The Essex Autonomy Project

Briefing Document

Mental Capacity Act 2005

&

Mental Health Act 1983

(Version 2)

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Introduction

In UK law, adult individuals are presumed to be sufficiently competent to make decisions about their own life, and to face the consequences that follow. However, in some circumstances it may appear that an individual lacks the capacity necessary to make certain choices, particularly those that are complex and/or give rise to potentially grave outcomes. The Mental Capacity Act 2005[1] (hereafter, the MCA) aims to provide a legal framework within which carers and care workers may judge an individual's capacity to make certain decisions where it is in doubt. Doubt may arise as a result of both physical and mental impairment, which may be either permanent or temporary. Where capacity is judged to be insufficient, others are permitted to make decisions on behalf of that individual, in that individual's best interests. Where, on the other hand, capacity is judged to be adequate, an individual is entitled to decide for herself, even if that choice produces serious risks to health or premature death.

The provisions of the MCA are distinct from the provisions of the Mental Health Act 1983 (hereafter, the MHA). The former 'aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves'[2], and to provide legal protection for carers/care workers. In contrast, the latter aims to 'allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people'.[3] So, whilst the MCA is concerned with individuals who lack capacity to make decisions for themselves, and legal protection for their carers/care workers, the MHA is concerned with 'minimising the undesirable effects of mental disorder' by maximising 'patient' safety and wellbeing and by protecting other people from harm.[4]

It is important to note that legislators wish to emphasise that a lack of mental capacity to make one's own decisions, as defined by the MCA, does not necessarily imply mental disorder, as defined by the MHA. Similarly, mental disorder does not necessarily imply a lack of mental capacity to make one's own decisions. Nevertheless, whilst legislation and guidance aim to distinguish between these two sets of provisions, both may come into play in particular cases.

It is a matter of considerable debate whether or not this dual legislative regime governing involuntary treatment: (a) gives rise to conflict/chaos when applied in practice; and, (b) is

[1] The Mental Capacity Act 2005 is available online at http://www.legislation.gov.uk/ukpga/2005/9/contents.
[2] Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice* (London: TSO), p. 15. Available online at http://www.justice.gov.uk/downloads/guidance/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf. (Hereafter cited as 'MCA Code of Practice'.)
[3] Department of Health (15 October 2009) 'Summary of the Mental Health Act 1983', retrieved on 7 April 2010 from http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034 .
[4] Department of Health (2008) *Code of Practice: Mental Health Act 1983* (London: TSO), p. 5. Available online at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf. (Hereafter cited at 'MHA Code of Practice'.)

prejudicial against those with mental health problems. As a consequence, a strong campaign for unifying mental health law is growing.[5]

Furthermore, in examining the practical implications of this dual regime, the possibility of an antinomy[6] arises. If the provisions of the MHA trump the MCA, thereby authorising compulsory treatment irrespective of decision-making capacity, then suicide attempts may be thwarted. Whilst this may intuitively feel like the proper response, a further concern is prompted. Aside from the issue of discrimination already noted, state intervention in preventing suicide may be at odds with current law on suicide, i.e. that suicide is not a crime.

Mental Capacity Act 2005

The foundations of the MCA are based on the recommendations for reform contained in The Law Commission's Report on Mental Incapacity (No. 231, 1995).[7] It aims to provide a statutory framework to both protect and empower individuals who may lack the capacity to make a particular decision for themselves. Significantly, lack of capacity does not have to be attributable to a mental disorder.[8]

Guiding Principles:

Five key principles underpin the MCA and are delineated within in:

> (1) A person must **be assumed to have capacity** unless it is established that he lacks capacity.
>
> (2) 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.
>
> (3) A person is not to be treated as unable to make a decision merely because he makes an **unwise decision**.
>
> (4) 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**.
>
> (5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as **effectively achieved in a way that is less restrictive** of the person's rights and freedom of action.
>
> Source: §1 of the Mental Capacity Act 2005 (my emphasis)

[5] See, e.g., Dawson, J. & Szmukler, G (2006) 'Fusion of Mental Health and Incapacity Legislation' in *The British Journal of Psychiatry,* Vol. 188, 504:9. Available online at http://bjp.rcpsych.org/content/188/6/504.full.pdf+html.
[6] A contradiction between two laws or principles.
[7] A summary of its recommendations are set out online at http://www.bailii.org/ew/other/EWLC/1995/231_s.html.
[8] Although, as we later note, there must be an impairment of, or disturbance in the functioning of, the mind or brain.

An Overview of the Statutory Framework:

Defining Incapacity: the Act defines people who lack 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.
>
> Source: §2 of the Mental Capacity Act 2005

The Act defines the inability to make decisions as follows:

> 'a person is unable to make a decision for himself if he is unable—
> (a) to **understand** the information relevant to the decision,
> (b) to **retain** that information,
> (c) to **use or weigh** that information as part of the process of making the decision, or
> (d) to **communicate** his decision (whether by talking, using sign language or any other means).
>
> Source: §3 of the Mental Capacity Act 2005 (my emphasis)

This amounts to a two-stage test.

