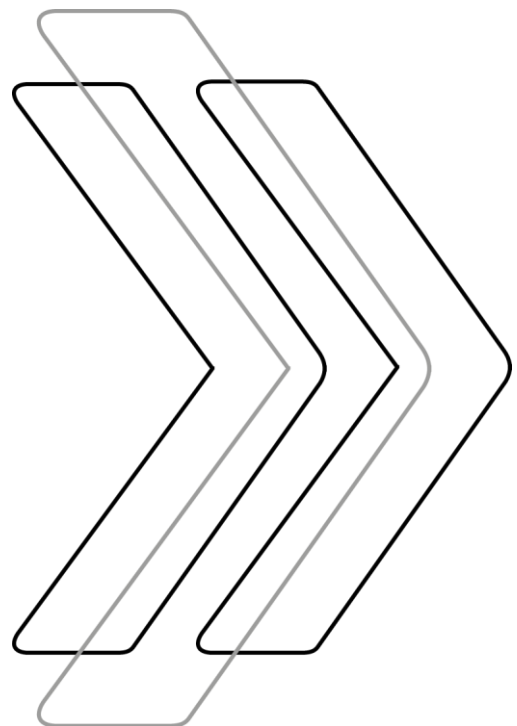


# **Understanding clinical decision- making at the interface of the Mental Health Act (1983) and the Mental Capacity Act (2005)**

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February 2021



This independent report was commissioned by the Department of Health and Social Care. The research was commissioned through the Partnership for Responsive Policy Analysis and Research (PREPARE), a collaboration between the University of York and The King's Fund that produces fast-response analysis and review to inform developing policy. The research programme is funded by the NIHR Policy Research Programme (grant number NIHR200702). The views in the report are those of the authors and not necessarily NIHR or the Department of Health and Social Care.

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# Summary

- The decision about whether to use the Mental Health Act or the Mental Capacity Act at the interface of the Acts has relevance across multiple areas of practice. A large proportion of participants in this research report encountering people to whom this decision applies at least once a month, if not weekly.
- This decision most commonly applies to people who have dementia, but also to people with a wide range of mental disorders, including those with functional mental illnesses, neurodevelopment and neurological conditions.
- Participants report most commonly applying this decision to people in community settings, but application also occurs in mental health and acute hospitals including in the emergency department.
- There is a lack of common understanding around fundamental issues on which this decision is based including core concepts of capacity and objection.
- When asked to consider the least restrictive option, the route that participants typically choose is influenced by their professional role. Professionals do not approach this decision from a position in which the two Acts are considered to provide equal protections or rights for those subject to them.
- Blanket rules exist within professional groups and across different settings that restrict decision-making. The rights afforded to people admitted and treated in some settings and areas of England may not be afforded to those in others.
- The majority of participants report that their training covered decision-making at the interface of the Acts. However, codes of practice and case law are described as difficult to understand and keep up to date with.

- Practitioners highlight a number of different ways in which patients are unlawfully deprived of their liberty as a result of the factors outlined above.

# 1 Background

The Mental Health Act (1983) (MHA) and the Mental Capacity Act (2005) (MCA) both provide a legal means by which people can be deprived of their liberty and admitted to hospital on a formal basis when they lack capacity to consent to their admission and treatment.

A key interface of the MHA and MCA is the authorisation of a deprivation of a person's liberty in hospital that may arise from some aspect of their care and treatment for mental disorder. Specifically, where an individual lacks capacity to decide whether to be admitted to hospital for purposes of receiving care and treatment for mental disorder, and their admission will give rise to confinement, a decision has to be made as to whether to MHA authorise the deprivation of liberty they will be subject to. If the individual is objecting to either the admission or all or part of the treatment for mental disorder, then there is no legal choice to be made. However, if they are not objecting, then the courts have held that those involved (including decision-makers under both the MHA and the MCA) need to decide which legislation is the least restrictive way of being able to carry out the assessment and treatment of the individual patient (AM v South London and Maudsley NHS Foundation Trust and the Secretary of State for Health 2013). Table 1 outlines some of the key concepts associated with the interface of the MHA and MCA Acts.

In practice, the law connecting the MHA and the MCA is complex. Both acts are supported by separate codes of practice but as emerging case law highlights, use of the Acts at this interface is subject to continual interpretation.

**Table 1** Key concepts relevant to the MHA/MCA interface

Capacity	<p>The MCA outlines the test to assess capacity when a person is affected by an impairment or disturbance in the functioning of their mind or brain. The test requires a person to be able to:</p> <ul style="list-style-type: none"> <li>• understand information given to them relevant to the decision in question</li> <li>• retain that information for long enough to be able to make the decision</li> <li>• use or weigh up the information available to make the decision</li> <li>• communicate their decision.</li> </ul> <p>In practice this means that being able to understand and accept admission to hospital and that they will comply with all the elements of what is proposed concerning their assessment or treatment.</p>
Objection	<p>The MHA Code of Practice states that 'whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patients objects, the reasonableness of that objection is not the issue.'</p> <p>The MCA says that, in deciding whether the person objects to something, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including their behaviour, their wishes and feelings, their views, beliefs and values, including past circumstances where it is still appropriate to do so. A patient is ineligible for deprivation of liberty authorisation under the MCA where they object either to being a mental health patient, or to receiving mental health treatment.</p>
Assessment and treatment	<p>The MHA allows for the detention of people for the purposes of assessment and treatment of mental disorder. The definition of treatment under the MHA is broad and includes nursing, psychological intervention and specialist mental habilitation and rehabilitation and care offered to alleviate or prevent a worsening of a mental disorder or one or more of its symptoms or manifestations.</p>

## Previous research

Previous research exploring the interface between the MCA Deprivation of Liberty Safeguards (DoLS) and the MHA was undertaken between 2010 and 2011 shortly after introduction of the MCA-DoLS (Clare *et al* 2013). It investigated practitioners' understanding of the interface through the application and authorisation of MCA-DoLS. They found that decision-making within psychiatric hospitals was strongly orientated to the MHA as the appropriate legal framework for patients receiving what practitioners described as 'active treatment' (medication, ECT, psychological interventions). The MCA-DoLS were seen to be appropriate for detaining people receiving what practitioners termed 'care' (support with personal care and/or everyday tasks) while awaiting discharge to residential accommodation. In contrast, medical practitioners in general hospitals were reported to be reluctant to consider the MHA even when it appeared appropriate for the treatment of their patients' mental disorders. They concluded that interface was not well understood reflecting fundamental differences between the principles and scope of, and criteria for, the MCA and the MHA.

## Independent Mental Health Act review

The Independent Review of the Mental Health Act 2013 (2018a) was established to explore reform of the MHA with a focus on:

- rising rates of detention under the Act
- the disproportionate detention of people from Black and minority ethnic groups under the Act
- stakeholder concerns about a number of processes relating to the Act seen to be out of step with a modern mental health system.

The interface between the MHA and MCA was considered by a topic-specific working group as part of the MHA review. The conclusion and recommendations of the working group were that in the case of inpatient admission and treatment for mental disorder, use of the MHA should continue to be predicated on whether a person is objecting to their admission or treatment necessitating the use of compulsory powers, but that if the person lacks capacity to consent to their admission for those purposes, and is not objecting, then only the MCA should be available.



## Considerations for a government White Paper

The success of the recommendations of the Independent Review of the Mental Health Act 2013 are dependent on their implementation. Although considerable expertise was involved in informing the Review's recommendations in relation to the interface of the MHA and the MCA, there has been no research to date on how the decision of whether to use the MHA or MCA when there is a genuine choice between them is made in practice.

## 2 Purpose

The mental health policy team and the liaison officers at the Department of Health and Social Care commissioned The King's Fund to explore how the MHA and MCA are *currently applied in practice* in relation to this recommendation; which individuals or groups of people the recommendation will most likely have an impact on and in which settings (ie, particular types of service/ward?).

Specific research questions include the following.

- Who are the individuals or groups that practitioners encounter who lack capacity to consent to admission or treatment and do not object to admission or treatment and in which settings has this occurred? Why was the MHA or MCA applied in these cases?
- When a patient may be made subject to either the MHA and MCA, what are the perceived pros and cons of each, and how does this influence decisions in practice?
- How does national and local policy guidance, current practice and training influence use of the MHA and MCA in these instances?

## 3 Methods

We designed a mixed-methods study with an online survey to capture the diversity of factors that influence decision-making across clinical groups, and qualitative interviews with clinicians and professionals to explore in depth their understanding of the interface and experiences of making this decision in practice.

### Survey

We developed an online questionnaire to collect cross-sectional quantitative and qualitative data from professionals involved in assessing people under the MHA or MCA. This includes approved mental health professionals (AMHPs), approved clinicians and section 12 (s12) approved doctors who are required to authorise detention and admission to hospital under the MHA, and best interests assessors (BIAs) who are required to assess eligibility for MCA-DoLS and whether these restrictions are in the best interests of the person. The questionnaire was disseminated via the Royal College of Psychiatrists to practising s12 approved doctors and approved clinicians in England on their mailing list, and via the Mental Health Social Work Lead at the Department of Health and Social Care to the AMHP leads forum, Principal Social Workers Network at Skills for Care, and key members of the Association of Directors of Adult Social Services. Quantitative data was analysed to provide descriptive statistics, and qualitative data was analysed using descriptive content analysis.

