

## Chapter

## 1

# Introduction

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The Mental Capacity Act 2005 (MCA) received Royal Assent in April 2005, coming into force during 2007 (MCA, 2005). The MCA incorporates into statute, principles and practices that had been established, through case law, over the years. It sets out how mental capacity is defined in law and how ‘best interests’ should be ascertained when a person lacks the requisite capacity to make the decision in question.

Prior to its introduction, clinicians and carers were in uncertain legal territory when making decisions of a social, health or financial nature for those individuals without capacity. Importantly, however, the statute is more than a solution to a recognised gap in English and Welsh Law; it is also about a culture change. It requires those in a caring and/or professional capacity to engage with a person, who may lack decision-making capacity, in a manner that involves him/her, and others important to them, in the process of decision-making. In doing so, they must have regard to past and present beliefs and values of the person concerned. The MCA, in its approach, is not so much giving power to others to make decisions, rather it is asking those who have to take a decision on behalf of another to do so in a manner that is transparent, justifiable and respectful of all issues relevant to that person. It is applicable in any situation where someone might lack capacity, including, for example, the person transiently incapacitated through excess alcohol or from a head injury requiring treatment, to people with potentially more enduring incapacity due to dementia or learning disabilities. It is therefore as relevant in intensive care as it is in social care. The MCA is both about the ‘here and now’, when an immediate decision may have to be made on behalf of a person lacking capacity at the present time but also about planning for the future; how individuals, whilst having capacity, can determine who can take decisions on their behalf in the event that they lose capacity through illness or injury at a later date.

Whilst it was a very significant Act of Parliament, much of what the MCA has brought into practice is what practitioners and others should have been adhering to on the basis of the developing case law. In its early development work, the Law Commission stated that people should be ‘enabled and encouraged to take for themselves those decisions they are able to take’. The pivotal concept, when determining whether or not the MCA is applicable, therefore, is whether or not the person having to take the decision has the requisite decision-making capacity. This concept of ‘capacity’ is defined in the dictionary quite simply as ‘the ability or power to do’. In a legal and/or clinical context, this might refer to an individual’s ability to make a decision regarding a healthcare matter, to undertake the process of making a will or to decide where to live – in other words decisions encompassing the social, welfare and the health needs of an individual (BMA, 2018).

The second edition of this book draws upon experience gained over more than a decade of the MCA being in force. In addition to updates on recent case law, it also focuses on its

application in different settings or circumstances, such as end-of-life planning and the relevance of MCA legislation in this regard. Of particular emphasis in this updated edition is the complexity of the use of the Deprivation of Liberty Safeguards (DoLS) that came into law as an addition to the MCA, followed by the development of case law in its wake. The ruling in the cases of *P v. Cheshire West and Chester Council* as well as *P and Q v. Surrey County Council* has led to a paradigm shift in our understanding of the terms ‘deprivation’ versus ‘restriction’ of liberty, and has thereby extended the circumstances when DoLS should be applied. The Supreme Court’s view on this is epitomised by the phrase used by Baroness Hale in her ruling on *Cheshire West* – ‘a gilded cage is still a cage’. As a result of this ruling, there has been a significant increase in the number of applications for DoLS ‘standard authorisations’ in England, overwhelming an already busy service. Reform is in the offing and Chapter 4 will discuss the replacement scheme for the DoLS, which instead have been termed the ‘Liberty Protection Safeguards’.

This introductory chapter gives an overview of the fundamental ethical and philosophical thinking that has shaped the MCA and a brief description of its historical development and scope. It also compares and contrasts the remit of the MCA 2005 with the Mental Health Act (MHA) 1983 as amended in 2007, as there are specific situations when, arguably, either Act might be applicable. Although the Human Rights Act 1998 is not formally dealt with, either in this chapter or the book as a whole, its principles are clearly interwoven into the fabric of both Acts.

