

Quick Reference Guide: Interface between the Mental Health Act and Mental Capacity Act

Learning from [SAR 'Eric' \(published February 2025\)](#) identified the need to develop a briefing to support the legal literacy of practitioners working with the Mental Health Act 1983 and the Mental Capacity Act 2005.

The law connecting the Mental Health Act (MHA) 1983 and the Mental Capacity Act (MCA) 2005 is complex and can be difficult to implement in practice, particularly in relation to authorising a deprivation of liberty. More guidance continues to emerge from case law, however this Quick Reference Guide aims to bring guidance from the codes of practice and other sources together as a valuable resource.

It uses a series of questions to set out the key points on the interface between the MHA and the MCA.

<p>What is the scope of the MHA?</p>	<ul style="list-style-type: none"> To fall within the scope of the MHA, the person must have a mental disorder, defined as: <i>'any disorder or disability of the mind'</i>. This excludes dependence on drugs and alcohol for the purposes of longer-term treatment powers and only includes those with learning disabilities if their disability is <i>'associated with abnormally aggressive or seriously irresponsible conduct'</i> (s1(2)). The MHA is focused on the assessment and treatment of mental disorders in hospital settings, which may be provided under compulsory powers, if the person is unable or unwilling to consent, and it is necessary to detain them to protect them and/or others from harm. Capacity and best interests are not central considerations under the MHA. Powers under the MHA can also be used to treat people in the community, which includes Guardianship (s7), Community Treatment Orders (CTOs) (s17A-17G), conditional discharge (s41) and leave of absence from detention (s17 leave).
<p>What is the scope of the MCA?</p>	<ul style="list-style-type: none"> To fall within the scope of the MCA, the person must be assessed as lacking the relevant capacity to make a decision <i>'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'</i> (s2(1)). There is a two-stage test for capacity, a functional test followed by a diagnostic test which must be applied alongside the first three statutory principles of the MCA, the presumption of capacity (s1(2)), taking all practicable steps to help the person make their own decision (s1(3)), and that the person cannot be assumed to lack capacity because their decision may appear unwise (s1(4)).

<p>What is the scope of the MCA?</p>	<ul style="list-style-type: none"> For those assessed as lacking the relevant capacity, any act of care or treatment provided to them must be in their best interests (s1(5)) and less restrictive alternatives must be considered first (s1(6)). If the proposed course of action includes potential restraint, the decision maker must reasonably believe that the restraint is necessary to prevent harm to the person and is proportionate to the likelihood and seriousness of the harm (s6). The decision maker should also consider whether the restraint will meet the Deprivation of Liberty threshold (known as DoLS in care homes and Community Deprivation of Liberty (CDoL) in other settings).
<p>What are the key differences between the MHA and MCA?</p>	<ul style="list-style-type: none"> The MCA relates to a person's functioning – that is their capacity to make a particular decision – whereas the MHA relates to a person's status as someone diagnosed as having a mental disorder within the meaning of the Act. The MCA requires acts done or decisions made on behalf of people who lack capacity, to be done or made in their best interest. Detention under the MHA contains no equivalent requirement. A person can be detained under the MHA solely on the basis of the risks that they pose to others. The MCA can cover nearly all decision-making whereas the MHA is limited to decisions about care in hospital and medical treatment for mental disorder. The MCA specifically excludes anyone giving a patient medical treatment for a mental disorder if the patient is, at the relevant time, detained and subject to compulsory treatment provisions under part 4 of the MHA.
<p>Circumstances where both the MHA and MCA can apply</p>	<ul style="list-style-type: none"> In cases where a person is detained in hospital under the MHA, but needs treatment for a physical health problem, then the MCA (and DoLS) could potentially apply alongside the MHA. If a person is detained under the MHA and needs physical health treatment related to their mental health, then the treatment can be given under the MHA, for example if a person has self-harmed. If a person required medical treatment unrelated to their mental health, for example for cancer treatment, then treatment can be provided under the MCA if it is in their best interests. Where a person detained under the MHA is placed on s17 leave and is transferred to a general hospital for physical treatment, then if their admission and treatment amounts to a deprivation of their liberty, then a DoLS authorisation should be sought.
<p>Deprivation of Liberty</p>	<ul style="list-style-type: none"> Both the MHA and DoLS codes of practice set out similar guidelines. As stated in the DoLS code of practice (4.14), an individual is not eligible for DoLS if they are detained in hospital as an inpatient under the MHA. However, a person on s17 leave is not considered 'detained' under the MHA and therefore DoLS can apply. For the purpose of the MHA, treatment for a mental disorder can include nursing care (MHA Code 23.2) and any other