### Interviews

We conducted semi-structured interviews with 12 participants whose role meant they were involved in making decisions about use of the MHA and/or MCA or who had been involved in overseeing clinical practice related to use of the MHA and/or MCA. Interviewees were identified through the survey and through individual networks and were purposely chosen to cover a range of professional roles and clinical settings in which they operated.

Interviewees were provided with information sheets and provided verbal informed consent. Interviews were conducted over the telephone and transcribed verbatim. Interviews were analysed using thematic analysis. Quotes taken from interviews are presented in italics in this report.

## 4 Findings

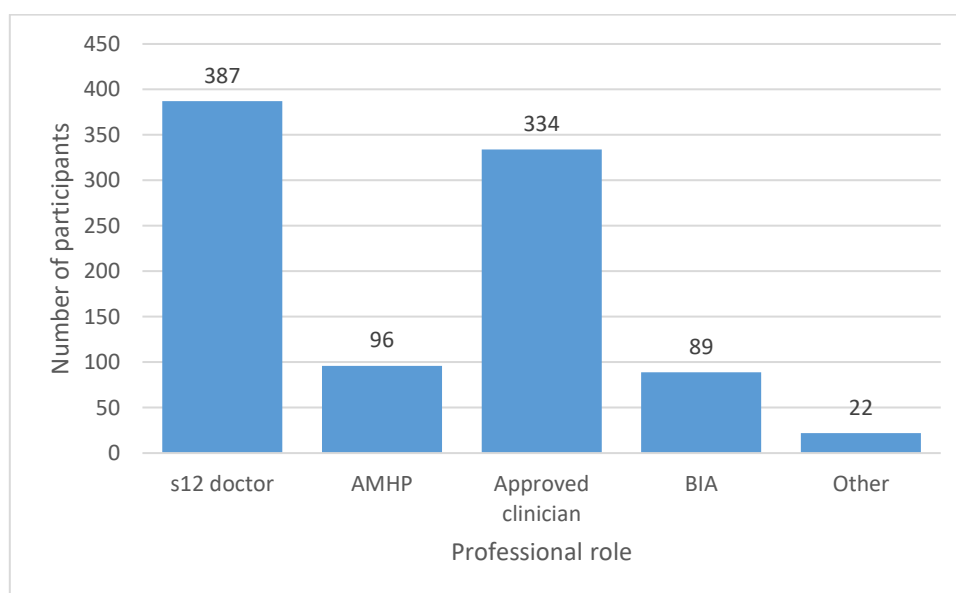
### Participant characteristics

#### *Online survey*

Data was collected between 7 March and 1 April 2020. In total, 634 people completed the survey, with 482 people completing all quantitative components of the questionnaire.

Section 12 approved doctors and approved clinicians made up the largest groups of participants although there was significant overlap in these, with 66 per cent of s12 approved doctors also recording their role as an approved clinician. Similarly, 48 per cent of AMHPs additionally recorded their role as a BIA.

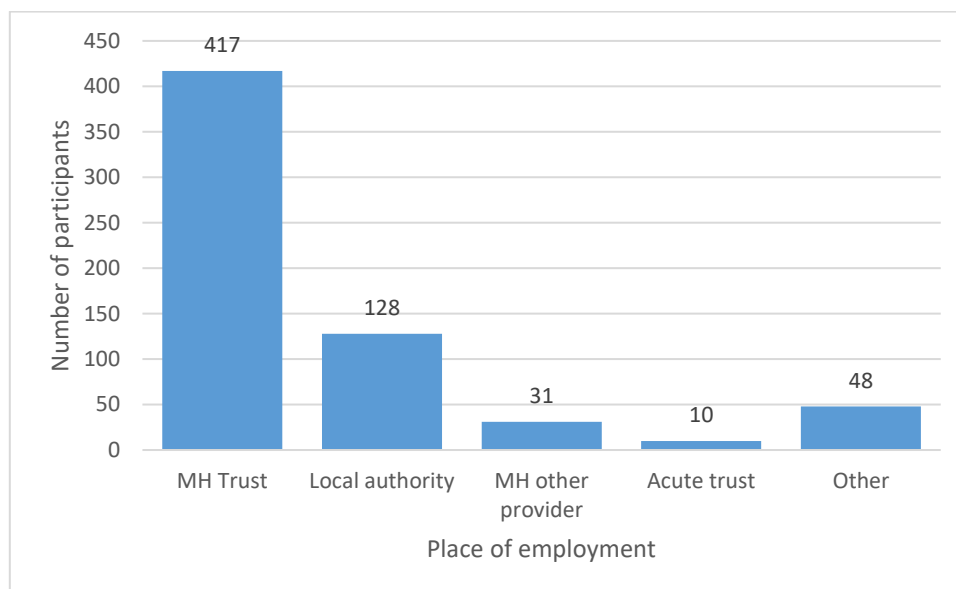
**Figure 1** Number of participants by professional role in relation to MHA/MCA (n=634)



Among those participants who defined identified themselves as s12 approved doctors and gave their area of specialty (n=385), 41 per cent worked in adult general adult psychiatry, 25 per cent in old-age psychiatry, with 6–7 per cent from each of liaison psychiatry, intellectual disability, forensic psychiatry, child and adolescent psychiatry and other.

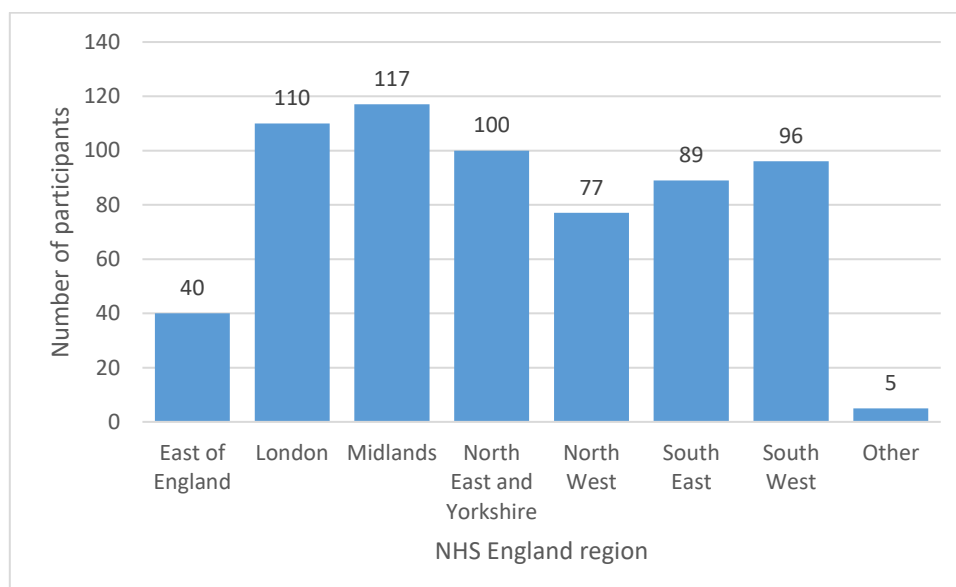
The majority of participants were employed by an NHS mental health trust (66 per cent), with the next largest group of participants employed by local authorities. The number of respondents from acute trusts was notably low given use of MCA-DoLS in particular in this setting.

**Figure 2** Number of participants by type of employing organisation (n=634)



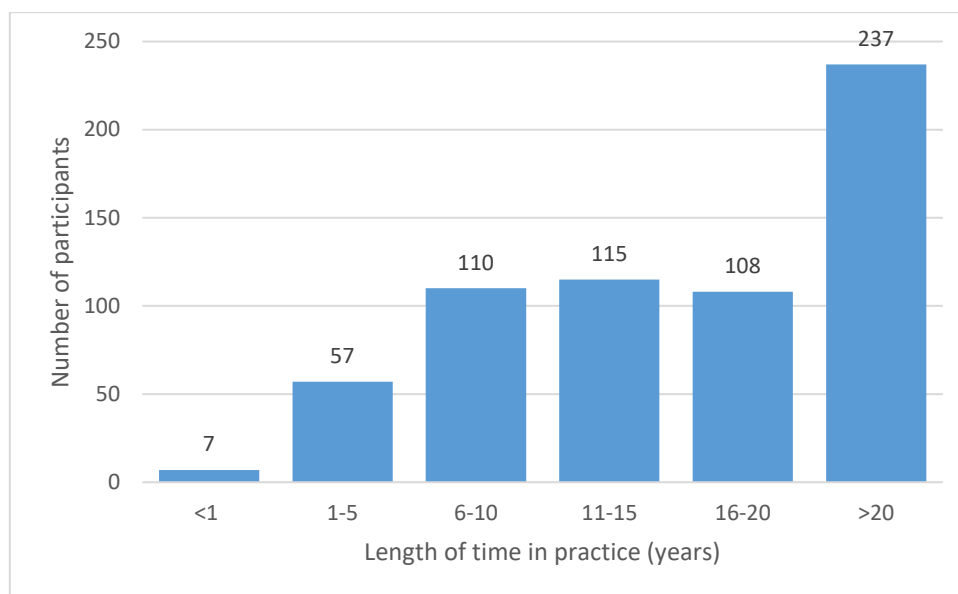
Data collected on geographical locations demonstrates a good spread of participants across NHS England regions, with slightly less representation among participants from the East of England region.

**Figure 3** Number of participants by region of practice (n=634)



Participants were more likely to have been in practice for a number of years, with more than a third having practised for more than 20 years.

**Figure 4** Number of participants by number of years in practice (n=634)



### *Qualitative interviews*

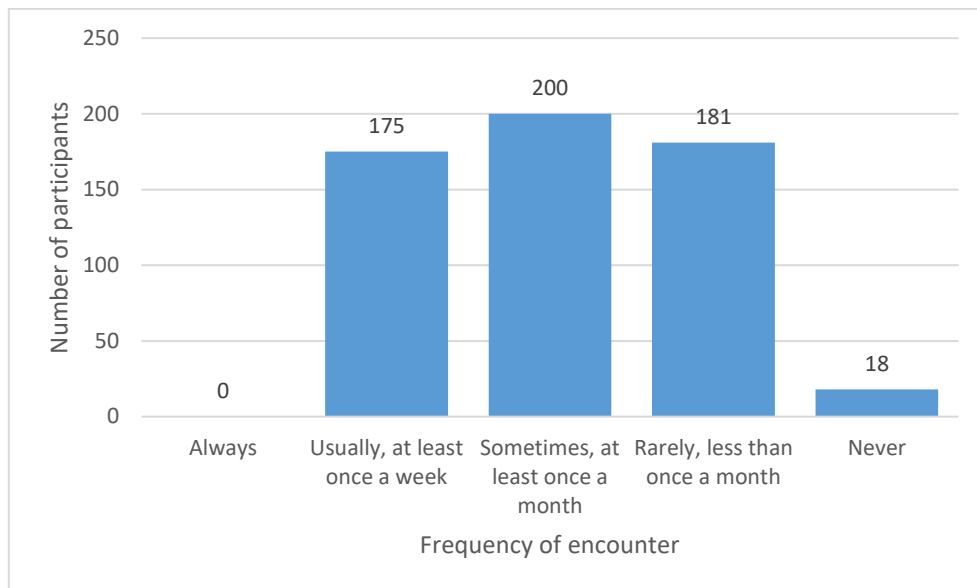
Semi-structured interviews were conducted with 12 participants. Participants' professional backgrounds included MHA managers, MHA and MCA leads, AMHPs, BIAs, MHA practice development leads, s12 approved doctors, s12 trainers, and a mental health safeguarding lead. Several participants had professional training in more than one area, eg, AMHP and BIA. Participants worked within a range of settings, including mental health trusts, acute general hospitals, liaison psychiatry, local authorities, and a clinical commissioning group.

### Data analysis

#### *How frequently does this interface decision arise?*

We asked survey participants how often they encountered people who lack capacity to agree to admission or treatment for mental disorder, and are not objecting to admission or treatment. Approximately one-third of participants reported that they encountered people who fit these criteria at least once a week, one-third encountered them at least once a month, and one-third less than once a month. A small number of participants (3 per cent) reported never encountering people who met these criteria.

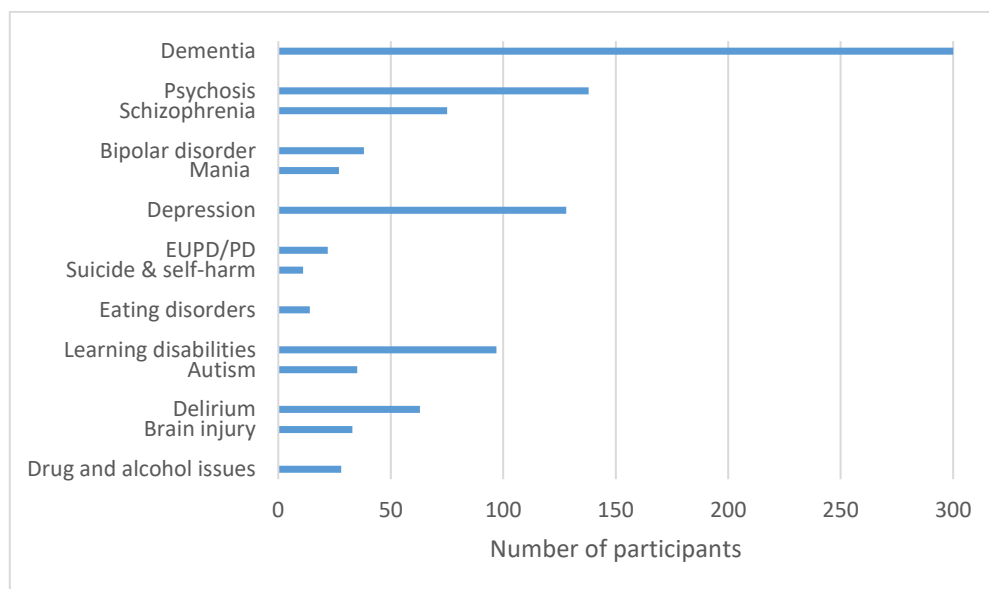
**Figure 5** Number of participants by frequency of which they encounter people to whom decisions at the MHA/MCA interface apply (n=574)



*Which disorders and clinical issues are most associated with this interface decision?*

We asked survey participants to describe the mental disorders or clinical issues that are most associated with people who meet these criteria. A total of 1,009 open-ended responses from 524 participants were categorised.

**Figure 6** Mental disorders and clinical issues commonly associated with people to whom decisions at the MHA/MCA interface apply



Descriptions provided by participants included common features of presentation in relation to specific disorders which were perceived to be relevant to the MHA and MCA interface (see Table 2).

**Table 2** Mental disorders and key features of presentation relevant to the MHA/MCA interface.

<b>Disorder</b>	<b>Features of presentation relevant to the MHA/MCA interface</b>
Dementia	People with behavioural and psychological symptoms and people who were not attempting to leave but could not consent to admission.
Psychosis and schizophrenia	People with chronic and treatment resistant schizophrenia, including cognitive impairment and those with a predominance of negative symptoms. People were described as compliant to admission or treatment but lacking 'insight' into their illness and the need for treatment.
Depression	People with severe depression or psychotic depression, and depression in older people, including those with dementia. People were described as showing apathy and amotivation leading to lack



	of objection, but also a lack of capacity to consent to admission; or viewing potential treatment as hopeless but not actively refusing.
EUPD/PD, self-harm and suicidality	People whose capacity may be transiently reduced due to poor mentalising, emotional dysregulation and dissociation. People who are experiencing high levels of distress and who may need help but want to leave.
Eating disorders	People who lack of the capacity to make decisions on treatment and care, but do not object to avoid risk of detention.
Learning disability and autism	People with challenging behaviours and people with co-morbid mental illness that requires treatment to which they lack the capacity to consent to.
Acute confusional states	People (both young and old) where it is unclear if the current mental impairment is as a result of mental illness or physical illness, or in first episode psychosis where an organic cause has not been ruled out.
Drug and alcohol issues	People with co-morbid mental health conditions; where drug use results in a transient impact on capacity; and people with cognitive impairment as a result of long-term alcohol use eg, Korsakoff's syndrome.

A common factor associated with descriptions of presenting features across these groups was co-morbid physical health and mental health problems. Participants noted this as inherent in delirium as a neuropsychiatric syndrome but also in relation to older people with severe depression or confusion leading to neglect and self-harm, and people with eating disorders who require admission for a physical health problem as a result of poor mental health. A second common factor was the combination of mental illness and cognitive impairment.

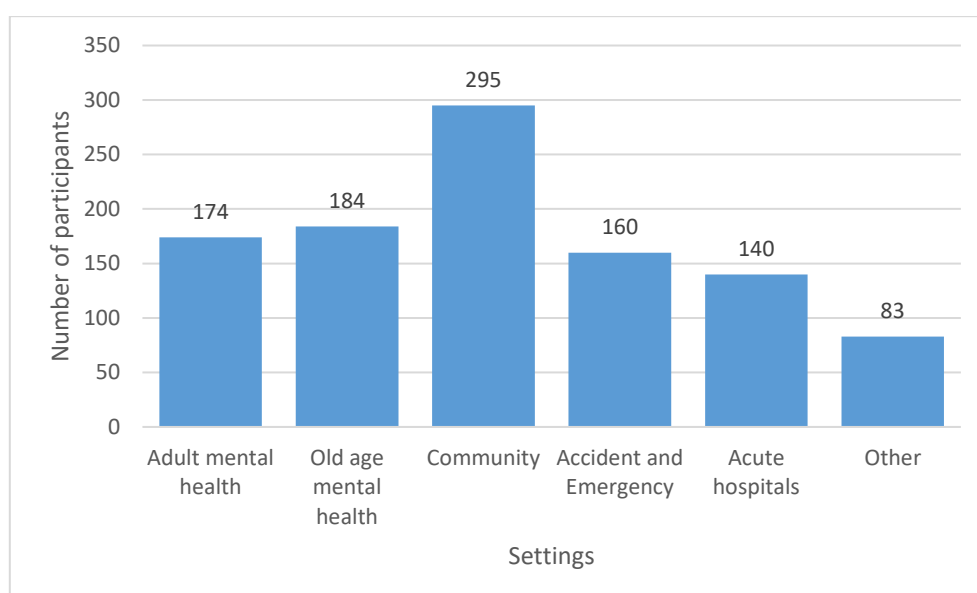
*In which settings does this interface decision occur?*

We asked survey participants – in relation to the decision of whether to use the MHA or MCA – what are the most common settings that they encountered people who lacked capacity to agree to admission or treatment but were not

objecting. The most commonly reported setting was in the community (54 per cent). Approximately one-third of participants reported encountering people who met the criteria in adult mental health settings and old-age mental health settings, and just under one-third reported encountering them in accident and emergency or acute hospital settings. Additional settings obtained from open-ended responses under the category 'Other' included:

- mental health wards for children and young people
- rehabilitation wards
- forensic wards and prison
- community hospitals
- residential units for people with learning disabilities
- care and nursing homes
- mental health crisis assessment units
- s136 place of safety
- in people's homes, on the streets, homeless hostels and day centres.