Two Stage Capacity Assessment

I. Does the person have an impairment of, or a disturbance in the functioning of, the mind or brain?

II. If so, does this mean that the person is unable to make a particular decision at the time it needs to be made?

Stage I: requires proof that the person has an impairment of, or a disturbance in the functioning of, the mind or brain (MCA §2 (1)). This need not be as a result of mental disorder as defined by the MHA (see below), and can include dementia, significant learning disabilities, long-term effects of brain damage, as well as conditions associated with some forms of mental illness (MCA Code of Practice, ¶4.12). The impairment or disturbance can be temporary or permanent (MCA, §2(2). If a person does *not* have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act.

Stage II: requires an assessment of whether, as a result of their impairment or disturbance, a person lacks the mental capacity to make a particular decision, at the time it needs to be made. Note, therefore, that the assessment is decision/time specific, i.e. capacity must be assessed specifically in terms of a person's ability to make a particular decision, at the particular time it must be made. Whilst an agent may lack sufficient capacity to make a decision in respect treatment, she may nevertheless have capacity to make a decision in respect other matters which are less complex and/or grave in their consequences.

This stage applies only if:

- It has been proven that the person has an impairment of, or a disturbance in the functioning of, the mind or brain (Stage One); and
- All practical and appropriate support provided to enable the person to make a decision has failed (MCA §1 (3)).

Other Important Provisions (in brief):[9]

Preliminaries: the Act applies only persons aged 16 and over (§2(5)).

Scope of Incapacity: the Act applies to lack of capacity caused by physical as well as mental illness, e.g. brain injury and the effects of stroke can cause memory loss and confusion. (MCA Code of Practice, ¶4.12).

Equality & Neutrality: Lack of capacity cannot be established 'merely by reference to' a person's behaviour, age or appearance (§2(3)), nor a judgement as to the wisdom of a particular decision (§1(4)).

The burden of proof lies with the carer/worker who doubts capacity and must be established on the balance of probabilities, i.e. it is more likely than not that mental capacity is lacking (§2(4)). Before carrying out an act in connection with care or treatment without a person's express consent, a care worker must: (a) take reasonable steps to establish whether the person has capacity in respect of the matter in question; and, (b) reasonably believe that the person lacks capacity and it will be in his best interests for the act to be carried out. (§5)

Best Interests: The determination of what is in a person's best interests (once a lack of capacity has been established) requires consideration of all relevant circumstances. In particular, the decision-maker must consider:

(1) Whether the person is likely to regain capacity. If so, can the decision be delayed until then?

(2) How it may be possible to involve the incapacitated person in the decision-making, and improve his ability to participate as much as possible.

(3) As far as is practicable, the person's past and present feelings and wishes, beliefs and values that may have a bearing on the decision if he were making it.

(4) The views of others considered to have an appropriate role in determining what is in the best interests of the person, e.g. someone nominated by the person, someone engaged in caring for him, someone holding a lasting power of attorney granted by the person. (§4)

The decision-maker will comply with regulations concerning the determination of what is in the person's best interests if such information is taken into consideration and in light of this

[9] Unless indicated otherwise, the bracketed references pertain to the MCA 2005.

information he reasonably believes that what he does/decides is in the person's best interests (§9).

Excluded Decisions: three categories of decisions are excluded under the Act: those relating to family relationships, voting rights and MHA matters (§27-29).

Interface with the MHA: The MCA stipulates that where a person has been compulsorily detained for emergency assessment under s.4 of the MHA, the MCA cannot be used to authorise treatment for a mental disorder where that person lacks capacity to consent. Instead the provisions of the MHA should be used (see below) (§28).

Restraint of a person for the purposes of carrying out an action of care or treatment is permitted only if: (a) the carer/worker reasonably believes it is necessary to carry out the act to prevent harm to the person, and (b) it is a proportionate response (§6).

The Court of Protection has the power to make declarations as to a person's capacity to make a decision in respect of a particular matter (§15).

Advance Decisions: a valid and applicable 'advance decision' (see below) to refuse treatment has the same force as a contemporaneous decision. In such circumstances, if a person lacks capacity care workers should act according to the terms of the 'advance decision'. If, however, at the material time the person has capacity to consent to or refuse to the treatment in question, then the 'advance decision' does not apply (§25).