## Medical ethics

It would be incomplete if a book on the MCA made no mention of the guiding principles that have come to underpin medical practice and this statute – sometimes referred to as the ‘bioethical’ approach. This is concerned with the framework within which a medical decision may be reached based on an individual’s views, values and wishes (Harris, 1985) and also with how conflicts and dilemmas might be resolved when there are disagreements. Such conflicts may be as extreme as whether or not to start or to continue specific treatments for life-threatening illnesses. However, in essence the clinical situation is described as follows: the doctor advises as to the treatment options taking into account the patient’s condition, prognosis and other relevant external factors. The patient, on due consideration, may or may not decide to accept the proposed treatment(s). The moral imperative remains with the doctor, using his/her medical expertise, to consider, after diagnosis, all the appropriate steps available to treat the medical condition and to give the patient sufficient information so that he/she can make a choice as to which treatment, if any, he/she wishes to undergo. Even though the competent patient has the absolute right to accept or refuse any of the treatments offered (except in the case of the assessment and treatment of a mental disorder where the MHA might be used to override the refusal of a competent person), barring the most exceptional circumstances, the patient cannot him/herself demand a particular treatment (Mason & Laurie, 2006).

Although a detailed discussion into the philosophical approaches that underlie the development of bioethics is beyond the scope of this book, it is appropriate to consider the theories that have influenced current medical practice. Various ethicists have put forward ideas based on different philosophical principles that have focused on either the rightness or wrongness of an act itself (deontological or Kantian theories), or the extent to which any act

promotes good or even bad consequences (utilitarianism). In the former, the essential message is that we should respect an individual’s right to autonomy and that each person is treated as an end in him/herself, rather than as a means to an end. Deontological theories are less concerned with the consequences or outcome of any act but rather with the factors that make it morally acceptable, and thereby uphold the integrity and beliefs of an individual. In contrast, utilitarianism highlights the moral dilemmas faced when considering the outcome of an act, that is the extent to which it leads to positive or negative consequences. This implies that the moral worth of an action is determined only by its resulting outcome. The utilitarian measure of a positive outcome, therefore, is the maximisation of happiness.

Drawing on these and other relevant philosophical theories, Beauchamp & Childress (2001) have suggested the concept of ‘principlism’ as a way to resolve medical ethical dilemmas. They broadly argue that the justification for our actions should be based on accepted values. They suggest that ethically appropriate conduct is determined by reference to four key principles, which are to be taken into account when reflecting on one’s behaviour towards others. These include:

- the principle of respect for individual autonomy (i.e. individuals must be viewed as independent moral agents with the ‘right’ to choose how to live their own lives),
- the principle of beneficence (i.e. one should strive to do good where possible),
- the principle of non-maleficence (i.e. one should avoid doing harm to others), and
- the principle of justice (i.e. people should be treated fairly, although this does not necessarily equate with treating everyone equally). (Beauchamp & Childress, 2001)

The principles of beneficence and non-maleficence are not by any means new concepts and their origins go back to the Hippocratic Oath, which states:

I will prescribe regimen for the good of my patients according to my ability and judgment and never do harm to anyone.

According to advocates of the four-principles approach, one of its advantages is that, because the principles are independent of any particular philosophical theory, theorists working in a variety of different traditions can use them. However, this approach has been criticised on the basis that it does not offer any clear way of prioritising between the principles in cases where they conflict, as they are liable to do (Savulescu, 2003). The principle of autonomy, for example, might conflict with the principle of beneficence in cases where a competent adult patient refuses to accept life-saving treatment, as will be highlighted in the next section. How then can a medical practitioner respect a patient’s right, in this case to allow his life to end, whilst simultaneously striving to do good, where possible, and at least avoid doing any harm? Current ethical thinking, which is moving away from paternalistic medical practice, indicates that, regardless of the consequences of the treatment, the treatment provider must accept the decision of the recipient. Yet this may not be applicable in all cases – most importantly where a patient does not have the capacity to decide. For this reason, greater clarity is needed as to when and under what circumstances each particular principle takes precedence. Despite these limitations, the principles remain useful as a framework in which to think about moral dilemmas in medicine and the life sciences.

Autonomy versus beneficence

The central notion around which informed choice and the importance of decision-making capacity is based is the principle of autonomy. ‘Autonomy’ has been variously defined but,

in this context, implies self-determination. People are autonomous to the extent to which they are able to control their own lives by exercising their own cognitive abilities. The acknowledgement of autonomy has served, in part, to overthrow medical paternalism and has led to the elevation of the patient from the previous position of being a recipient to being an equal partner in a treatment plan (Kirby, 1983).

In the context of the delivery of healthcare, ethicists consider respect for an individual's autonomy as morally required because it is that individual's life and well-being which are at stake in medical treatment. Respect for human dignity requires that the person him/herself should ultimately determine what his/her well-being consists of, and therefore what should or should not be done to him/her in order to achieve it. This conception of autonomy clearly implies that patients have a 'self' which is capable of determining what should or should not happen – that is, they have a set of values, the sense of what is or is not in their own interests, which may be described as the patient's 'own' values (Harris, 1985). In prioritising individual values, clinicians recognise the importance of patients' views on illness, dying, death, goals for the future, and personal relationships, when making health-care decisions. These values are highly personal and likely to result from the patient's own experience of life and his or her own reflections on that experience.

The significance of self-determination and the weight placed on autonomous choice by the courts is clearly evident in case law. As Lord Donaldson MR stated in the case of *Re T (Adult)* (1992):

As I pointed out at the beginning of this judgement, the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent. That his choice is contrary to what is to be expected of the vast majority of adults is only relevant if there are other reasons for doubting his capacity to decide.

Although it is evident that contemporary medical and legal practices broadly embrace the concept of autonomous choice of the individual, it is important to bear in mind that full autonomy and autonomous choices are ideal concepts, which we can, realistically, only attain in partial measure. This is due to the presence or not of factors that may compromise an individual's autonomy, including: difficulties in reasoning, which may be temporary or permanent; the inadequacy and uncertainties of the information available to inform choice; and fluctuations in the stability of an individual's wishes (Harris, 1985). There are also other limitations to the claims of autonomy, which include economic and financial constraints – a fair distribution of resources would clearly not allow unlimited privileges to a single individual. Personal choice must therefore be viewed in the context of the needs of 'a community' as a whole. Notwithstanding these limitations, both the ethical and legal duty lies with the healthcare professional to ensure that any impairments and limitations are minimised when initiating medical interventions.

## Consent and the doctrine of necessity

It is a requirement of English Law – specifically the law pertaining to assault and battery – that consent must be obtained before any treatment or procedure involving the patient can be lawfully carried out. This is clearly expressed in a statement by Cardozo J:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault. (*Schloendorff v. Society of New York Hospital* [1914])

Therefore, as a general rule, medical treatment, even of a minor nature, should not proceed unless the doctor has first obtained the patient’s consent, which may be either expressed or implied. There are nonetheless exceptions to the above rules, which are essentially to do with situations, such as unconsciousness, where consent cannot be obtained, or where, due to a disability of the brain or mind, a person lacks the capacity to take the decision. Until the passing of the MCA, the principle that applied to treatment in these cases was that of the *necessity doctrine*. The basis of this doctrine is that, acting out of necessity in the best interests of a patient operates as an alternative defence to that of consent, which remains the preferable defence. Although the doctrine of necessity arose in relation to emergencies, in many cases this defence can be used when there is not an emergency in the ordinary sense of the word. Rather, when the usual defence is not available, that is consent, but the treatment is still considered by the treating doctor as necessary.

