

The Mental Capacity Act 2005: mental capacity and mental illness

Bridgit Dimond

Abstract

In this series of articles on the Mental Capacity Act 2005 (MCA) the author now turns to the interrelation between mental capacity and mental disorder and between the Mental Health Act 1983 (MHA) (as amended by the Mental Health Act 2007 [MHA, 2007]) and the Bournemouth safeguards. The article explains how the MCA and the MHA are designed to cover distinct situations: the one mental capacity; the other mental disorder and the different definitions are considered. The article also looks at the different principles which apply and the different powers available under each Act. The different forms of protection under each Act are contrasted. Because of criticism of the UK by the European Court of Human Rights in the Bournemouth case, amendments have been made by the MHA 2007 to the MCA to provide protection for those incapable of making decisions who suffer from mental disorder and whose best interests require a loss of liberty.

Key words: Bournemouth safeguards □ Mental Capacity Act □ Mental disorder □ Mental incapacity □ Mental Health Act

The Mental Capacity Act 2005 (MCA) is concerned with making decisions or taking action on behalf of those who lack the requisite mental capacity to make their own. It provides a statutory definition of mental capacity as follows:

'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' (Section 2.1).

Mental disorder, which may or may not involve a loss of mental capacity, has an entirely different definition. It is set out in the Mental Health Act 1983 (MHA) and is as follows:

'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.'

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All the terms shown above, except mental illness, are further defined in the Act. The MHA 2007 abolishes the four separate categories of mental disorder and replaces it by the simple term 'mental disorder', but this amendment has not yet been brought into force.

It was the aim of the legislators of the MCA, as far as possible, to keep the two pieces of legislation separate and there are many sections in the MCA which states that a particular provision does not apply if a person is detained under the MHA. It is the purpose of this article to analyse how the two pieces of legislation exist side-by-side, where they overlap, and some of the possible complexities which face health professionals.

Differences between the MCA and the MHA Decision-making

The MCA enables decisions to be made on behalf of those who lack capacity. Decisions can cover all areas including personal welfare and property and affairs. The MHA only covers the treatment of mental disorder and does not enable decisions to be made in other areas of life.

Loss of liberty

While the MCA enables restraint to be used if it is in the best interests of a person lacking the requisite mental capacity, and only permits a loss of liberty (which would otherwise be a breach of article 5 of the European Convention on Human Rights) if the Bournemouth Safeguards are followed (see below).

Box 1. Scenario of a detained patient

Martha had suffered with schizophrenia for many years and for the most part her condition was controlled by medication. However, there were occasions when she failed to take her medication, and these sometimes led to detention in a psychiatric hospital. She also had diabetes and failed to keep to the diet. She was detained in a psychiatric hospital under section 2 of the Mental Health Act 1983 for treatment for her mental disorder. She was referred to a general hospital because of a gangrenous foot and was advised that she should have an amputation of her foot, as a life-sustaining necessity. She refused to give consent to this operation, but there were concerns as to whether she had the mental capacity to understand the significance of her refusal and to make a decision.

The MHA enables a patient to be detained for a specified period under the legislation in circumstances where there would otherwise be a breach of article 5.

Protections

Under the MCA, the Court of Protection is given supervisory jurisdiction for decisions made on behalf of mentally incapacitated adults and can appoint deputies and general and special visitors to interview those on whose behalf decisions are made.

Under the Mental Health legislation, mental health review tribunals (MHRT) hear cases for discharge from a section. In addition visits are made by the mental health commission of all detained patients to ensure that the legislation is complied with and to hear any complaints. There is a legal obligation on managers to refer patients to a MHRT if a specified time has passed within which the patient's detention has not been reviewed.

Best interests

The MCA requires that decisions are taken in the best interests of the patient as defined in the Act.

The MHA does not statutorily require decisions to be made in the best interests of the patient, and detention may be required for the protection of others.

Tools under the MCA and the MHA

The MCA enables a person to ensure that decisions are made on their behalf at a future time when he or she has lost the requisite mental capacity. By means of an advance direction a person when mentally competent may refuse specified treatments at a future time, when the capacity is lost.

By means of a lasting power of attorney a person when mentally competent can appoint a donee to make personal welfare and property and affairs decisions on their behalf. The power in relation to personal welfare only takes effect when the donor no longer has the requisite capacity.