**Figure 6** Number of participants by settings in which they encounter people to whom decisions at the MHA/MCA interface apply (n=546)



Interview participants described the different situations in which the decision to use the MHA or MCA arises, the majority of which relate to individual settings.

### Adult and old-age mental health wards

On mental health wards this decision was described as most commonly related to individuals who had been detained under MHA for a period of time and were compliant with care and treatment, and at the point that detention was under review.

*...occasionally we will see on our older peoples wards, usually when someone has been there for a while, that actually they have become quite used to the routines on the ward and they're quite happy with it, they're not objecting, they are wholly compliant with the care, and on occasions where you would see due for renewal of detention they will at that point consider, you know, is it more appropriate for DoLS.*

Mental health legislation lead

Other examples highlight consideration of MCA-DoLS when mental health treatment had ended, and the patient was deemed no longer to meet the criteria for s3 or is explicitly taken off a section but is not objecting to remaining on the ward. Many of the examples described are within the context of discharge planning.

Consideration of the MHA and MCA-DoLS was also described at the point of admission. MCA-DoLS is described as an alternative to informal admission for someone who lacks capacity and a means of enacting admission to a mental health ward, with a view that a MHA assessment could subsequently be used if the individual did not settle and where informally admitted patients may be subject to continuous supervision and control as a result of admission.

### Community settings

Interviewees shared several examples where the community setting in question was an individual's home. Interviewees drew attention to different aspects involved in this process including entering someone's home, removing them from the home, and conveying them to hospital, the legal basis for which needs to be appropriately considered. Furthermore, one interviewee raised the question of whether all options for providing treatment in the home had been exhausted before considering the decision of whether a person should be admitted to hospital using the MHA or MCA.

Conveyance of patients was the most common part of the process raised by interviewees, either from home to hospital, or from an acute hospital to a mental health hospital. There were different views as to the circumstances by which someone could be legally transported to hospital using the MHA or MCA. Factors that influenced this included whether the person was being taken to hospital for a physical or mental health problem, whether transport was to a mental health hospital or an acute hospital, and whether an individual's capacity and lack of objection was deemed likely to change during the process potentially requiring additional intervention. Examples given suggested that people who lack capacity and are not objecting are transported using all these options, including 'informally' where the patient was deemed to be co-operative without use of legislation.

### Accident and emergency departments

Particular attention was drawn to decision-making in relation to people with a diagnosis of personality disorder, people with eating disorders and people under the influence of drug and alcohol within A&E settings. Use of legislation in A&E was highlighted as problematic by interviewees.

*A&E's always a problem, but it's mainly a problem because there's no frameworks for anybody. There's not really... you can't really use Mental Health Act other than a 136, you can't actually repeatedly put people on 136s, and DoLS is not often used in the A&E department, so they're really limited.*

Mental health safeguarding practitioner

### Acute hospitals

Examples within the context of acute hospitals focused largely on patients with delirium and/or dementia, but also included people with eating disorders. In each example the presence of both physical and mental health symptoms was noted and where it was not always clear which symptoms took primacy, or whether one group of symptoms was a function of the other.

*What tends to be happening is... you cross over with your DoLS, so elderly patients, patients who come in acutely confused, need physical investigations for that. It may well be they're delirious because they've got an infection, etc. They do all the tests, they may well have had actually genuine delirium, but then actually they still remain unwell, or actually it's been a relapse in their schizophrenia and there's no physical cause for their ongoing confusion or behaviour, and then... but... and they've got two medical recommendations, and they are*

*waiting for a psychiatric admission.*

Mental health safeguarding practitioner

Use of the MCA-DoLS, in particular application of urgent DoLS, was described as the usual approach within acute hospitals, particularly given an initial emphasis on treating presenting physical health problems. However, some interviewees questioned the continued use of MCA-DoLS when restrictive and coercive interventions such as intramuscular injections, physical restraint and one-to-one nursing were required over a prolonged period of time, and whether in these circumstances the MHA may be more appropriate due to its safeguards. The decision of whether to use MHA or MCA-DoLS was also raised in relation to patients who despite physical investigations and treatment, remained unwell and required admission to a mental health ward.

### Rehabilitation and residential care settings

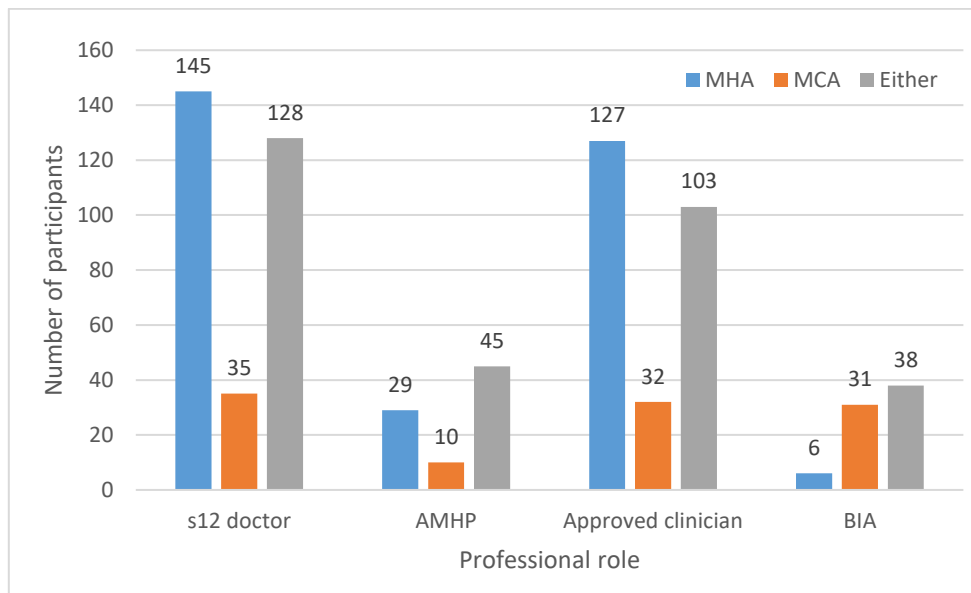
Examples shared from rehabilitation and residential care settings highlight this decision arising in relation to the type of care an individual may be receiving. Participants noted that within these settings there was often a reliance on MCA-DoLS for providing care, but that in several cases the type of care that people were receiving, and particularly use of psychiatric medication and use of restrictive practices, led them to question whether use of the MCA-DoLS was appropriate, and if the MHA may be equally, if not more, applicable to provision of that care.

### *Decision-making at the MHA and MCA-DoLS interface*

We asked survey participants which route they typically took when assessing someone who lacked capacity to be admitted to hospital for assessment or treatment, and who is not objecting to admission or treatment. 42 per cent of participants reported taking the route of the MHA, 42 per cent reported taking either and 16 per cent reported taking the MCA-DoLS route.

Section 12 approved doctors, approved clinicians and AMHPs were more likely to report taking the route of the MHA or either the MHA or MCA whereas BIAs were more likely to report taking the route of the MCA or either. Differences within groups may be an indication that patterns of decision-making may, in part, be influenced by professional group or training.

**Figure 8** Number of participants by route they typically take when assessing people to whom decisions at the MHA/MCA interface apply



We asked survey participants to identify whether there were particular groups they would consider the MHA or MCA-DoLS more suitable for when someone lacked capacity and did not object to admission or treatment. A total of 641 open-ended responses (313 related to the MHA, 327 related to the MCA) were provided by participants (n=352). Content was grouped according to whether it reflected different types of illness, individual settings, aspects of treatment and care, presentation of the patient or duration of illness and perceived recovery (see Table 3).