The application of the doctrine of necessity has been clarified by two Canadian cases where the courts clearly differentiated the overwhelming need for a particular treatment from the mere expediency of such an intervention. In the first case, *Marshall v. Curry*, the plaintiff sought damages against the surgeon who had removed a testicle in the course of an operation for a hernia. The surgeon stated that the removal was essential to the patient’s health and life as the testicle was diseased. The court held that the removal of the testicle was therefore necessary and could not have been done at a later date. In another case, however, *Murray v. McMurchy*, the plaintiff succeeded in an action of battery against a doctor who had sterilised her without her consent. In this case, the doctor had discovered, during a caesarean section, that the condition of the plaintiff’s uterus would have made it hazardous for her to go through another pregnancy, and he took the decision to tie the fallopian tubes. As there was no pressing medical need for the procedure to be undertaken, the court held that it would have been reasonable to postpone the procedure until after obtaining the patient’s consent.

Thus urgent or expedient medical interventions are not an exception to the requirement to obtain consent. Minimum interventions to preserve life are expected in emergency situations, but in cases where there is an expectation that capacity to make a decision may improve, case law and now statute require the consideration by the healthcare professional of a delay in treatment if, on medical grounds, it is reasonable and possible to do so. The implication, therefore, prior to the MCA was that consent was imperative to all treatment; however, if that consent was not possible and the intervention was necessary, urgent and/or in the patient’s best interests, the doctrine of necessity could have justified action in specific clinical situations. When applying this doctrine of necessity, it also had to be demonstrable that treatment could not have waited for the capacity of the individual to recover. It is this concept that is now codified in the MCA 2005. A surgeon working in England and Wales faced now with either of the above dilemmas, that is a patient who clearly lacked capacity due to being under a general anaesthetic, would have to follow the best interests process, unless urgent and life-saving action was required and the intervention could not wait. Thus, it is good practice for surgeons to seek their patients’ views as to what they might wish to be done in the event of possible, but unexpected, clinical situations arising whilst he/she is under general anaesthetic.

In the UK, current medical and legal thinking incorporates these above bioethical approaches when resolving ethical dilemmas in the practice of healthcare delivery. This is clearly reflected not only in the MCA legislation, but also in the reform of DoLS legislation with the Mental Capacity (Amendment) Bill, July 2018 and the Interim Report into the Independent Review of the Mental Health Act (May 2018). These legislative changes

go some way in addressing the principles proposed by Beauchamp & Childress (2001), of autonomy, justice, beneficence and non-maleficence.

## Development of Mental Capacity Legislation

Scotland was the first country in the UK to formally enact legislation to enable substitute decision-making under particular circumstances (Adults with Incapacity (Scotland) Act (2000)). In England and Wales, the impetus for development of capacity legislature arose for a number of reasons, including the needs of professionals and carers who required guidance as to what should happen if a medical, social or financial decision needed to be made for a person who they recognised was unable to take that decision for him/herself. The case of *Re F* (1990) in particular stimulated debate about the role of the courts in medical decisions. *Re F* involved the medical sterilisation of an adult lacking mental capacity, who was sexually active and whose family were concerned about an unintended pregnancy. The court's ruling in favour of medical sterilisation stated that doctors have the power and, in certain circumstances, the duty to treat incapacitated patients provided the treatment is in their best interests. In this instance, an unplanned pregnancy was not considered to be in *F*'s best interests. Some argued, however, that *Re F* went too far in giving doctors sole responsibility and power to make unilateral decisions, based on the doctrine of necessity. The concern was that 'leaving medical decisions solely to the medical profession might imply that they were to be taken only on medical criteria' (Hoggett, 1994). It was further argued that certain decisions were so important that a court, or at least an independent forum of some sort, should make them.