A Particular Look at Advance Decisions:

> '"Advance decision" means a decision made by a person ("P"), after he has
>
> reached 18 and when he has capacity to do so, that if—
>
> (a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and
> (b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment,
>
> the specified treatment is not to be carried out or continued.'
>
> Source: §24(1) of the Mental Capacity Act 2005

The MCA sets out the effect of an advance decision as follows:

> 'If [a person] has made an advance decision which is—
> (a) valid, and
> (b) applicable to a treatment,
> the decision has effect as if he had made it, and had had capacity to make it, at the time when the question arises whether the treatment should be carried out or continued.'
>
> Source: §26 of the Mental Capacity Act 2005

The following additional provisions are worth highlighting for the purposes of this briefing:[10]

- An advance decision is not valid if: (a) the person has withdrawn it at a time he had capacity: (b) the person subsequently conferred authority to make such a decision to another person under a lasting power of attorney; or, (c) the person has done something which is clearly inconsistent with his commitment to the terms of it (§25 (2).

- An advance treatment is not applicable to a particular treatment if: (a) the advance decision doesn't specifically relate to that treatment: (b) the circumstances specified within the advance directive are absent: or, (c) there are reasonable grounds to believe that that circumstances have arisen which were not anticipated by the person at the time of the advance decision and that this would have influenced his decision if he had anticipated them (§25(4).

- Advance decisions (except in case of life-sustaining treatment) need not be in writing. (§25)

- An advance decision is only applicable to life-sustaining treatment if (a) it is in writing (b) the person makes a written statement that it should apply to that treatment, even if has the effect of placing his life at risk, (c) it is signed by the person (or another person as his direction) in the presence of a witness (d) the witness signs it in the person's presence (§25(6)-(7)).

- The person may withdraw or amend the advance decision at some later time, provided that they have capacity to do so (s.24(3)).

Questions Arising:

Medical and Legal Questions:

1. Given the presumption of capacity required in law, what concerns/events (properly?) trigger an assessment of capacity, thereby entitling care givers to question an individual's capacity and to subject her to intrusive questioning?

2. In practice, where does the burden of proof lie – with the practitioner or the individual?

Philosophical Questions:

1. Are advance decisions autonomous decisions? In what sense can we predict how we would choose in a set of hypothetical circumstances that we predict may arise in the future? How do advance directives account for personal identity over time?

[10] Unless indicated otherwise, the bracketed references pertain to the MCA 2005.

2. Does the test for capacity (the ability to understand, retain and weigh) adequately account for pathological values and psychotic delusions, which may impair autonomous judgement? Can the threat of these factors be fully accounted for within the test for using/weighing?

Mental Health Act 1983

The MHA is concerned with the care and treatment of persons suffering from a serious mental disorder which places them or other people at risk of harm. For the purposes of the MHA, mental disorder means 'any disorder or disability of mind'. (MHA, §1)

The guiding principles:

1. **Purpose principle**

Decisions under the Act must be taken with a view to **minimising the undesirable effects of mental disorder**, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

2. **Least restriction principle**

People taking action without a patient's consent must attempt to **keep to a minimum the restrictions they impose on the patient's liberty**, having regard to the purpose for which the restrictions are imposed.

3. **Respect principle**

People taking decisions under the Act must **recognise and respect the diverse needs, values and circumstances of each patient**, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

4. **Participation principle**

Patients must be given the opportunity **to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care** to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

5. **Effectiveness, efficiency and equity principle**

People taking decisions under the Act must seek to **use the resources available to them and to patients in the most effective, efficient and equitable way**, to meet the needs of patients and achieve the purpose for which the decision was taken.

Source: Mental Health Act Code of Practice, ¶1.2.–6, (my emphasis)

Overview of Statutory Framework:

Application of the MHA:

> 'The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.'
>
> Source: §1(1) Mental Health Act 1983

Definition of 'Mental Disorder':

> '"[M]ental disorder" means any disorder or disability of the mind; and "mentally disordered" shall be construed accordingly.'
>
> Source: §1(2) Mental Health Act 1983

The Code of Practice expands upon this definition. Firstly, it states that relevant professionals should determine this matter in accordance with 'good clinical practice and accepted standards of what constitutes such a disorder or disability' (MHA Code of Practice, ¶3.2) Secondly, it provides a list of clinically recognised conditions which could be regarded as a mental disorder under MHA. This list includes:

- Schizophrenia and delusional disorders;
- Dementia;
- Eating disorders;
- Personality disorders;
- Behavioural and personality changes attributable to brain injury/damage;
- Affective disorders, including depression; and
- Neurotic, stress-related and somatoform disorders, including post-traumatic stress disorder (MHA Code of Practice, ¶3.3).

The following, however, are NOT to be regarded as a mental disorder for the purposes of the MHA, although they may be regarded as an impairment of, or a disturbance in the function of the mind or brain, under the MCA:

- Alcohol or drug dependence. (MHA, §1(3))
- Learning disabilities, unless they are accompanied by **abnormally aggressive or seriously irresponsible conduct** and as such are subject to the following MHA powers:
    - Detention in hospital for treatment;
    - Guardianship;
    - Supervised Community Treatment; and
    - Criminal justice orders under Part 3 MHA. (MHA, §1(2A)-(2B))

If we compare the MHA and MCA at this point, we see that:

1. The MCA is somewhat *narrower* in scope than the MHA because it requires mental incapacity. In other words, the MCA has both a status test (impairment or disturbance of mind or brain) and a function test (decision-making incapacity as a result of this impairment or disturbance. In contrast, the MHA has only a status test, i.e. mental disorder of a nature of degree that warrants detention.

