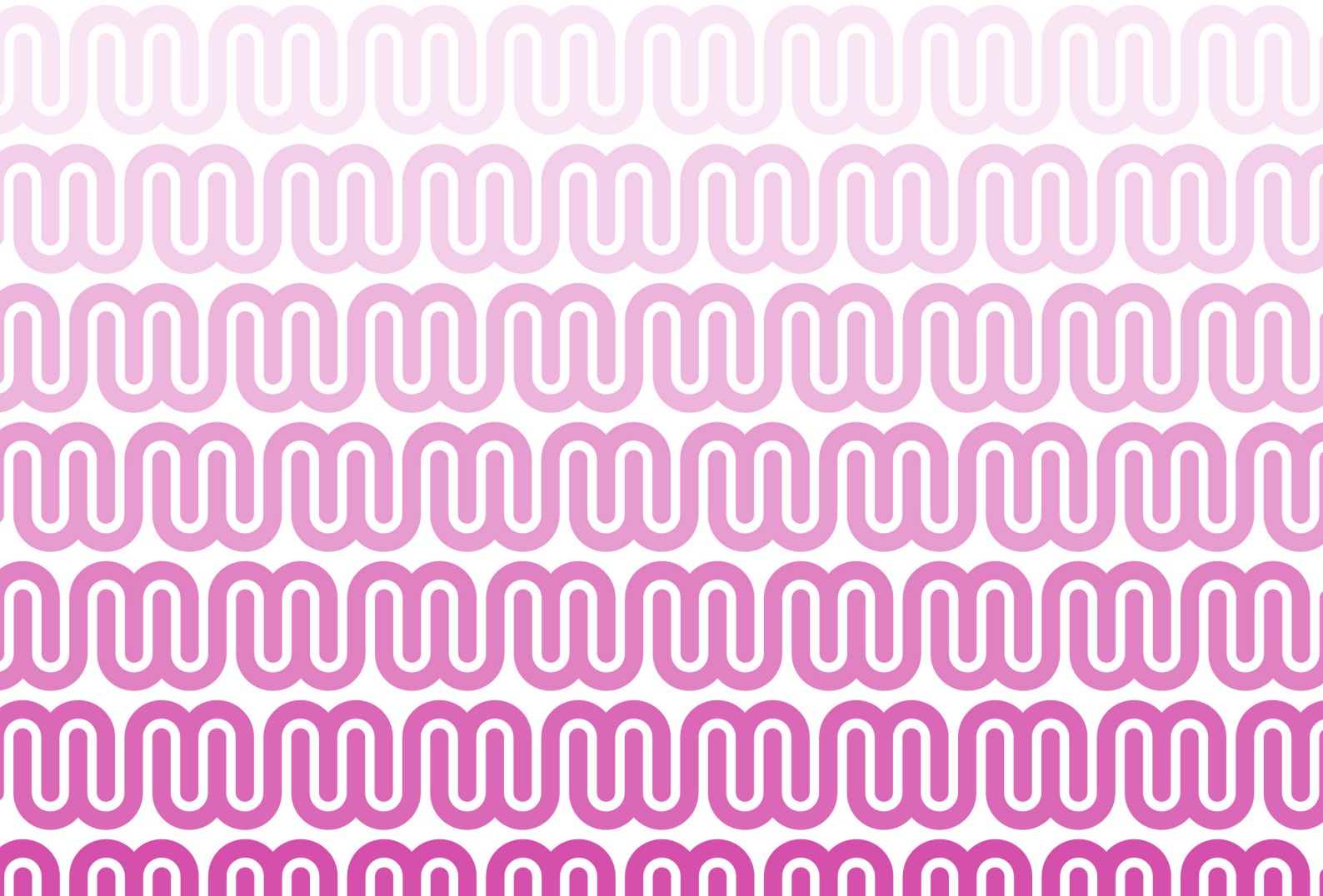
mental welfare commission for scotland

Medical treatment: which Act to use?

Use of mental health legislation to treat physical ill-health when an individual is subject to compulsory care and treatment.

Good practice guide

August 2025



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

Medical treatment: which Act to use?

Use of mental health legislation to treat physical ill-health when an individual is subject to compulsory care and treatment: a position statement from the Mental Welfare Commission for Scotland.

For individuals subject to compulsory care and treatment, there is a complex interplay in Scotland between the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) when it comes to physical healthcare. When the individual is subject to compulsory care and treatment under the Mental Health Act (or the Criminal Procedure (Scotland) Act 1995), the question arises: when can this Act be used to authorise treatment for physical illness? And when is the AWI Act more appropriate to use?

This document sets out the Commission's position on how the two Acts should be used when this situation arises. This should be read in conjunction with our guidance documents: *Right to treat*[1] and *Medical treatment under Part 16 of the Mental Health Act*[2].

[1] Right to treat: https://www.mwcscot.org.uk/node/509

[2] Medical treatment under Part 16 of the Mental Health Act: https://www.mwcscot.org.uk/node/319

What the Acts say

The AWI Act defines medical treatment as "*any procedure or treatment designed to safeguard or promote physical or mental health*".[3] Subject to the principles of the AWI Act, treatment may be administered under s47 with a certificate of incapacity. While the legislation at present is not specific, it is generally understood that this authority does not apply where the individual is subject to treatment for "*mental disorder*" that is authorised under Part 16 of the Mental Health Act.

The Mental Health Act defines medical treatment as "treatment for mental disorder." It goes on to state that treatment includes care, nursing, habilitation, rehabilitation and psychological intervention[4].

The Code of Practice to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Code) draws a distinction between physical illnesses that are a direct cause of a mental disorder and those that arise as a consequence of it. Where a physical condition, such as thyroid disease or hypoglycaemia, is directly responsible for the mental disorder, the Code states that its treatment would be authorised under Part 16 of the Act.

In contrast, where the physical condition is the result of the mental disorder, the Code is less prescriptive. The only example it provides is self-harm, including overdose, where it states that such treatment may be given under the Mental Health Act. This "may" is deliberately less certain than "would", signalling that the Act can be used, but does not require its use, and that other legal routes – such as the AWI Act or common law emergency powers – may also be appropriate.

The wording therefore places greater emphasis on the Mental Health Act as a framework for treating a physical illness that precipitates a mental disorder and adopts a more discretionary approach where the illness is a consequence of that disorder, such as self-harm.

Case law

We know of no directly applicable case law in Scotland. There are court judgements in other jurisdictions. While having regard to these, the Scottish legislation and Codes of Practice appear to us to have greater relevance in areas of uncertainty.

English courts have taken a broader view of what constitutes "treatment for mental disorder".[5] However, the definition of treatment in the Mental Health Act 1983

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[3] S47 Adults with Incapacity (Scotland) Act 2000

[4] S329 Mental Health (Care and Treatment) (Scotland) