Imposing care: using the Mental Health Act, Mental Capacity Act and Common Law.

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Principles

• The Common Law was codified into statute law by the Mental Capacity Act.
• Therefore where the Mental Capacity act applies Common Law does not apply.
• Therefore Common Law only applies where statute law does not apply.
MCA vs MHA

- The Mental Capacity Act does not apply where the Mental Health Act does apply
- Therefore Common Law applies only where neither the MCA or MHA apply
MHA

• Applies for the provision of psychiatric treatment in approved settings when it has been applied
• Is applied subsequent to the sectioning of someone
MCA

• Applies to both physical and mental treatment where the person lacks the capacity to consent to treatment specified.
• Gives us duties of care
• Allows restraint under section 6 justified by the prevention of harm to self.
Difficult cases (1)

• Mrs Y.
• Found on floor by GP, unable to stand, previously well
• Called ambulance and refused to go
• GP visited again
  – Unwell
  – Unable to stand
  – Called second ambulance
  – Refused to go!
• Called me
  – 7pm called ambulance while I was there
  – Clear that we would take her to hospital
  – Ambulanced men doubted their rights and duties
  – Went to hospital
• On picking her up, she was stuck to the floor with faeces that had dried into the carpet for 2 weeks
• (tidy house)
• Had Hb of 4 and dementia
Forms of agreement

- Valid Consent
- Assent
- Dissent
- Valid Refusal
What legal jurisdictions applied here?

• What could have been done.?
MHA

- Not really
- She was physically ill and needed physical care
- But spoke eloquently (without mental capacity) of her rejection of that care
Restraint

- Is anything imposed in the face of resistance
- Disallowed unless the following apply
  - Harm if treatment/intervention not applied
  - Proportionate to the likelihood and seriousness of that harm
  - Less restrictive option
Restraint (Section 6)

• If patient is restrained then
• You reasonably believe that it is necessary to do the act in order to prevent harm to P.
• And that the act is a proportionate response to—
• (a) the likelihood of P’s suffering harm, and
• (b) the seriousness of that harm.
Duties of restraint

• Cover both emergency situations and also routine ones.
  – Locked doors
  – Covert medication
  – DoLS
  – And the MHA
Remember

• You have a DUTY to restrain those who lack capacity and who will suffer harm if you do not restrain them.
Case vignette 2 (would you hide medication in this patient's food?)

- Severely confused elderly man previously well admitted with severe hypothyroidism
- Refuses all oral or injected treatments.
- Without treatment likely to die
- With treatment good prospect of recovery
- Injection may need restraint which would be distressing and may be dangerous
A little a bit more about the MCA and advance decisions
Stages of mental capacity

- Full capacity
- Limited capacity which can be enhanced with information and support
- Incapacity
Principles of capacity

- Different decisions require different levels of capacity
- Capacity fluctuates and is situation specific
- Incapacity leads to use of either common law or the Mental Health Act depending on
  - whether proposed procedure is covered by the Mental Health Act
  - timescale and ability to use Mental Health Act
Advance statements

• Not legally binding but useful and strongly advisory.
Advance Decisions to refuse treatments

- Statements of REFUSAL OF health care choices written in advance, while in possession of mental capacity
- Made legally binding by capacity act but subject to
- But can easily produce effects that were not anticipated at the time of writing (e.g. if the patient comes to harm as a result of the enforcement of a directive)
- Must be specific to situation and clearly so
- Must not have any of the following problems with validity.
Reasons why ADRT’s may not be valid

• An advance decision is not valid if P-
  (a) has withdrawn the decision at a time when he had capacity to do so,
• (b) has, under a lasting power of attorney created after the advance decision was made, conferred authority on the donee (or, if more than one, any of them) to give or refuse consent to the treatment to which the advance decision relates, or
• (c) has done anything else clearly inconsistent with the advance decision remaining his fixed decision.
• An advance decision is not applicable to the treatment in question if at the material time P has capacity to give or refuse consent to it.

• An advance decision is not applicable to the treatment in question if-
  (a) that treatment is not the treatment specified in the advance decision,
  (b) any circumstances specified in the advance decision are absent, or
  (c) there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.
Validity of ADRT's (2)

• An advance decision is not applicable to life-sustaining treatment unless-
  (a) the decision is verified by a statement by P to the effect that it is
to apply to that treatment even if life is at risk, and
  (b) the decision and statement comply with subsection (6).

• A decision or statement complies with this subsection only if-
  (a) it is in writing,
  (b) it is signed by P or by another person in P's presence and by
      P's direction,
  (c) the signature is made or acknowledged by P in the presence of
      a witness, and
  (d) the witness signs it, or acknowledges his signature, in P's
      presence.