2. At the same time, the MCA is also somewhat *wider* in scope than the MHA because it extends beyond mental disorder and includes cases of impairment or disturbance of the mind or brain, which includes cases of learning disabilities (without qualifications imposed under the MHA) and cases which involve effects of alcohol and drug use as well (that are excluded under the MHA).

3. The MCA can authorise treatment for physical illnesses, even if they are not related to the mental disability of the subject.[11].

Applications for Assessment and Treatment:

Three main applications are provided for within the MHA:

1. Admission for Assessment (§2)
2. Admission for Treatment (§3)
3. Admission for Assessment in Case of Emergency (§4)

An application for detention may only be made where the specified requirements are satisfied either under §2 or §3.

'An application for admission for **assessment** may be made in respect of a patient on the grounds that—

(a) he is suffering from 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**.'

Source: §2(2) of the MHA (my emphasis)

[11] We will return to this issue below, when we discuss *B v Croydon Health Authority* [1995] 2 W.L.R. 294.

An application for admission for **treatment** may be made in respect of a patient on the grounds that—

(a) he is suffering from **[mental disorder] of a nature or degree which makes it appropriate** for him to receive medical treatment in a hospital; and
(b) . . .
(c) 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
(d) appropriate **medical treatment is available** for him].

Source: §3(2) of the MHA (my emphasis)

'An **emergency application [for admission for assessment]** may be made either by an [approved mental health professional] or by the nearest relative of the patient; and every such application shall include a statement that it is of **urgent necessity** for the patient to be admitted and detained under section 2 above, and that compliance with the provisions of this Part of this Act relating to applications under that section would involve **undesirable delay**.'

Source: §4(2) of the MHA (my emphasis)

The MHA Code of Practice helps define some of the terms used within these provisions, including:[12]

- '**nature and degree' of mental disorder**: 'Nature refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder. Degree refers to the current manifestation of the patient's disorder'. (¶4.3)

- **'health and safety of the patient':** factors to be considered in assessing this aspect of the test include 'the evidence suggesting that patients are at risk of: suicide; self-harm; self-neglect ... evidence suggesting that the patient's mental health will deteriorate if they do not receive treatment ... the reliability of such evidence'. (¶4.6)

- **'protection of others':** 'the factors to consider are the nature of the risk to other people arising from the patient's mental disorder, the likelihood that harm will result and the severity of any potential harm [psychological as well as physical]. (¶4.7)

Treatment Which May Be Administered Without Consent under the MHA

It is important to note that there are limitations on the medical treatment that can be administered to patients detained under the MHA without the patient's consent. Of particular interest, is the provision which prevents clinicians from imposing medical treatment which is not for the purpose of treating the medical disorder.

[12] Unless otherwise indicated, all references pertain to the MHA Code of Practice.

Treatment not requiring consent
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**[, not being a form of treatment to which section 57, 58 or 58A above applies,][13] if the treatment is given by or under the direction of the [approved clinician in charge of the treatment].

SOURCE: §63 of the MHA (my emphasis)

The MHA defines medical treatment for mental disorder as follows:

(1) "medical treatment" includes nursing, [psychological intervention and specialist mental health habilitation, rehabilitation and care (but see also subsection (4) below)];

[(4) Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed 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**.]

Source: §145 of the Mental Health Act 1983 (my emphasis)

This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder **(eg treating wounds self-inflicted as a result of mental disorder)**. Otherwise, the Act does not regulate medical treatment for physical health problems.

Source: Code of Practice – Mental Health Act 1983, ¶23.4 (my emphasis)

Symptoms and manifestations include the way a disorder is experienced by the individual concerned and the **way in which the disorder manifests itself in the person's thoughts, emotions, communication, behaviour and actions.** But it should be remembered that not every thought or emotion, or every aspect of the behaviour, of a patient suffering from a mental disorder will be a manifestation of that disorder.

Even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment. It should never be assumed that any disorders, or any patients, are inherently or inevitably untreatable. **Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person's underlying disorder make medical treatment to help manage their condition and the behaviours arising from it either inappropriate or unnecessary.**

Source: Code of Practice - Mental Health Act 1983, ¶6.5.–6 (my emphasis)

[13] Exceptions to s.63 are: (a) s.57 'Treatment [for mental disorder] requiring consent and second opinion', such as neurosurgery; (b) s.58 'Treatment [for mental disorder] requiring consent or second opinion', such as medication after initial 3 month period; and, (c) s. 58A 'Electro-Convulsive Therapy [for mental disorder] etc.