Deprivation of Liberty	<p><i>'medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations'</i> (MHA Code 23.3).</p> <ul style="list-style-type: none"> The DoLS code of practice (4.48) also says <p><i>'Even where a person does not object and a deprivation of liberty authorisation is possible, it should not be assumed that such an authorisation is invariably the correct course. There may be other factors that suggest the MHA 1983 should be used'</i>.</p>
Circumstances when I have a choice of the MHA or MCA	<ul style="list-style-type: none"> There are cases where decision makers have a choice between the MHA and MCA in authorising a Deprivation of Liberty in hospital in the case of a <i>'compliant incapacitated psychiatric inpatient'</i> which stems from AM v South London & Maudsley Foundation Trust & Secretary of State for Health [2013] UKUT 0365 (AAC) In principle, a DoLS authorisation and detention under the MHA would both be available subject to the assessments required for a DoLS authorisation. It is important to note that a person cannot be detained under the MHA at the same time as being subject to a DoLS authorisation or Court of Protection order. The choice of using the MHA or MCA should never be based on the decision maker's preference for one regime or the other, rather it should be based on which regime would be less restrictive for the person, balanced against any potential benefits associated with the other regime. The nature of the safeguards under each regime is different and decision makers must consider which safeguards will best protect the interests of the person. It should be noted that in the case of Manchester University Hospital NHS Foundation Trust v JS and Manchester City Council [2023] EWCOP 12 Judge Burrows confirmed that <p><i>'If the patient has to be detained for treatment for their mental disorder, and there is no alternative outside the hospital setting, and no other treatment plan available, then it seems clear to me the patient should not be detained under the MCA but rather under the MHA.'</i></p>
Application of the MHA in the community	<ul style="list-style-type: none"> MHA powers can be used in the community which includes: <ul style="list-style-type: none"> Guardianship (MHA s7) Community Treatment Orders or CTOs (MHA s17A-17G) Conditional discharge (MHA s41 and s72 for certain forensic patients, that is those entering MHA detention from the criminal justice system considered to pose a high level of risk) Leave of absence from detention (known a s17 leave) Where a person is subject to any of the above, then authorisation under DoLS can be granted as long as the person meets the <i>'qualifying requirements'</i> for DoLS and DoLS authorisation is not in accordance with a requirement imposed by one of the above powers, for example a DoLS authorisation could be requested to

<p>Application of the MHA in the community</p>	<p>keep a person in care home A but the person's Guardian wishes them to live in care home B, therefore a DoLS authorisation could not be granted to deprive the person of their liberty in the care home A as this is not in accordance with the guardian's decision. In GW v Gloucestershire County Council: [2016] UKUT 499 (AAC) - GOV.UK it was confirmed that guardianship does not allow a deprivation of liberty and if a care plan amounts to this, then authorisation under DoLS or a court order must be sought.</p>
<p>Using DoLS and managing risk in the community</p>	<ul style="list-style-type: none"> • You should be cautious about using DoLS where there is a risk to others in the community. DoLS focuses on risk to the person and in P v A Local Authority [2015] EWCOP 89 the DoLS authorisation was discharged because the risk was not of harm to the person but of harm to others. However, in other case law, such as N v A Local Authority [2016] EWCOP 47 the judge ruled that factors relating to harm to others can sometimes be relevant. • In these more complex cases, you should seek legal advice and consideration should be given to take the matter to the Court of Protection under s16 of the MCA, rather than risking a flawed DoLS authorisation.