The reforms put forward by the Law Commission focused on the fact that people should be enabled to take decisions for themselves but, under certain conditions and where necessary and in their best interests, someone else should be in a position to take decisions on their behalf. It was recognised that there was a wide range of decisions made by individuals, ranging from medical or dental decisions, to decisions about property and affairs, and broadly how to lead the activities of everyday life. Whilst it is, in general, appropriate for adults to take such decisions for themselves, the Law Commission highlighted that people who were vulnerable and may lack capacity should be protected against exploitation of any kind. Any legislation should be both enabling and protecting. The consultation paper *Mentally Incapacitated Adults and Decision-Making: An Overview* (Law Commission, 1991) recommended that there should be a single comprehensive piece of legislation to make new provision for people who lack mental capacity. The resultant Mental Incapacity Bill was examined by a pre-legislative scrutiny committee of the Joint Houses of Parliament before going to the floor of both Houses for due consideration. This pre-legislative committee, having taken written and oral evidence, made a number of recommendations, including changing the name to 'The Mental Capacity Act', a requirement for advocates and the need for the Act to address the complex issue of research involving people lacking the capacity to consent to inclusion in the research. The Government accepted many of the recommendations and the Mental Capacity Act (MCA) received Royal Assent on 7 April 2005 just prior to the dissolution of Parliament for the general election.

The broad aims of the Law Commission reforms are now embodied in statute. In Section 1 of the MCA 2005, the key principles that underpin the use of the Act are stated. These include:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.



- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done or decision made, under this Act, for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be affectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

Summary of the provisions of the MCA

Whilst the Code of Practice is an extremely useful guide in interpreting the provisions of the MCA 2005, a brief introduction to some of the significant changes that came about with the MCA will be presented here (Department of Constitutional Affairs, 2007). The MCA deals broadly with two specific scenarios. The first involves ‘Acts in connection with care and treatment’ in which an individual, lacking the capacity to make a particular decision, which it would be normal for that person to make, needs that decision to be made on his/her behalf. Secondly, it addresses the issue of how a competent individual, wishing to plan for the future in the event of later incapacity through illness or injury, might make their wishes known to, or appoint, a person to take the decision on their behalf in the event that they lack the capacity to do so for themselves. This involves the following options:

- *Lasting power of attorney (LPA)*: The MCA allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is not dissimilar to the previous Enduring Power of Attorney in relation to property and affairs, but the MCA also allows people to empower an attorney to make health and welfare decisions.
- *Advanced decision-making*: In addition to giving professionals and carers legal rights and obligations to ensure care is provided to those without capacity, the Act makes provisions for patients to have their own specific wishes respected even if/when they are incapacitated. This was addressed by the introduction of the ‘advance decision to refuse treatment’ (MCA 2005, Sections 24–26). A person can express his/her wish as to what should happen if he/she lacked the capacity to make the necessary decision. Where such advance decisions state a *wish* for some particular treatment or some other action, they must be considered but they are not necessarily legally binding as a person cannot insist on something that may be impossible when the time comes (e.g. wanting to live with someone who couldn’t or doesn’t wish to care for them), or may be medically inappropriate and harmful (e.g. the use of a treatment that was inappropriate for the illness in question). However, valid and applicable advance decisions to *refuse* treatment are legally binding as they represent an extension of the individual’s right to refuse treatment when having capacity.

An important development was the introduction of independent mental capacity advocates (IMCAs), for those who have not appointed a lasting power of attorney and who have no others who might support them when an important decision needs to be made. The IMCA can speak on behalf of individuals, who are without family or friends, to represent their ascertainable wishes as far as these are possible to ascertain. Its purpose is to help vulnerable people who, whilst lacking capacity, require decisions to be made. These may vary from serious medical treatment to a change of residence – for example, moving to a hospital or care home. NHS bodies and local authorities have a duty to consult the IMCA in

decisions involving people who have no family or friends. Of course, an IMCA, unlike a donee, *cannot* make a final decision on behalf of a patient; however, they offer independent advice to the professional bodies as to what they believe may be in patients' best interests.