Whether a particular intervention amounts to medical treatment for the mental disorder under s.63 and is consistent with the above statutory definitions – thereby removing the requirement for consent – is debatable. Consider *B v Croydon Health Authority* [1995] 2 W.L.R. 294.[14]

A 24-year-old woman suffered from a psychopathic disorder for which the only known treatment was psychoanalytic psychotherapy. One of her symptoms was a compulsion to harm herself. While she was compulsorily detained in hospital under section 3 of the Mental Health Act 1983, she stopped eating and her weight fell to a dangerous level. A threat of feeding by nasogastric tube resulted in some improvement, but when her weight fell to a critical level tube feeding was again threatened. B. made an ex parte application to the High Court for an injunction to restrain the health authority from tube feeding her without her consent. Thorpe J. held that **tube feeding constituted medical treatment for the mental disorder from which B. was suffering and that her consent was not required by virtue of section 63 of the 1983 Act.** On appeal by B, the Court of Appeal upheld this judgement.

SOURCE: Transcript downloaded from Westlaw (my emphasis)

It is noteworthy that the appeal court declined to rule on B's capacity (the lower court had held that she did have capacity) and instead considered the appropriateness of compulsory treatment under the MHA. However, the appeal judge observed that whilst B's evidence demonstrated her intelligence and self-awareness, it was nevertheless difficult for him to accept that she was capable of making a 'true choice' in the matter. In this case, then, the MHA trumped the MCA and so, irrespective of her capacity to refuse treatment, she was subject to compulsory feeding.

Questions Arising:

Legal Questions

1. Was B subject to discrimination on account of her mental disorder? After all, had she not been suffering from a mental disorder, the court would have had to consider her capacity and, perhaps, accept that she had capacity to refuse treatment.

2. Can the choice of which provisions to apply first (MHA or MCA), prejudice the determination of a case?

Medical and Philosophical Questions

3. Despite B's ability to understand, retain and weigh the information relative to her treatment decision, the common law test for mental capacity may well have been satisfied. To what extent could it be argued that her capacity to weigh was influenced by distorted (pathological values), e.g. compulsion to harm herself.

[14] Although amendments to the MHA under the Mental Health Act 2007 have significantly extended the scope of such treatment since *B v Croydon*, this matter may still trigger debate, clinically and legally.

Interface Between MHA and MCA

As outlined above, the MCA aims to empower and protect persons who decision-making capacity, whilst the MHA aims to provide professionals with powers to assess, treat and care for persons with serious mental disorder without consent. Understanding this interface is particularly important in the context of decisions to refuse life-saving treatment following self-inflicted harm, whether the intention is suicide or not. As shown in the case of *B v Croydon* above, a patient suffering from a mental disorder can be subjected to compulsory medical treatment irrespective of their decision-making capacity. But, as in the case of *Wooltorton*, patients suffering from a mental disorder can also be permitted to refuse treatment and die, as a matter of respect for their decision-making capacity.

Kerrie Wooltorton was a 26 year old woman with a long history of psychiatric intervention and admissions to hospital, including detention under the MHA during the last year of her life[15], both for assessment (under s.2) and treatment (under s.3). From the age of 15 she had engaged in self-harming activities and was described as having an 'untreatable' emotionally unstable personality disorder. On 19 September 2007, Kerrie died as a result of deliberately consuming anti-freeze. On a number of previous occasions she has consumed anti-freeze but had (eventually) accepted treatment. However, on this occasion she refused treatment that, more likely than not, would have saved her life. Medical practitioners considered that she had capacity to refuse treatment and that there were no grounds upon which to treat her under section 3 of the Mental Health Act 1983. The coroner's verdict was that Kerrie did have capacity, and he apparently accepted evidence that there were no grounds for detaining and treating her under the MHA.

Source: The Coroner's Report[16]

In this case, both the MCA and the MHA were potentially applicable. Which should be considered first? The following guidance is provided in this respect:

MCA or MHA?

- Before making an application under the MHA, decision-makers should consider whether they can achieve their aims safely and effectively using the MCA instead (MCA Code of Practice, Ch 13)

- The provisions of the MHA may be more appropriate than the MCA in the following situations: (See Chapter 13 of the MCA Code of Practice)

    - Deprivation of liberty is necessary to provide necessary care or treatment.

[15] On 29 January 2007 and 2 February under s.2 and on 11 March 2007 under s.3.

[16] 'Summary of Evidence' presented by Mr W. Armstrong (HM Coroner Greater Norfolk District) at the Inquest into the death of Kerrie Wooltorton held on 28 September 2009. All subsequent quotes are taken from this document.

- Necessary treatment cannot be provided under the MCA due to the existence of a valid and appropriate advance directive (a clear example of how the MHA can trump the MCA).
- Restrain which is not allowed under the MCA may be required.
- Compulsory treatment is the only means to assess and treat person safely and effectively.
- The person lacks capacity to decide on all elements of the treatment planned, but has sufficient capacity to refuse a vital element of it and has done so.
- For some other reason a person may not get the treatment they need and as a result they or someone else may suffer from harm.