**Table 3** Frequently cited examples of characteristics that professionals perceive the MHA or MCA-DoLS more suitable for (qualitative content analysis of open-ended responses)

	<b>MHA</b>	<b>MCA</b>
Type of illness	<p>Functional mental illness, including psychosis, mood disorders (mania and depression)</p> <p>Suicidality and self-harm</p> <p>Dementia and mental illness</p>	<p>Dementia</p> <p>Learning disabilities</p> <p>Organic disorders, brain injury</p> <p>Delirium</p> <p>Physical illness as the cause of loss of capacity</p>
Setting	Admission to a mental health ward	Within the context of general medical wards, community, care homes
Treatment and care	<p>Requiring treatment for mental illness eg, psychotropic medication, ECT</p> <p>Behaviour that requires management eg, behavioural and psychological symptoms of dementia</p> <p>Likely to require restraint</p>	<p>In hospital for treatment of a physical health problems</p> <p>In hospital as a result of social issues, or for safety, awaiting social care placement</p> <p>No significant behavioural issues</p> <p>Challenging behaviour resulting in breakdown of care placement</p>
Presentation	<p>Risk to others</p> <p>Fluctuating capacity – changeable mental states</p> <p>Objection by patient</p>	

Transience of capacity	Acute episodes of mental illness, recurrent mental illness  Likely to recover following treatment	Likely to recover quickly  Long-term cognitive impairment
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Open-ended responses of survey participants (n=426) to the question of which route they typically take when making a decision between the MHA and MCA-DoLS at the interface provide further detail on the reasoning for these choices.

Many participants described the decision simply as the MHA was for admission and treatment of people with mental health problems, and the MCA-DoLS for physical health problems. Delineations were made between mental disorders such as psychosis and neurological or neurodevelopmental disorders such as dementias and learning disabilities; and the type of setting and its function to provide active mental health treatment versus physical health treatment or care within a place of residence, whether that be someone's home or a dedicated facility. Responses also highlight the type of treatment someone would be expected to receive. The MHA was described as more appropriate for the provision of treatments such as psychotropic medication as part of the active treatment of mental illness or used in the management of behaviour which required active intervention. Participants who routinely chose the MHA also referenced the broad scope of treatment and wider range of powers, such as s17 leave. These were described as providing flexibility in managing illness and associated risk as well as having clear routes for initiating and continuing treatment. A further reason given for use of the MHA was the likelihood that someone would be subject to continuous supervision and restrictive practices, such as restraint or rapid tranquilisation, and where this may be required to prevent risk to others as well as risk to self. There was a difference of views as to the appropriate use of legislation in relation to the management of behaviour. Some participants reported that individuals requiring intervention should be managed under the MHA, while others saw the MCA as appropriate for this purpose. One explanation given for use of the MCA-DoLS was where challenging behaviours had resulted in the breakdown of a care placement requiring admission by necessity, rather than for the purpose of assessment or treatment, until a suitable placement can be identified.



The likelihood that an individual's condition may change was also highlighted in responses. Even among those who said they typically take either the route of the MHA or the MCA, participants described a preference for using the MHA to enact admissions to a mental health ward, with MCA-DoLS a potential option at the end of a s2 or s3 if the person is not objecting. Risks identified with use of the MCA-DoLS as a means for admission to a mental health ward were that a person might regain capacity, or that they may object to subsequent treatment during the course of their admission or want to leave. Participants described a reluctance among staff on some mental health wards to have to apply for s5(2) or s5(4) of the MHA or convert to the MHA if the clinical picture changed. Participants also shared concerns that staff on mental health wards may mistakenly authorise leave or allow someone to discharge themselves if they not detained under the MHA.

Participants also described the MHA as a suitable route for treating people with acute and recurring episodes of mental illness and where there was a likelihood of recovery. Use of the MHA in these cases was described as providing a framework for treatment for practitioners, and the right for appeal for patients if capacity changes, while the MCA-DoLS was highlighted as more appropriate for those whose care may be less subject to change due to ongoing cognitive decline. An exception to this was in relation to emergency treatment in acute hospitals, where use of the MHA could be seen as 'heavy handed' if lack of capacity is transient and symptoms improve quickly.

### *Factors influencing decision-making*

We asked survey respondents to identify which route they typically took when assessing someone who lacked capacity to consent and was not objecting. Table 4 summarises reasons shared by participants who identified a preference for one or the other Act.

**Table 4** A summary of the reasons given by participants who specified the MHA or the MCA as their typical choice when assessing someone who lacked capacity and did not object to admission or treatment.

<b>MHA</b>	<ul style="list-style-type: none"><li>• Level of restriction on mental health wards, including locked wards</li><li>• Low threshold for objection</li><li>• More accessible rights, safeguards and greater scrutiny</li><li>• Better framework for people with mental illness</li><li>• Clear routes for treatment including use of restrictive interventions and managing risk. Wider range of powers, eg, section 17 leave</li><li>• Changing nature of capacity and clinical presentation</li><li>• Assessment of capacity subject to a lot of variation</li></ul>
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	<ul style="list-style-type: none"> <li>• Organisational and professional admissions policies – including restrictions on use of DoLS on MH wards</li> <li>• Processes associated with MHA assessment simple and relatively quick. Availability of assessors</li> <li>• Trained that use of MHA is preferable or best practice</li> <li>• Familiarity – professionals and providers use MHA daily and are confident in use and understand purpose and what it permits them to do</li> <li>• Difficult to admit to mental health wards unless detained under MHA</li> </ul>
<b>MCA</b>	<ul style="list-style-type: none"> <li>• Presentation due to temporary state or underlying physical health problem</li> <li>• Not requiring psychotropic medication</li> <li>• Ability to involve others to obtain supporting information and act in best interests</li> <li>• Organisational and professional admissions policies limiting use of the MHA in acute hospitals</li> <li>• Easier to apply – no formal assessment and less administrative burden</li> <li>• Understood by broad range of professionals, particularly in acute settings</li> <li>• Objection and behaviours not specifically linked to illness, may be a function of communication, eg, in people with learning disabilities</li> <li>• Inability of patients with enduring loss of capacity to participate in MHA processes in any meaningful way</li> </ul>

The free text responses also included a number of fixed statements relating to use of the Acts, and questions regarding the validity of concepts that define the MHA/MCA interface. Common examples included:

- the MHA is for assessment and treatment of mental disorder, the MCA is for physical health treatment
- the MHA is for mental health wards, the MCA is for is acute hospitals and care home settings
- the MHA trumps the MCA
- the MHA is reserved for people who are objecting
- lack of objection cannot be assumed if the patient lacks capacity to consent
- lack of recognition of MCA as an option in MH settings – alternative to MHA seen as informal admission.

The following section explores decision-making in more depth drawing on issues identified by interviewees and from the analysis of open-ended responses obtained from survey respondents (n=438) to the question 'What

are the main factors that influence your decision on whether use of the MHA or MCA-DoLS is most appropriate for people who lack capacity to consent and are not objecting to admission or treatment?’

### Perceptions of the legislation

Interviewees describe a number of different ways in which they understand the foundations and purpose of the legislation which impacts on decision-making. The MHA was described as being inherently restrictive, should be used as a last resort with an aim to discharge from as soon as possible. Considering the MHA as a ‘least restrictive’ option therefore was seen as counter-cultural to this narrative. Likewise, the MHA was also seen as inherently linked with objection – using it to deprive people of their liberty who were not objecting to admission or treatment once again ran counter to perceptions around this. These views are described as influencing the emphasis that practitioners place on different aspects of the criteria.

*Some of our AMHPs have really got themselves in a knot about one statute being greater and more restrictive than the other.  
MCA lead*

A further component of decision-making was the extent to which legislation was seen as a means to facilitate clinical decisions and treatment. Interviewees described decisions being driven by which legislation could support the immediate clinical or treatment plan, eg, admission, rather than which legislation would provide a sufficient framework for all the care and treatment an individual may receive.

### Legal literacy

Interviewees spoke about, and their narratives demonstrated, fundamental differences in how they understood and interpreted key concepts of capacity and objection associated with decisions at the MHA and MCA-DoLS interface. The process of making a capacity assessment outlined by the MCA was used to highlight differences in understanding and ascertaining capacity they had encountered. The notion of capacity outlined in the MCA – relevant to individual decisions, that should be presented to an individual and that require the individual to use and weigh up, understand and put that information into practice to confirm capacity – was countered with examples of professionals who approached capacity as either being present or absent, or where capacity was considered in relation to the immediate decision or action, rather than expectations of care individuals would be subjected to as a consequence.

Interviewees and survey participants also raised questions about the relationship between capacity and insight. Conflicting appraisals were shared – lack of insight was described by some participants as being indicative of a lack of capacity, while others noted lack of insight as inherently different from lack of capacity to make a decision. Interviewees pointed towards examples where insight was conflated with capacity, and where there was a failure to account for key requirements for assessing capacity outlined in the MCA, such as an individual being given the appropriate information relevant to the decision.

The notion of capacity was frequently intertwined with that of objection. Examples were shared where an individual was said not to have the capacity to object, and one interviewee described applying the balance of probabilities used to appraise capacity in the same way in judging objection. A general appreciation of what objection is under the different legislation and codes of practice was highlighted as problematic.

