing mental and physical illnesses. In managing these cases, dilemmas had arisen in the provision of treatment encompassing both legal frameworks. These cases helped to emphasise the decision-specific and time-specific nature of assessment of mental capacity, requiring clinicians to assess on a case-by-case basis over a suitable period. Often, principles from both legal frameworks may be applied by the treatment team. These cases help to highlight the significant overlap between mental and physical health, which often cannot be managed independently. This may call for the need to better integrate the current legal frameworks, and the optimal involvement of specialists across both settings.

Key words: Best interest; Consent to treatment; Legal framework; Mental health ethics; Physical health

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Fangyue Chen[1]

Eladia Ruiz-Mendoza[1]

Julius Essem[2]

Author details can be found at the end of this article

Correspondence to:
Fangyue Chen;
Fangyue.chen@nhs.net

Introduction

The ethical principles of beneficence and autonomy are paramount to the practice of modern-day medicine (Beauchamp and Childress, 2019). The Mental Capacity Act 2005 aims to balance the wellbeing of a patient against the preservation of autonomy. It is based on three fundamental principles: decision-making capacity, best interest and anticipatory decision making (Blackman and Dodge, 2019). However, the Mental Health Act 1983 (amended in 2007) places greater emphasis on beneficence – doing good, at times compromising the individual's autonomy. The patient may be detained under the Mental Health Act if they are suffering from a mental disorder of a nature or degree which warrants detention, in the interest of their own health or safety, or with a view to the protection of other persons (Lawton-Smith, 2008).

In general, the Mental Health Act is applied to the treatment of a mental health disorder, while the Mental Capacity Act is applied to the treatment of a physical illness. Nevertheless, there is a significant overlap between physical and mental health with bidirectional causality (Behan et al, 2015). In those circumstances, the interface between the Mental Capacity Act and Mental Health Act can be complex.

At present, section 63 of the Mental Health Act states that 'the consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering.' Section 145(4) defines 'medical treatment', in relation to mental disorder, as a reference to 'medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations' (Senasinghe, 2018). In these circumstances, the Mental Health Act can override the Mental Capacity Act. The decision regarding the treatment must be made in the patient's best interest, involving the multidisciplinary team, patient and the relatives, as best as possible.

This article describes four patients with co-existing mental and physical illnesses who were admitted to an old age psychiatry inpatient service, and examines in detail how the Mental Health Act and Mental Capacity Act were applied as appropriate in each circumstance.

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Case 1

An 85-year-old woman with schizoaffective disorder was admitted to the inpatient psychiatric unit for electroconvulsive therapy. On assessing her capacity to consent tp treatment, she was deemed unable to weigh up the decision to have electroconvulsive therapy. Therefore, she was assessed by a second opinion appointed doctor, and electroconvulsive therapy was prescribed for her best interest under the authority of form T6 (certificate of second opinion). During her inpatient stay, she developed a urinary tract infection. She was able to understand her illness, weigh up and communicate her decision to start treatment. In this instance, her capacity was retained.

Case discussion

Currently, under the Mental Health Act 1983, electroconvulsive therapy cannot be given without the consent of the patient who has retained capacity (Curtice and James, 2016). This patient was deemed to lack the capacity to consent to electroconvulsive therapy, because of her inability to weigh up the decision. However, she retained capacity to give consent to treatment for her urinary tract infection. This case highlights the fact that mental capacity is decision specific.

Case 2

A 74-year-old woman with poorly controlled type 2 diabetes on insulin was admitted to the inpatient psychiatric unit. She presented with grandiose religious delusions, paranoid delusions and auditory hallucinations. Owing to the risk she posed to herself, she was detained under section 2 of the Mental Health Act. During her admission period, there were two occasions when she refused insulin administration. On the first occasion, she refused to accept a newly increased Novomix dose. She gave an acceptable rationale for her decision that she was concerned about a hypoglycaemic episode, despite knowing the dangers of a high blood glucose level. Her decision was thus followed.

On a separate occasion, she refused insulin administration, the reason being 'it is within God's plan,' and that 'other people need it,' and she wanted to 'give it to them.' On this occasion, the treatment team felt that her refusal of treatment was a direct result of her mental disorder. Therefore, insulin administration fell under the definition of medical treatment given in the Mental Health Act. Fortunately, she later accepted the treatment.

Case discussion

For this patient, legal criteria from both the Mental Capacity Act and Mental Health Act were used. On the first occasion, she was able to understand and retain the information, communicating to clinicians an acceptable rationale for refusing insulin treatment. Therefore, her capacity at that specific timepoint for the specific decision was intact. On the second occasion, she displayed features of grandiose religious delusions. The refusal of insulin treatment was a direct cause of her mental illness, and therefore fell under medical treatment as defined in section 62 of the Mental Health Act 1983. Her consent was thus not required. Treatment was given in her best interest.

Discussion

The interface between the Mental Capacity Act and the Mental Health Act can be complex, particularly relating to patients with mental illness in a physical health setting, and vice versa. These four cases highlighted the complexity in managing these patients, requiring the involvement of the multidisciplinary teams, patients and relatives. The assessment of mental capacity in these patients should be implemented on a case-by-case basis, and should be decision-specific, over a suitable period. Both legal frameworks may apply in managing patients.