On mental capacity and mental disorder:

- 'Many people covered by the MHA have the capacity to make decisions for themselves. *Most people who lack capacity to make decisions about their treatment will never be affected by the MHA, even if they need treatment for a mental disorder*.' (MCA Code of Practice, ¶13.2 – my emphasis)
- Compulsory treatment under the MHA is not an available option if the patient's mental disorder does not justify detention in hospital or the patient's treatment need is for a physical illness or disability unrelated to the mental disorder
    - They suffer from a **qualifying mental disorder**
    - The mental disorder is **severe enough** to warrant inpatient treatment
    - Treatment is **necessary to safeguard a person's health or safety**, or for the protection of others, and cannot be provided without detention; and
    - **The purpose of treatment is intended to improve their condition or stop it getting worse**. (MCA Code of Practice, ¶13)
- Whilst clinicians can treat people for mental disorder under MHA without their consent, they 'cannot simply ignore a person's capacity to consent to treatment. As a matter of good practice (and in some cases in order to comply with the MHA) they will always need to record whether patients have capacity to consent to treatment and, if so, whether they have consented to or refused treatment'. (MCA Code of Practice, ¶13.30)

Can this guidance assist us in our understanding of why *B* and *Wooltorton* were treated differently, the former under the MHA and the other under the MCA?[17] Arguably, the circumstances of both patients – diagnosis of personality disorder, persistent, long-standing self-harm and recent psychiatric admissions under section - were such that justification for detention and compulsory treatment under s.3 was at least a possibility. In the case of B, the court was of this view and made a ruling under this provision (somewhat controversially in that it was held that force feeding amounted to qualifying medical treatment under the MHA). There appeared to be reluctance on the part of the appeal court judges to consider her capacity according to the standard common law test of capacity: understanding, retaining and weighing. It seemed that the court felt that the test lacked something it intuitively felt critical to that assessment: value?

But in the case of *Wooltorton*, the health care professionals involved in her case decided that the criteria for detention and compulsory treatment were not satisfied. The unanimous decision of the clinical team was that she was not exhibiting any signs of mental disorder and that she had decision-making capacity under the MCA. This, of course, was a clinical judgement, an evaluation of which is beyond my expertise. But given this woman's psychiatric history, it may be perplexing for a layperson to understand. Looked at positively, we may argue that it is a triumph for the right to self-determination, and a decision which afforded Kerrie the same respect as people whose lives have not be stigmatised by being labelled 'mentally disordered'. But, looked at suspiciously, one might wonder if in an effort to treat her equally and to respect her autonomy – by allowing her to end her life at the time and in the manner of her own choosing –the ultimate act of self-determination – Kerrie was abandoned to the pathological force of values distorted by the hopelessness of depression and self-loathing. If so, have we unwittingly failed to respect her autonomy?

These two cases, their similarities and their differences, start to illuminate the complexities of the issues – medical, legal and philosophical – that arise when the decision-making capacity of people suffering from mental disorder is in question. This is particularly acute in the case of life-threatening self-harm and suicide.

Philosophical Questions:

1. On what moral basis can we justify treating a patient against her wishes irrespective, and in spite, of her capacity to refuse treatment? (e.g. *B v Croydon*)
2. Can someone autonomously choose to die (or self-harm with the likelihood of death), and should the state respect this choice?
3. In the sense that pathological values are in some sense distorted, can they be regarded as authentic and can the decisions they generate be regarded as autonomous?

[17] At the time of *B v Croyden HA,* the MCA was not if force. However, the common law test for capacity is more or less the same.

Legal/Medical Questions:

4. How do pathological values impair decision-making capacity?
5. To what extent does the presence of a dual statutory regime contribute to inconsistency in clinical responses to decisions refusing life-saving treatment? Would a unified, capacity based regime (as suggested by Szmukler *et al*) resolve this problem?
6. Is there a potential antinomy, between the MHA and the law on suicide?

This final question is tentatively explored in the next section, and in order to do so I will return to the case of Kerrie Wooltorton.

Potential Antinomy?

The case of Kerrie Wooltorton has been the subject of considerable debate amongst clinicians and has prompted an Early Day Motion in parliament which stated: 'Members were repeatedly warned that this was exactly the kind of case which could result from the law'.[18] Clues as to the nature of these concerns can be gleaned from Hansard, particularly Lord Brennan's proposed, but subsequently withdrawn, Amendment to the Mental Capacity Bill, in which he sought to distinguish between inapplicable decisions and merely unwise decisions. He proposed that:

> '... any decision, whether unwise or not, is inapplicable and invalid if it is –
>
> (a) Wholly irrational in the opinion of the medical practitioner responsible for the treatment, and any other decision maker including a court;
>
> (b) In all the circumstances against the public interest, namely-
>
> i. To preserve life;
> ii. To prevent suicide;
> iii. To protect the integrity of the medical and nursing professions; and
> iv. To protect third parties.'[19]

This Amendment was motivated by Lord Brennan's belief that:

> '[this was the] proper way in which society should work; namely, that it should not saddled with the consequences of wholly irrational decisions. ... A choice wholly irrationally expressed cannot be in the interests of the person making it, nor of the society required to implement it. ... **Any society concerned with the exercise of personal autonomy which may involve a decision that might result in the end of life is entitled to consider how that decision affects the community in which the**

[18] EDM 167, 23 November 2009 '*Kerrie Wooltorton and the Mental Capacity Act'*, retrieved on 12 April 2010 from http://edmi.parliament.uk/EDMi/EDMDetails.aspx?EDMID=39706&Session=903.
[19] House of Lords Debate on the Mental Capacity Bill, 25 January, 2005, Hansard, cc1143-209.

person making it lives. ... Are we supposed to allow [people to commit suicide]? Is personal autonomy absolute?'[20]

The Government sought to allay the concern expressed both in the Commons and in Lords, that the Mental Capacity Bill would force medical practitioners to stand back and allow people to die when they could be saved:

> 'We know that there is a significant link between mental illness and suicide. The BMA already advises that health professionals will conclude that a suicide attempt or an express statement indicating a wish to be helped to commit suicide, is not a sustained and competent expression of intention. **The common sense view is that if someone with nothing seriously wrong with them ... refused treatment in advance because they do not want to go on living ... there must be doubt about whether or not they have capacity to make that decision.** So a doctor faced with an apparently suicidally motivated advance decision will have strong grounds for doubting the capacity of the person who made it. **That doubt is enough under the Bill for the doctor to go ahead and treat the patient.** The Bill makes it easier to treat in such circumstances than it is under the current common law. So the people about whom my noble friend is concerned will be much better off under the Bill than now.'[21]

This does not appear to have been the case when Kerrie Wooltorton was admitted to hospital having swallowed a fatal quantity of anti-freeze and clutching a letter refusing life-saving treatment. Kerrie continued to refuse life-saving treatment and she was deemed to have decision-making capacity to make that decision. Consequently life-saving treatment would only have been permitted if the conditions for compulsory treatment under the MHA were satisfied, i.e.

> (a) Kerrie was deemed to be suffering from a mental disorder of a nature and degree that merited detention;
>
> (b) detention was necessary to prevent harm to self or others; and
>
> (c) the treatment qualified under s.63 of the MHA, as treatment for the mental disorder.

Doctors decided that (a) was not satisfied. This is perplexing given the evidence presented at the inquest into her death:

- On 15 August 2007, the mental health team involved in Kerrie's case discussed her low mood, recurrent plans to drink anti-freeze and refusal of intervention: 'there was a clear consensus on this occasion, and this is only a few weeks before Kerrie's death, that Kerrie

[20] Ibid. (my emphasis)
[21] House of Lords Debate on the Mental Capacity Bill, 17 January, 2005, Hansard, cc1143-209. (My emphasis)

did understand the implications of drinking anti-freeze, she did have capacity to refuse treatment, she was aware of the risk of what she was doing and thinking about doing but it was felt that they had to engage in what's referred to in Mental Health terms as positive risk taking because there had been a benefit of this in the past ... [and] mental health professionals felt that Kerrie needed to be encouraged to take responsibility for what she was doing and there was also reference to the fact that in the past, whenever she had taken anti-freeze she had always or normally got some help afterwards.'

- On 16 August 2007 '[t]here was a team decision that a Mental Health Act assessment wasn't appropriate and she should be supported in the community. Again the feeling was first of all she had capacity to refuse treatment should she decide to do so and also there were no grounds for her compulsory detention under the Mental Health Act unless they are suffering a mental disorder of nature and degree that warrants detention and is necessary in the interests of their own health or safety or the protection of others.'

- The need/justification for an assessment under the Mental Health act was subsequently reviewed on a number of occasions and the view that it was not justified was maintained.

- On 13 September, a few days before she consumed the last fatal dose of anti-freeze, a home visit to Kerrie revealed that: 'she was tired of fighting, didn't want to live like this anymore, didn't want help, she wasn't scared of death but she was of dying.' It was noted that 'she didn't present as being specifically distressed or depressed and [the judgement was made] that there was no deterioration in her mental health'.

- On 17 September, Kerrie ingested a substantial quantity of anti-freeze and phoned for an ambulance. Verbally and in a letter[22] dated a few days before which she presented to the medical team, Kerrie explained that she did not want any life-saving treatment and only wanted intervention necessary to keep her comfortable as she died. The unanimous decision of the clinic team was that Kerrie had capacity (to choose to end her life) and was not exhibiting any signs of mental disorder

The implication of this tragic case is that the right to decide for oneself under the MCA extends to the right to end one's life, unless one qualifies for compulsory treatment under the MHA, in which case that right is suspended.