*...objection is kind of defined in the [MH] Act not clearly – but you can deduce what the Act is saying – and it says that the default position is 13.5(5) – the decision maker should err on the side of caution and when in doubt take the position that the patient is objecting.*

MCA lead, MHA and DoLS trainer

*It says in the code of practice, if the person is not objecting but they would they object if they could object they're taken as objecting, and that leads to sort of eye-rolling from your colleagues because they say, well he's not objecting so he's not objecting... you the section 12 psychiatrist come with quite a legal mindset as it were and the clinicians... are taking a very pragmatic sort of view and this leads to quite a lot of discord and disharmony.*

s12 approved doctor

Use of the MHA was described as being strongly associated with objection, and examples were shared where practitioners believed that the MHA could not apply to people who were not objecting. The legal bar for objection was described as low and was seen as limiting use of the MCA-DoLS in mental health settings unless people were completely compliant with care and the environment in which it was provided. The broad definition of 'treatment' under the MHA was presented as a reason for why use of MCA-DoLS in mental health settings was limited as most care provided within this setting was seen to fall within its scope. Interviewees questioned use of MCA-DoLS when the

person might object were it not for being in receipt of mental health treatment, and where admission might result in an individual being subject to coercive practices, such as restraint, sedation, and enhanced levels of supervision as a consequence of the ward environment and the delivery of care.

Interviewees also drew attention to how the timeliness of objection relates to its perceived legitimacy. For instance, initial objection followed by subsequent agreement, or objection on a single occasion was interpreted by some interviewees as personal preference while more frequent instances of refusal or avoidance of treatment were described as indicative of objection. Interviewees described a number of instances where care and treatment was adapted to avoid objection such as stopping medication that a person is refusing to take. An interviewee questioned the legitimacy of this approach when it is achieved through use of restriction of choice.

*They gave me his care plan and the first thing it says is that when he leaves his bedroom in a morning, lock the door. So, I asked, 'Well why do you lock the door when he leaves in a morning?' They said, 'Well, if we don't lock the door he'll go get back into bed and he won't engage in any of his treatment.' So, I said, 'Well, that's objection straightaway.'*  
AMHP/BIA

One of the key points of contention raised by interviewees in decision-making is around how care and treatment are defined in the Acts and the impact this has on perceived eligibility as well as what could be delivered within the context of either Act. Examples given by participants of what could be done under each Act highlighted a number of conceptual boundaries. One such boundary was whether someone was receiving 'active' treatment for a mental disorder rather than mental health medication being as part of their routine care, or PRN medication which an individual may opt to take. Particular note was also made around the use of sedation and covert medication. Some interviewees were clear that all of these fell within the MHA definition of care and treatment, while others described the applicability of the MHA as limited to active treatment. A second area of contention related to the breadth of care and treatment. Provision of personal, nursing and rehabilitation care within hospital was perceived by some professionals as care that individuals would have had if they had been in their place of residence and provided under the MCA-DoLS, but others described all care requirements required as result of a mental health problem, or provided as part of care within a mental health setting, to deem individuals ineligible for the MCA-DoLS. Challenges to

decision-making also arose when individuals objected to part of their treatment plan. Examples given included objection to taking mental health medication when admitted for physical health treatment, refusal of support with personal care, and refusal to engage in aspects of care such as s17 leave when part of a rehabilitation plan. Questions were raised about the continued use of MCA/DoLS for individuals despite evidence of objection, demonstrating ongoing confusion in the appropriate application of legislation.

A final area of contention related to whether an individual's presenting issue was perceived to be a function of mental disorder and requiring of assessment and treatment. These examples were highlighted primarily within the context of A&E departments and are particularly related to people with a diagnosis of personality disorder and eating disorders, where despite being identified as in need of intervention, are described as ineligible for the MCA and are deemed not to meet the criteria for detention under the MHA.

*Although we do have the debate especially around, you know, personality disorder clients and people with eating disorders, etc. So again, you know, we occasionally get difficult conversations from our acute physical health provider about what does that mean. So we can't apply a DoLS to this person because they appear to have capacity but actually they appear to need mental health treatment, that mental health provider says 'No, they don't.'*

MCA lead

### Professional roles and settings

Interviewees and survey participants shared multiple examples of blanket rules among professionals. These applied to individual settings, such as wards, and across geographical areas which professional groups worked. These rules were also reported at an organisational level which restricted the use of the MHA or MCA-DoLS in that setting. Interviewees highlighted concerns that such practices often reflected a lack of regard to the care and treatment that individuals were receiving and the purpose for which they were deprived of their liberty.

Participants often associated these rules with views about whether care settings predominantly provided physical or mental health care. However, a number of specific reasons were given for rules. One interviewee shared a reluctance by AMHPs to use the MHA within the acute trust due to concerns in being able to provide appropriate treatment.

*...if people are eligible for the Mental Health Act and we feel that's the more appropriate framework to use, what do we need in place, who's going to be the responsible clinician, what's the expectation for the level of treatment for that patient, how often should they be reviewed, rather than it just being all this, there's no criteria or guidance from our [acute] trust about that. So it makes AMHPs even less likely to want to detain.*

Mental health safeguarding lead

Familiarity was also noted as a reason for preferential use of legislation and in some cases a lack awareness that both the MHA and MCA-DoLS may be appropriate. This extended to ward staff who would be subsequently required to deliver care within the parameters of the legislation.

*So often, what I find is people pick a framework that they're more familiar with, not the framework that's the most appropriate for the patient... we're not supposed to be doing that, but how can you pick a framework you've no knowledge of, I guess*

Mental health safeguarding lead

This is one area where participants noted significant differences of opinion arising in relation to use of the Acts. Examples demonstrated how experience of these conflicts and existence of blanket rules in turn influenced decisions about use of legislation, with participants opting for practical solutions – ie, choosing legislation that avoids the risk of multiple assessments, delays in access to care, or not having a legal framework in place – at the expense of considering the 'least restrictive' approach at an individual level.

#### Considerations in weighing up 'least restrictive'

One of the most commonly mentioned factors by both interviewees and survey participants that influenced decision-making was the safeguards associated with each Act. Safeguards were described as providing patients with rights but were also noted to provide staff with confidence that their decisions were covered by a level of scrutiny and were highlighted as being particularly important where patients were subjected to coercive and restrictive interventions during the course of care and treatment. The MHA was described as providing more safeguards and a level of independent scrutiny. The various safeguards provided multiple opportunities to challenge care and treatment, involved a number of people and a level of independence. The ease and timeliness of response was also highlighted as important. Finally, these safeguards were described as having been developed

specifically within the context of caring for and treating people with mental disorder.

*I personally think that the safeguards available under the Mental Health Act, are a lot stronger than those under DoLS. Because the Mental Health Act was designed specifically for that situation, and DoLS wasn't. So, I think people should look at, what is it that the person's actually being treated for, and if they're actively treated for a mental disorder, which they probably are in a psychiatric hospital, then why not afford them the Mental Health Act safeguards? Why take away things like SOADs [second opinion appointed doctors], and tribunals and nearest relatives and replace them with a much more flexible best interests process?*

MHA manager

The MCA was seen as having fewer safeguards. Urgent DoLS were not routinely subject to review and MCA-DoLS could authorise care for up to 12 months before review and the likelihood of an appeal or representation to request discharge was more limited. Particular concerns were raised around the MCA safeguards when patients were subject to prolonged forcible treatment. The appeal process through the Court of Protection was noted as particularly slow.

*So we try to treat people under the Mental Capacity Act, as far as we can, but then there often very difficult situations, and it feels very uncomfortable where you are actually needing to give somebody intramuscular medication more than once, to keep them safe, but they're also physically ill, and how they are as part of their physical illness, but you don't feel like they've got adequate protections under the MCA.*

Liaison psychiatrist

In contrast, the MCA was described as being better at protecting the autonomy of patients. Participants highlighted the clear set of principles that govern decisions including that they are in the best interests of the person and are proportionate to risk. The MCA-DoLS was also seen as providing greater opportunities for involvement of the family and other professionals ensuring that decisions drew on a range of views from those involved. In contrast the MHA was described as having no clear definition of risk, and once detained the broad definition of care and treatment of patients meant that patients were subject to whatever care clinicians involved specified.



Access to additional support through section 117 of the MHA was mentioned by a minority of participants. Views were also shared that high use of s3 incurring s117 aftercare could be seen as an issue by some commissioners, although this was reported as a perceived barrier, rather than having been directly experienced.

The risk of perceived stigma through use of the MHA was also reported to be a consideration by a minority of participants. The MCA-DoLS was not perceived to have this stigma. In the majority of examples, concerns raised relate to the notion that use of the MHA is stigmatising due to it being inherently restrictive rather than a judgement on the perceived impact that stigma may have on an individual.

*[The MHA] produces very strong emotions... the staff don't want to section a little old lady who's got a confusional state because of the stigma that that carries and the grief they get from the relatives.*  
s12 approved doctor

A final group of considerations highlighted by participants relate to the practical application of the Acts, including timeliness, ease of use and resource requirements. Among those who typically chose the MHA, the MCA-DoLS could be seen as requiring more effort and consideration in relation to decisions around care in comparison with the MHA which covered a broad scope of care and treatment in a single decision. Concerns were also raised around delays created through the involvement of multiple agencies in MCA-DoLS assessments. Conversely, among those who typically chose the MCA, the MHA could be seen as more burdensome with its requirements around formal assessment and associated administrative processes.

### *Systemic issues that influence practice*

A number of issues were highlighted by interviewees and open-ended responses of survey participants which draw attention to the impact of wider systemic issues that are shaping decisions at the MHA and MCA interface. One issue raised was access to mental health beds. Participants reported access to beds in some areas being dependent on people being detained under the MHA. Although in some cases this appears to be a function of blanket rules, in others it is put down to bed shortages. A second issue was availability of MCA-DoLS and MHA assessments. Several participants referred to long waits for BIAs in local authorities, and a few participants noted delays in MHA assessments.