The first case was relatively clear-cut, highlighting the decision-specific nature of mental capacity assessment. In case two, the patient's capacity to decide regarding the same treatment fluctuated over time, and both legal frameworks could be applied. Under the Mental Capacity Act, 'a person is not to be treated as unable to make a decision, unless all practical steps to help him do so have been taken without success.' Therefore, the treatment team should be encouraged to maximise the patient's autonomy by encouraging

Case 3

A 67-year-old man with a known recurring brain tumour was admitted to the inpatient psychiatric unit because he had increasing confusion and mania, described by him as an 'out of body experience.' This was likely induced by dexamethasone, a symptomatic treatment for his brain tumour. He was admitted under section 2 of the Mental Health Act, as treatment at home was considered unsafe because of his lack of insight and his inability to care for himself. During his admission period, he was started on olanzapine. After discussion among the treatment team and the family, considering the man's wishes, a decision was made to gradually reduce the dose of dexamethasone in order to relieve the psychiatric symptoms, despite the impact this would have on the treatment of his brain tumour.

Case discussion

In this case, the patient suffered a mental illness as a result of the treatment for his progressive physical disease. On admission, his lack of capacity and lack of insight into his mental disorder warranted his detention under section 2 of the Mental Health Act. There was a conflict between the treatment for his physical disorder (dexamethasone to control the symptoms of a brain tumour) and the treatment for his mental illness. The decision was eventually made in his best interest.

Case 4

A 67-year-old man with a diagnosis of Parkinson's disease was admitted to the inpatient psychiatric unit because he had increasing confusion and persecutory delusions. Initially, he was deemed to have mental capacity and agreed to be admitted informally. Within a few days of admission, he became increasingly aggressive and disorientated. On assessing his capacity, he was unable to understand or weigh up the decision for admission. As a result, he was detained under section 2 of the Mental Health Act. During his admission period, his Parkinson's disease medications were appropriately adjusted, and he was started on a rivastigmine patch, both of which contributed to the resolution of his psychotic symptoms. His Mental Health Act section 2 was rescinded as he no longer met the admission criteria. Initially, he agreed to stay, allowing for the arrangement of his social support, but on the next day he asked to be discharged home. On assessing his capacity, he was clearly able to understand the situation, retain and weigh up the decision with good rationale, and communicate his wishes. His decision was respected, and he was therefore discharged home into the care of the community team.

Case discussion

The mental capacity of this man fluctuated over time. When he lacked capacity, the decision for his admission and treatment was made in the interest of his own health and safety, as well as the protection of other persons (his wife). The adjustment of the medications for his physical disorder was part of the treatment for his mental health disorder, and therefore fell under the definition of medical treatment given in the Mental Health Act 1983 (amended in 2007), not requiring his consent. Later, when he regained his capacity, his mental disorder was no longer of a nature or degree that warranted detention. Therefore, the Mental Health Act no longer applied. He expressed good rationale behind his wish to be discharged, so this was respected by the treatment team.

her to make her own decision. The Mental Capacity Act also states that 'a person is not to be treated as unable to make a decision merely because an unwise decision is made.' The rationale behind her second refusal of insulin treatment could have been viewed as an unwise decision, rather than as a result of her inability to weigh up information. On the other hand, her comment that 'it is within God's plan' was consistent with features of her mental disorder, making insulin part of her mental health treatment. Therefore, the decision whether to respect her decision may vary depending on the treatment team involved, and how these two legal frameworks are applied.

Cases three and four both involved patients with progressive physical conditions who were admitted to a mental health unit because they had features consistent with having a

Key points

- There is often significant overlap between mental and physical health which cannot be managed independently.
- The interface between the Mental Capacity Act 2005 and Mental Health Act 1983 can be complex, particularly among patients with co-existing mental and physical illnesses.
- The assessment of mental capacity in these patients should be performed on a case-by-case basis, should be decision-specific, and should last for a suitable period. Both legal frameworks may apply in managing these patients.
- Given that there is significant overlap between physical and mental health with bidirectional causality, it is often challenging to determine the optimal setting for managing patients with co-existing mental and physical health illnesses.
- The complexity in managing patients with both physical and mental ill-health may call for changes to optimise patient care, including integration of the legal frameworks as well as optimal involvement of specialists across both settings.

mental health disorder. However, the treatment for both patients involved adjustment of the medications for their physical illnesses. Therefore, it could be argued that a physical health hospital would be a more suitable setting for their treatment. On the other hand, a mental health hospital would be better equipped with the expertise in managing patients at risk to themselves or others. Given that there is significant overlap between physical and mental health with bidirectional causality, it is often challenging to determine the optimal setting for managing these patients.

The complexity of managing patients with both physical and mental ill health may call for changes to optimise patient care. First, it may offer a suggestion for fusion of the two legal frameworks, as exemplified by the Mental Capacity Act 2016 in Northern Ireland, which replaced the Mental Health Order (Northern Ireland) (Lynch et al, 2017). Under the Mental Capacity Act (Northern Ireland) 2016, impairment of decision-making capacity and best interest are the only criteria to be used when making decisions across health and social care. Additionally, it highlights the need for psychiatric specialists to assume greater responsibility in managing the physical health of patients with mental disorders. Psychiatrists are often reluctant to monitor the physical health of the patients, with many assuming their sole role to be managing psychiatric symptoms (De Hert et al, 2011). Finally, it may call for better integration of psychiatric and physical health services, allowing for optimal involvement of specialists across both settings.

Conclusions

This article uses four illustrative cases to highlight the intricacies of managing patients with co-existing physical and mental health disorders. This may call for fusion of current legal frameworks, and better integration of psychiatric and physical health services, in order to allow for optimal management of these patients.

Author details

[1]Department of General Medicine, Peterborough City Hospital, Peterborough, UK

[2]Older People's Mental Health, Cavell Centre, Edith Cavell Hospital, Peterborough, UK

Conflicts of interest

The authors declare that there are no conflicts of interest.

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