During the process of reform, the Law Commission considered the need for an integrated statutory jurisdiction for making personal, welfare, healthcare and financial decisions on behalf of those lacking capacity and for resolving disputes through a new court system. The importance of this area of jurisdiction was emphasised in the setting up of the Court of Protection (CoP), which has jurisdiction relating to the whole MCA. The CoP has the remit of being the final arbiter in matters related to mental capacity, best interests principles, appointment of a lasting power of attorney and other matters in connection with interventions providing for those without capacity when specific decisions have to be made. It deals with decisions concerning property and affairs, as well as health and welfare decisions. It is particularly important in resolving complex or disputed cases. These courts are based in venues in a number of locations across England and Wales and are supported by a central administration in London. Recent data suggest that in excess of 90% of applications made to the CoP concern property and financial decisions, whilst most of the remaining applications concern health and welfare decisions on behalf of the individual lacking capacity (Alghrani *et al.*, 2016).

A new Public Guardian was created under the Act. The Public Guardian has several duties and is supported in carrying out these duties by the Office of the Public Guardian (OPG). The Public Guardian and his staff are the registering authority for lasting power of attorney and deputies. They supervise deputies appointed by the CoP and provide information to help the CoP make decisions. They also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating.

## **The Mental Health Act 1983 (with 2007 amendments) and the Mental Capacity Act 2005: overlapping and differentiating criteria in their application**

Mental health professionals are perhaps in the unique position to observe and compare the statutes and the Code of Practice of both the MHA 1983 and the MCA 2005. In doing so, it becomes clear that these two Acts are based on different and potentially conflicting principles. The MCA 2005 respects the principle of autonomy for capable adults and sets out 'best interests' principles regarding the management of adults who lack capacity to make decisions for themselves. The use of mental health legislation in the form of the amended MHA 1983 enables treatment of a mental disorder to non-consenting patients, *whether or not the individual is capable*, a fact which has been considered by many to be discriminatory (Department of Health, 1999). The MHA is largely concerned with the circumstances in which a person with a mental disorder can be detained compulsorily for treatment of that disorder. It also sets out the processes that must be followed, and the safeguards for patients, to ensure that they are not inappropriately detained in hospital. Using a rather broad description of the purpose of the legislation, it is to ensure that people with serious mental disorders can be 'detained in the interests of his/her health or safety, or with a view to the protection of other persons' (MHA 1983).

Notwithstanding the many distinctions, there is some commonality in the defining criteria of the two acts. The Mental Capacity Act 2005 defines an individual as lacking



capacity ‘if at the material time he is unable to make a decision for himself in relation to a matter because of an impairment of, or disturbance in the function of, the mind or brain’; the Mental Health Act 2007 defines a mental disorder simply as ‘any disorder or disability of the mind’. Other overlapping principles relate to the requirement to use the least restrictive alternative when considering care and minimising restrictions on liberty. Both statutes enable clinicians to care for patients who need healthcare interventions and who either cannot (because of incapacity) or will not, in the case of MHA 2007, agree to what is considered to be the necessary intervention. The legislation takes into account the wishes of the nearest relative and those of family or friends, and, where there is no one at hand, independent mental capacity advocates and independent mental health advocates are available to speak on behalf of the individual, although the final arbiter in terms of the action proposed is the treating clinician. The significant differences between the two Acts primarily relate to the condition for which treatment is required. Mental health legislation usually, but not always, takes precedence over mental capacity legislation when health professionals are dealing with the treatment of a mental disorder. When dealing with physical or non-psychiatric treatment in a patient without capacity, the MCA 2005 legislation is applicable.