*Your decision to admit will be hugely scrutinised and questioned by everybody in the chain, which makes us all very concerned that we're becoming more prone to using the Mental Health Act, than we necessarily need be, because of service pressures.*

Liaison psychiatrist

*...orders take ages to come back from the court of protection, so we're having to use Section 17 leave for longer periods than we might ideally like do, while we wait for the court of protection order.*

MHA/MCA policy and practice development lead

### *Unlawful deprivation of liberty*

Several interviewees described discussions they had been involved in around use of the Acts and practices that question the boundaries of legality, as well as identifying areas where patients were being unlawfully deprived of their liberty. An issue which repeatedly arose in interviews was the informal admission of patients to mental health units who lack capacity but who are not objecting. A number of reasons were given for this, including staff not being clear about the right pathways for people who lack capacity, and that some wards may still be working to old practices where people were held informally.

*I think our policy reflects some of the perhaps slight ambiguousness that's in the statutory guidance. We haven't, for example, prohibited informal admissions for people who lack capacity or taken any steps like that within our service.*

AMHP lead

More than one interviewee reported having patients on their wards who been deemed ineligible for both the MHA and MCA leaving them in effect in legal limbo, but where the hospital was reluctant to discharge them due to potential risk to the individual.

*...we have had one or two such patients in the past. They sort of fall between two stools when they are not... they do not meet the criteria for detention under the MHA and at the same time they don't meet the criteria for DoLS... We're going to have to continue holding them on the ward but they fall into this strange category where we're not really sure what legal regime we're holding them under.*

MHA manager

Several examples were provided of patients who were unlawfully detained in acute hospitals.

*I had someone say to me... that on a Friday night at 1am in the morning when there are seven or eight confused patients, they just lock the door and there's large numbers of patients who should be on a section.*

s12 approved doctor

An interviewee described the findings of an audit of detentions under the MHA and MCA in their acute trust. They identified three key issues that resulted in people being unlawfully detained. The first comprised errors in paperwork, such as staff not completing section 5(2) of the MHA properly, or the paperwork not being received by the trust, meaning that technically the patient is not legally detained, despite being treated as if they were. A further example was of staff making a DoLS application, but not recording that they had already received a recommendation for detention under the MHA. The second occurred when patients were kept on the ward despite making attempts to leave while they awaited transfer to a mental health bed having been deemed appropriate for detention under the MHA. The final issue was the continual use of MCA-DoLS despite the patient being ineligible by means of objection to treatment, or no longer requiring treatment for physical health problems.

Delays for MHA assessments in acute hospitals and MCA-DoLS assessments in mental health hospitals were highlighted as contributing to unlawful deprivation of liberty. In each case, the patient continued to be detained, having been deemed ineligible for both the MCA-DoLS and the MHA. Interviewees reported acknowledgement or even acceptance of delays on the part of assessor.

*You arrange a Mental Health Act assessment, that then seems to be a tremendous hassle, and in some cases never gets done and you're on the ward three weeks later for somebody else and you still see the person sitting there, you have a quiet word with the nurse, 'Are they sectioned? No. Are they on DoLS? No.' They're just sitting there and, you know, so that's it.*

s12 approved doctor

*There are currently a lot of delays with local authorities providing BIA assessors. It takes them ages sometimes to come and we end up*

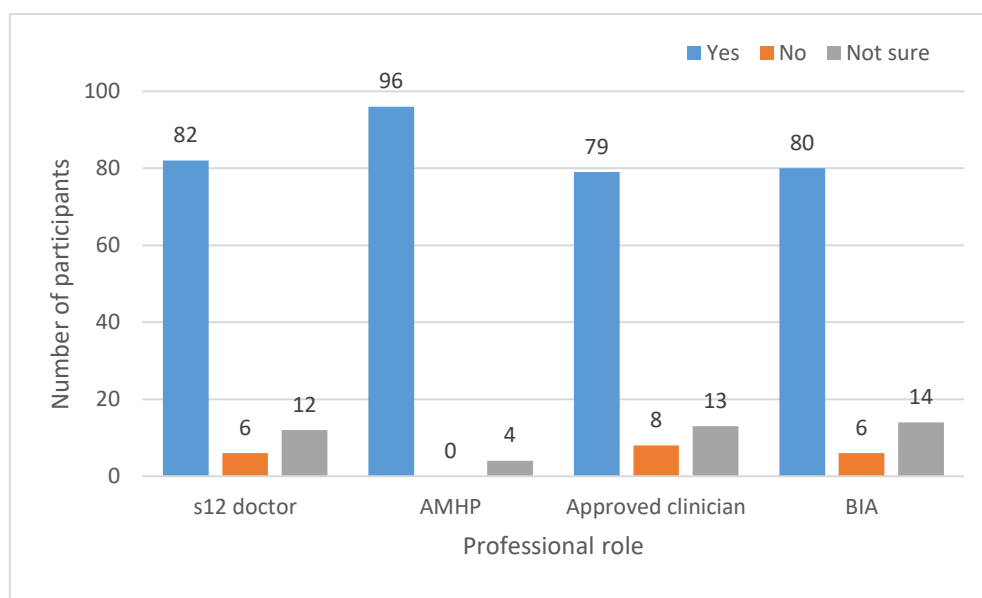
*detaining somebody, de facto detaining a patient who is not eligible for Mental Health Act and there is a huge, sometimes months and months, delay for a DoLS assessment. And they are in exactly the same kind of legal limbo where we don't know where we stand.*

MHA manager

### *Training in making decisions at the interface*

The majority of survey participants reported that their training in use of the MHA and MCA involved consideration of when to use each option (see Figure 9).

**Figure 9** Percentage of participants who reported that their training involved consideration of when to use the MHA and MCA



There were mixed views among interviewees about the extent to which training provided a clear understanding on decision-making at the interface of the MHA and MCA. The complexities and nuances of decision-making could mean that different people could end up taking different things away from the session.

*I think one of my worries has been that in the past when I've done training with staff and stuff like that, that people have kind of gone out of the training more confused rather than more confident at times.*

AMHP lead

Interviewees noted that decision-making at the interface required not only an understanding of the respective codes of practice, but how this is changes in relation to legal rulings, which added a further layer of complexity. The impact of training was described as being mediated by practice, with understandings of the legislation and capacity developing within the context of health settings, such that professionals evolved their own ways of making these decisions.

*The guidance about choosing between the two varies depending on where you look. I mean, we've got the DoLS code of practice, we've got the MHA code of practice, we've got case law. The codes of practice haven't kept up to date with the case law, and the case law is really difficult to understand. What I find happening in practice, is people coming up with a simplified understanding that suits them.*

MHA manager

Several interviewees highlighted the value of staff being trained in both the MCA and the MHA. This came from practitioners who were trained in both, as well as those who worked in teams where staff were trained in both. Dual training was described as enabling practitioners to come at the decision from the different perspectives that underpin the Acts which, in turn, influenced decision-making in practice.

*I think the more training people do, the more likely they are to find people ineligible [for DoLS].*

s12 approved doctor

Access to training may be an issue in some settings. One interviewee shared that there was no mandatory training on the MHA within their acute trust, and another that the MCA was part of the curriculum in old-age psychiatry, but that access to training subsequently was limited.

## 5 Discussion

This project was commissioned within the context of the Independent Review of the Mental Health Act and recommendations made in respect of considerations of the MHA and MCA interface. The research sought to explore the context in which the decision of whether to use the MHA or the MCA to authorise a deprivation of liberty is made and the different factors that practitioners use to assess and weigh up which Act is most appropriate and 'least restrictive' for the individual concerned.

Our research found that a large proportion of practitioners are likely to encounter people to whom this decision applies at least once a month, if not weekly. We also found that the people they encounter are most likely to have dementia but include people with a wide range of other disorders including both functional mental illnesses, neurodevelopmental and neurological conditions. And they were encountered across a wide range of settings, most commonly in the community where decisions are being taken regarding admission to hospital – which may reflect the diversity of settings that this encompasses – but also in mental health and acute hospitals, and on the wards as well as in the emergency department. This suggests that far from being a niche issue, it is a decision that has relevance across multiple areas of practice.

One of the most striking findings is the lack of a common understanding around the multitude of factors that influence how decisions are made. This includes core concepts of capacity and objection, which are fundamental to the question of whether someone can be admitted informally and whether they are eligible for DoLS under the MCA, even before practitioners are required to weigh up which of the Acts is least restrictive. This confusion may, in part, reflect the fundamental differences in the Acts. The MCA is entirely capacity based and where – outside the situation of the interface – the presence or absence of objection is not a trigger deciding whether or not use of DoLS (or application to the Court of Protection outside of situations where DoLS applies) is required, if they cannot consent to a confinement required to provide care and treatment. Conversely, the MHA is not capacity based, and objection is the core determinant as to whether the person will be admitted informally or detained where it is considered that they meet the criteria for admission for assessment or treatment. Challenges in decision-making based

on understandings of capacity and objection were highlighted as specifically problematic in relation to care and treatment of people with a diagnosis of personality disorder and eating disorders. However, the considerable variation in descriptions of how this is understood and the contexts in which it is described within this research suggest that this is a more fundamental issue.

