The Interface between MHA and MCA/DoLS

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The starting point

“In medicine, as in the law, it is not always possible to discern clear dividing line”

Baker J.

Criteria for the use of the MHA

s.2 (2) An application for admission for assessment may be made in respect of a patient on the grounds that -

(a) he is suffering from a mental disorder of a nature or degree which **warrants** the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; **and**

(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

s.3 (2) An application for admission for assessment may be made in respect of a patient on the grounds that -

(a) he is suffering from a mental disorder of a nature or degree which makes it **appropriate** for him to receive treatment in hospital, **and**

(b) it is **necessary** for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section, **and**

(c) appropriate medical treatment is available for him

Qualifier and Exclusions

Qualifier

- s.1(2A) – a person with learning disability shall not be considered by reason of that disability to be –

(a) Suffering from mental disorder…

(b) Requiring treatment in hospital for mental disorder…unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part

Exclusions

- s.1(3) – Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind

Treatment

s.145(1) ‘medical treatment’ includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care

Secretary of State for Justice v RB [2011]

The Court of Appeal said that the policy of the Act is treatment, not containment

Interface

- Schedule 1A, Part 1 (DoLS/MHA)
- Part 4 and Part 4A MHA 1983
- Chapters 13, 24, 25 and 26 MHA 1983, code of practice
- The updated Mental Capacity code of practice?

Which Act?

	Individual objects to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder	**Individual does not object** to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will received there for mental disorder
Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the **MHA** is available	The **MHA** is available. **Voluntary admission** might also be appropriate. Neither DoLS/LPS authorisation or Court of Protection order available
Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the **MHA** is available	The **MHA** is available. **DoLS/LPS** Authorisation is available, or potentially a **Court of Protection order**

Interface

- Patients who are who are not objecting to being in hospital for mental health treatment (or to that treatment), and lack capacity to consent to the admission may be made subject to a DoLS authorisation or be detained under the MHA

- Patients who are liable to being detained in hospital may be made subject to a DoLS authorisation providing there is no conflict with the conditions to the community section.

Interface - exceptions

- A patient who is subject to a conditional discharge **who lacks** capacity to consent to the conditions that amount to their being deprived of their liberty **may be** subject to a DoLS authorisation

- A patient who is subject to a conditional discharge **who has** capacity to consent to the conditions that amount to their being deprived of their liberty **cannot** be conditionally discharged to such circumstances

Capacity interface - Treatment

- MHA sets out times where capacity **must** be assessed and who by.
- MHA sets out where capacitious refusal can be overruled (admission to hospital, restraint, seclusion, treatment, transfer, Tribunal and Hospital Managers Hearings, withholding of mail)
- MHA does not recognise advance decisions to refuse treatment for mental disorder (except for ECT)
- MHA does not recognise advance decisions to refuse life sustaining treatment for the treatment of mental disorder
- MHA treatment is limited to treatment for the mental disorder, but does extend to physical disorder which have given rise to the mental disorder or arise as a direct consequence of the mental disorder

s.63 MHA – Treatment not requiring consent

- A range of acts ancillary to the core treatment that the patient is receiving fall within the term “medical treatment” as defined in s.145(1)

- Treatment is capable of being ancillary to the core treatment if it is nursing and care “concurrent with the core treatment or as a necessary prerequisite to such treatment or to prevent the patient from causing harm to himself or to alleviate the consequences of the disorder…”

s.63 MHA – Scope

- Relieving the symptoms of the mental disorder is just as much a part of treatment as relieving the underlying cause (reflected in s.145(4)
- Treatment for a physical disorder will not amount to a treatment for a mental disorder where the treatment for the physical disorder is entirely unconnected with the pre-existing mental disorder
- “may apply to the treatment of any condition which is integral to the mental disorder” ie is treating a symptom of the disorder

B v Croydon Health Authority [1995]

s.63 MHA – The courts say includes;

- The suturing of a wound created in the act of deliberate self-harm and the administration of antibiotics to prevent infection

- Medical and surgical treatment for the physical consequences of self-poisoning or self-injury if they can be categorised as either the consequence of or a symptom of the patient's mental disorder. The treatment could include measures taken to prevent the patient from interfering with a self-inflicted wound

Manchester v JS

- Evidence of objection
- Evidence of mental disorder within the meaning of the MHA
- Evidence of risk
- Very restrictive care plan that was aimed at responding to one or more of the manifestations or symptoms of her mental disorder.
- Treatment as defined by the MHA was being provided
- She lacked capacity to consent to the admission or the care and treatment
- The discharge care package was not ready and there was nowhere for JS to be discharged to.

- Impact from the interpretation of s.145(1) – Delayed discharges.
- Impact - Tribunal or Hospital Managers discharging the section

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Scenario

- Bob is admitted to a Learning Disability unit under s.2 MHA under the qualifier conditions.
- Assessment finds no evidence of mental disorder but abnormally aggressive and seriously irresponsible behaviour remains present and above his usual baseline. Was regraded to a s.3
- Assessment and treatment has resulted in the usual clinical team learning Bobs triggers and warning signs and are usually able to deescalate the situation and direct him to self-soothing activities to help him self-regulate and avoid an aggressive outburst.
- At renewal the RC finds that Bob has returned to his usual level of challenging behaviour (when upset will nip or hit out at staff). That Bob only remains on the unit because his placement has served notice and the alternative placement identified is in the process of being built and will then need to work through recruitment and CQC registration.

What are your options?

Scenario

- Chloe is 16years and 8 months and has been admitted to the acute Trust for treatment of her eating disorder. Her BIM is 12 and there is a real and immediate risk of a sudden cardiac event. She wishes to die and is objecting to the NGT feeding removing it at any opportunity or preventing its insertion. The acute Trust assess Chloe to have capacity to make her treatment decisions.

- The wait for a specialist Tier 4 bed is currently 4 months.

- The Gastro team say that treatment is possible to bring her weight to a safe level for transfer to a specialist Tier 4 bed.

- The treatment plan includes using sedation 2:1 (minimum) observations, cot sides and physical restraint. Physical restraint carries risks due to her low BMI and fragile state. Sedation cannot be provided orally only via cannula or potentially general anesthetic in ICU.

- Without treatment Chloe will die. Her parents want her to be treated.

What are your options?