Suicide and the Right to Choose for Oneself: a conflict in law?

Suicide ceased to be a crime following the introduction the Suicide Act 1961. In this sense, can it be said that suicide is lawful, an act which a mentally competent person is entitled to perform without restraint? Or is there a countervailing interest, such as the public interest, as Lord Brennan suggested, which permits the state to prevent suicide?

[22] It should be noted that because health professionals judged that Kerrie had capacity at the time she refused treatment, the letter she presented stating her wishes was irrelevant and consequently the judgement of its validity as an advance directive under §24 of the MCA was unnecessary.

In the *Bland*[23] case, Thorpe J. stated:

> '... a patient who is entitled to consent to treatment which might or would have the effect of prolonging his life and who refuses to so consent, and by reason of the refusal subsequently dies, does not commit suicide. A doctor who, in accordance with his duty, complied with the patient's wishes in such circumstances does not aid or abet a suicide.'

Does this ruling suggest that suicide can only be committed by an act? That death, following refusal of life-saving treatment to counter the effects of self-harm, particularly where suicide was intended, is not suicide? Professor John Finnis, one of the witnesses cited in the Early Day Motion, disagrees:

> 'The law firmly and rightly holds that those who have undertaken to provide treatment or nourishment are not absolved from their duty by the patient's adamant refusal if that refusal is either incompetent or unlawful. A refusal which is motivated by suicidal intent is unlawful, even though suicide itself is not a criminal offence; that is why assistance, and agreements to assist, in suicide are serious criminal offences.'[24]

Is suicide unlawful, and if so under what statute? And are doctors under a legal duty to treat patients against their will where their refusal is motivated by their wish to die? If so, the MCA is in conflict with these provisions.

But let us bracket Finnis's opinion for now and assume that suicide is lawful (in the sense that it breaches no laws) and that life-saving intervention without consent is permitted only if the provisions of either the MCA or MHA can be invoked. According to the clinical team treating her, Kerrie Wooltorton had mental capacity and was entitled to refuse life-saving treatment. The MCA is therefore consistent with the Suicide Act 1961. Now consider *B*,[25] whose mental capacity was judged irrelevant, since the provisions of the MHA were invoked. *B* states in her evidence that her intention was not suicide, just self-punishment. However, for the sake of argument, imagine that her refusal to eat was suicidally motivated - is there reason to think that the outcome would have been any different? Since the MHA trumped the law on mental capacity, can we argue that her suicide was rendered *de facto* unlawful (though not criminal) on account of her mental disorder? If so, one might wonder if the MHA conflicts with the Suicide Act 1961, in the sense that the MHA renders suicide *de facto* unlawful in the case of patients whose circumstances trigger compulsory treatment irrespective of consent and capacity.

[23] *Airedale NHS Trust v Bland* [1993] AC 789

[24] Finnis, John (1994) 'Living Will Legislation', in Gormally, Luke (ed), *Euthanasia, Clinical Practice and the Law* (London: The Linacre Centre), p.167 – cited by The Society for the Protection of Unborn Children in their written evidence to the Joint Committee on the Draft Mental Incapacity Bill.

[25] *B v Croydon*

Concluding Questions

1. Does the presence of a dual legislative regime lead to unfairness, inconsistency, discrimination or an antinomy?

2. Whilst promoting the autonomy of the patient is a positive function of the MCA, safeguarding the interests of care givers is its negative function. Is there a tension between these dual functions in finely-balanced cases, and to what extent might this impact upon clinical decisions?

3. In contrast, the principle function of the MHA is to empower clinicians to assess, treat and care for persons with serious mental disorder to prevent harm to the patient or to others. Does the risk to others carry greater weight that the risk to the patient, particularly where the patient has capacity to refuse treatment?

4. In the case of risk to health or safety of a mentally disordered patient, should the provisions of the MHA trump the MCA? The practice guidance seems to suggest not, by emphasising (a) the fact that people suffering from mental disorder will not necessarily lack decision-making capacity, and (b) that before making an application under the MHA, decision-makers should consider whether they can achieve their aims safely and effectively using the MCA instead. However, is this true in practice?

5. Do cases which fall for consideration under both MCA and MHA reveal/illuminate an antinomy, a conflict in the law? Or rather, do they simply reveal/illuminate the problems of applying dual legislation?

6. If an antinomy is revealed, how might this aid our understanding of autonomy and its application in public policy?

7. Is, as Finnis argues, suicide unlawful, and if so under what statute? And are doctors under a legal duty to treat patients against their will where their refusal is motivated by their wish to die? If so, the MCA is in conflict with these provisions.

8. In the words of Lord Brennan, is it true that ‘any society concerned with the exercise of personal autonomy which may involve a decision that might result in the end of life is entitled to consider how that decision affects the community in which the person making it lives. ... Are we supposed to allow [people to commit suicide]? Is personal autonomy absolute?’