Occasionally, however, there is debate as to which of the legal statutes apply and emerging case law suggests that in several instances, the CoP’s opinion is required to provide clarity regarding the matter. *GJ v. the Foundation Trust* is a case in point. *GJ*, a gentleman with a diagnosis of vascular dementia, Korsakoff’s (2009) syndrome due to alcohol abuse and diabetes, was detained in hospital initially under the MHA 1983 for treatment of his mental disorder. In due course, the hospital felt it would be more appropriate to treat him under mental capacity legislation, as he was primarily receiving nursing care and treatment for his diabetes. A standard authorisation for the MCA Deprivation of Liberty Safeguards (DoLS) was made on 13 August 2009 and additionally an application was made to the Court of Protection. The question posed to the courts was whether he was ineligible to be dealt with via the MCA DoLS on the grounds that his circumstances fell more properly within the scope of the MHA 1983 and that he was actively objecting to treatment. The judge resolved the dilemma by clarifying that if it were not for the treatment of the physical problem, the patient would not be detained; thus, the only reason for detention was for physical treatment. Clearly, this is not within the scope of MHA legislation. In addition, the judge held that although *GJ* could not be detained under DoLS authorisation *purely* for the treatment of his mental disorder, he could be so in order to receive care and treatment for his physical disorder (diabetes). As such, he was eligible to be deprived of his liberty and the MCA rather than MHA was the more appropriate statute in this case.

The judge also highlighted, as a general point:

The MHA 1983 has primacy in the sense that the relevant decision makers under both the MHA 1983 and the MCA should approach the questions they have to answer relating to the application of the MHA 1983 on the basis of an assumption that an alternative solution is not available under the MCA.

It is therefore important that treating clinicians are familiar with the underlying principles of the MCA 2005 and the MHA 1983 and the different clinical situations within which each legislative framework can be applied.

Table 1.1 summarises some of the key legal, and clinical, differences between the two Acts and circumstances under which one or the other might apply (Dimond, 2008).

**Table 1.1** Main clinical and legal differences between the Mental Health Act 1983 (as amended in 2007) and the Mental Capacity Act 2005

	Mental Capacity Act 2005 (MCA)	Mental Health Act 1983 (MHA)
<b>Mental capacity</b>	The MCA applies only to those who are unable to make specific decisions.	The MHA does not require a lack of capacity.
<b>Mental disorder</b>	MCA only applies to people with mental disorder who lack the capacity to make the decision in question.	The MHA only applies if the patient requires assessment and/or treatment for mental disorder as defined by the Act.
<b>Best interests</b>	The MCA requires that all decisions be taken in the patient’s best interests.	The MHA does not require decision to be made in the best interests of the patient and detention may be required for the protection of others.
<b>Range of treatments</b>	MCA enables whatever care and treatment is considered to be in the best interests of the patient.	MHA only authorises the administration of treatment of Mental Disorder. However, this has a wide definition and may include feeding and basic care.
<b>Protections available</b>	The MCA provides protection via the Court of Protection but an application has to be made to trigger its jurisdiction.	The MHA has a wide range of protections including Mental Health Review Tribunals (MHRT) and managers with responsibilities for making applications to the MHRTs if the patient has not done so themselves.
<b>Restraint</b>	The MCA enables only limited restraint to be used in narrowly defined circumstances. It originally did not permit a loss of liberty within the definition of Article 5 of the Human Rights Act. This proviso was repealed in the MHA to fill the Bournemouth Gap (see Chapter 4). It will, therefore, be possible for loss of liberty under the MCA where the DoLS process has been approved.	The MHA provides the legal framework within which a patient can lose his or her liberty and be restrained lawfully without any contravention of Article 5.
<b>Decision when capacity is lost</b>	MCA recognises several devices for ensuring that decisions are made in accordance with the wishes of a person when he or she had the requisite mental capacity, to cover situations when capacity is lost. These include advance decisions and lasting power of attorney.	The MHA, as amended, does take into account advance decisions. Clinical decisions are the responsibility of the responsible clinician; and in certain circumstances, where a person is unable or unwilling to give consent to treatment for a mental disorder, a second medical opinion must be sought before the treatment can be given.