When it comes to the interface decision, we found that the route that practitioners report most commonly taking, ie, 'MHA', 'MCA' or 'either' was influenced by their professional role. This demonstrates that, in practice, practitioners do not approach this decision from a position in which the two Acts are considered on an equal basis. This may in part reflect that professions are most likely to make these decisions in relation to their area of training. However, our research also highlighted fundamental differences in how the legislation is perceived. This included perceptions around use in relation to physical vs mental health conditions, and around what constitutes care and treatment. Perhaps most notable was the perception of the MHA as inherently restrictive – which itself undermines the basis of a decision that asks practitioners to consider the path of least restriction to achieve the assessment and treatment of a person for mental disorder where they lack capacity to consent to their admission. This suggests that in making this decision, many of the factors already come with an inherent weighting even before the individual subject to the decision is considered.

The presence of blanket rules within professional groups and across different settings is perhaps most concerning in relation to how this decision is made in practice, because by nature of a blanket rule, there is no decision. The differences in how these blanket rules apply introduces a level of variation such that the rights accorded to people admitted and treated in some settings and areas of England may not be afforded to those in other settings and areas.

A small number of systemic factors were highlighted as part of this research as influencing decision-making. This included availability of both MHA and DoLS assessors, delays in access to mental health care as a result of mental health inpatient bed capacity, and delays in transfer of care, particularly to residential care settings. These factors were not only described as influencing decisions, but they also constrained decisions – forcing practitioners to opt for what was possible rather than what was 'least restrictive'.

These findings highlight that the decision at the interface is not only influenced by the complexity of the different factors professionals are asked to

weigh up, but is further complicated by the lack of a common understanding around the fundamental nature of the legislation and criteria which frames the interface decision. The majority of participants in our survey reported that their training did cover decision-making at the interface, but interviewees raised concerns that different legislation, codes of practice and case law were often difficult to understand and keep up to date with. This has resulted in practitioners developing their own understandings and in some cases the development of rules that run counter to the very ethos of the decision.

While the consequences of these findings point to the challenges presented by this decision in day-to-day practice, for patients those consequences can be more fundamental. We heard about a number of different ways in which patients are unlawfully deprived of their liberty as a result of the factors outlined above. This raises questions about whether sufficient recognition and prioritisation is given to the role of legislation in protecting the rights of people who are deprived of their liberty; the care and treatment they will be subjected to during this period; and whether oversight and accountability is robust enough to ensure this happens.

### Limitations

One of the strengths of the research is the large number of responses and representation from practitioners across different areas of England and from different professional groups involved in making this decision. However, while these findings may reflect a broad range of practice, the survey was completed by a self-selecting group of practitioners. Further research is required to identify the prevalence of different practices and variations in practice between professional groups, settings, and areas of England.

In seeking to understand how the decision at the interface of the MHA and MCA is made in practice, we made no judgement about the quality of practice and participants understanding of the legislation. As such, responses may reflect poor practice as well as differences in practice and interpretations of the legislation that are inaccurate. It is also noted that the limitations of free text responses may result in an oversimplification of stated factors that influence decision-making, although this is, in part, mediated and explored through the data obtained in the interviews.

### Implications

Reflections of the working group for the Independent Review of the Mental Health Act that considered the interface of the MHA and the MCA noted that



any solution in relation to the interface question could not be entirely satisfactory, (1) because the MCA and the MHA were so different in terms of their approaches, safeguards and entitlements; and (2) because of the difficulty of imposing a binary legal classification upon the complex realities of individual patients (Independent Review of the Mental Health Act 1983 2018b).

Their recommendation on balance was that use of the MHA should be predicated upon whether a person is objecting to admission or treatment necessitating the use of compulsory powers, and that if the person lacks capacity to consent to their admission for these purposes, and is not objecting, then only the MCA should be available. This research finds that in practice the issues outlined by the working group are more fundamental and relate to the core components that frame the decision itself including how the concepts of capacity, objection and care and treatment are understood. This raises the question about how the Acts are understood and applied individually, even before the question of how they are understood at the interface.

The current status quo, however, is resulting in people being unlawfully deprived of their liberty and not afforded their appropriate rights. Many of the findings of this research echo those of research conducted shortly after the introduction of MCA-DoLS almost a decade ago (Clare *et al* 2013). That such established cultures of practice continue to prevail raises questions about the extent to which legislative changes are meaningful to practitioners and the contexts in which they are required to implement them. However, any future changes of legislation need to take account of this if they are to result in systematic changes in practice.

Several of the issues raised in this research have implications for areas of policy beyond the scope of the independent Mental Health Act review recommendations. Suggestions for further work as a result of this research include:

- a review of MHA and MCA policy to consider opportunities for alignment and simplification with the aim of reducing the complexities underpinning differential implementation of the legislation in practice
- a review of the safeguarding measures in place to ensure appropriate and legal use of the Acts, including provisions for monitoring of the MHA and MCA with an aim of reducing unlawful deprivation of liberty.

These issues are likely to require the engagement of the separate policy teams at the Department of Health and Social Care responsible for the MHA and the MCA and at the Ministry of Justice responsible for the MCA. The involvement of the Care Quality Commission in its role of monitoring use of the MHA and the MCA should also be considered, particularly with regard to examples of unlawful deprivation of liberty identified by participants as part of this report.

This research starts from the position of the decision-makers. Through this we have been able to identify who this decision applies to and the way in which it is applied. However, as a decision that is made by professionals but applies to individuals, further research is vital to understand how professional perceptions of what is least restrictive and the consequences of those decisions are experienced by those subject to them and their carers.

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## 7 Acknowledgements

We would like to acknowledge and thank the following individuals and groups for their generous contributions:

- The Mental Health Policy Research Unit for its input into the design of the research, and the reflections of the Lived Experience Working Group on the findings
- Alex Ruck-Keene for helping us to navigate what is a highly technical and somewhat legal quagmire and sharing thoughts and invaluable suggestions on the findings
- Mark Trewin at the Department of Health and Social Care, and the Royal College of Psychiatrists' membership team for helping to disseminate the survey via their professional networks.
- Our external and internal reviewers who provided vital feedback and suggestions for changes to help clarify and strengthen the findings.

## 8 Appendix

### Interview topic guide

1. Can you tell me about your role and how this relates to use of the MHA and/or MCA?
2. What is your understanding of the how the MHA or MCA applies when someone lacks capacity to decide whether to be admitted to hospital or to receive treatment but is not objecting to admission or treatment.
  - a. What is the balance of factors and your view on how these should influence decision-making?
3. How is this issue dealt with in your organisation/training?

We understand that sometimes there are differences in practice between different settings, providers and areas of the country.

4. Do you come across instances where there is a difference of opinion as to which route to take (eg, MHA vs MCA)?
  - a. If yes, can you tell me a bit more about this?
5. How do you perceive the relative pros and cons of the MHA vs the MCA for people who meet these criteria?
  - o What is your view on how these influence decision-making?

## Online survey

1. What is your role in relation to the use of the Mental Health Act 1983 and/or Mental Capacity Act 2005 (please tick all that apply)

- Section 12 approved doctor
- Approved MH Practitioner
- Approved clinician
- Best Interests Assessor
- Other (please specify)

2. What area of psychiatry do you specialise in (for s12 approved doctors only)

- General adult psychiatry
- Old-age psychiatry
- Liaison psychiatry
- Intellectual disability
- Forensic psychiatry
- Child and adolescent psychiatry
- Other (please specify)

3. What type of organisation are you employed by?

- Local authority
- NHS MH trust
- Other MH provider
- NHS acute trust
- Other (please specify)

4. What region are you based on?

- East of England
- London

- Midlands
- North East and Yorkshire
- North West
- South East
- South West
- Other (please specify)

5. How long have you been in practice?

- Less than a year
- 1–5 years
- 6–10 years
- 11–15 years
- 16–20 years
- More than 20 years

6. Do you encounter people who fit these criteria when assessing someone for use of the MHA and/or the MCA?

- Always
- Usually, at least once a week
- Sometimes, at least once month
- Rarely, less than once a month
- Never

7. In which settings do you most frequently encounter people who fit these criteria (tick all that apply)

- Adult mental health
- Old-age mental health
- Community settings
- Accident and emergency

- Acute hospitals
- Other (please specify)

8. Please describe the mental disorders/clinical issues which are most commonly associated with people who meet these criteria

9. When assessing someone who lacks capacity to consent to admission or treatment and is not objecting to admission or treatment, which route do you typically take?

- Mental Health Act
- Mental Capacity Act
- Either – depending on the circumstances

10. In your role are there particular groups that would consider the MHA or the MCA more suitable for?

- Mental Health Act – open responses
- Mental Capacity Act – open responses
- Either – open responses

11. What are the main factors that influence your decision on whether use of the MHA or MCA is most appropriate for people who lack capacity to consent and are not objecting to admission or treatment?

12. Does your training in use of the MHA and/or MCA involve consideration of when to use each option?

- Yes
- No
- Not sure