There are no such powers under the existing Mental Health legislation but the amendments introduced by the MHA require account to be taken of an advance decision drawn up by a patient.

The Bournemouth gap

The European Court of Human Rights (ECHR) ruled in the Bournemouth case (*L vs UK* [Application No 45508/99] Times Law Report 19 October 2004) that the UK was acting illegally and contrary to article 5 of the European Convention on Human Rights when it allowed a person with learning disabilities to be detained in a psychiatric hospital using common law powers and not being placed under the MHA. The effect of this decision would mean that many thousands more people who lacked the capacity to give consent to admission would be locked up under the MHA. This was seen as too bureaucratic and formal a solution. As a consequence the Department of Health undertook to remedy the defect identified by the ECHR and published a consultation paper in March 2005 for options to fill the Bournemouth gap. Its report on the consultation was published on 29 June 2006.

Subsequently amendments have been made to the MCA by the MHA 2007 to provide protection for those adults who are incapable of making decisions on admission and treatment but whose liberty needs to be restricted. The provisions include the following safeguards:

- A supervisory body (local authority or primary care trust) to authorize the loss of liberty
- Assessments of the individual to ensure that the required conditions are satisfied before liberty can be lost (including an assessment that deprivation of liberty is necessary in their best interests to protect the person from harm)
- The supervisory body to determine the duration of the loss of liberty which cannot exceed 12 months
- The appointment of a person independent of the supervisory body and the care home or hospital to represent the person's interests for the duration of the authorization
- The loss of liberty can be challenged by application to the Court of Protection
- The principle that those exercising these powers must act in the best interests of the person and in the least restrictive manner.

Further details on the Bournemouth safeguards can be obtained from the websites of the Department of Health and the Ministry of Justice.

Application of law to the scenario

Martha is detained under the MHA. This means that all decisions relating to her treatment for mental disorder must be made under Part 4 of that Act. Her responsible medical officer can decide what she requires and even if she has the mental capacity to refuse to consent, her refusal can be overruled under the powers given by the MHA. Only after 3 months of compulsorily medication is it necessary to bring in a second medical opinion on what should be given to her. (If Electro Convulsive Treatment (ECT) was recommended for her, then a second doctor must be appointed immediately and new provisions covering ECT are to be introduced under the MHA 2007.) The powers under Part 4 of the MHA, however, only relate to treatment for mental disorder. Section 28 of the MCA makes it clear that where treatment for mental disorder is being given to a patient detained under the MHA then:

'Nothing in the MCA authorizes anyone to give a patient medical treatment for mental disorder, or to consent to a patient 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 4 of the MHA.'

However, the proposed amputation of her foot cannot be seen as treatment for mental disorder, therefore, this treatment does not come under Part 4 of the MHA.

The amputation comes under the MCA. The first question which has to be asked is, does Martha have the requisite mental capacity to give or withhold consent? Is Martha unable to make a decision for herself in relation to the amputation because of an impairment of, or a disturbance in the functioning of,

her mind or brain? If the answer to that question is 'no' then Martha's refusal must be respected. However, if she is assessed as lacking the requisite mental capacity, then action can be taken in her best interests according to the criteria set out in section 4 of the MCA. Her wishes, feelings, values and beliefs should all be taken into account in determining what is in Martha's best interests. For example, if Martha had belonged to a religious group which did not believe in surgery, this could be taken into account in determining her best interests. In the event of a dispute over either her lack of capacity or what is in her best interests, an application could be made to the Court of Protection for a declaration.

Conclusion

Both the MCA and the provisions of the MHA 2007 have taken many years to develop and be implemented. The future will show whether they work well side-by-side and what modifications are required to both sets of legislation. Both Acts of Parliament are significant in safeguarding the rights of the individual and close monitoring will be essential to ensure that they are effective in this aim. **BJN**

L v United Kingdom (Application No 45508/99) Times Law Report 19 October 2004
Department of Health (2006) *Protecting the Vulnerable: The "Bournewood" Consultation*. HMSO, London

KEY POINTS

- The Mental Capacity Act 2005 (MCA) and the Mental Health Act are designed to cover distinct situations: one relates to mental capacity; the other to mental disorder.
- They operate according to different principles and use different tools.
- Different forms of protection are provided for those coming under the Acts.
- The Bournewood Gap has been filled by amendments to the Mental Capacity Act to provide protection for those incapable of making decisions who suffer from mental disorder and whose best interests require a loss of liberty.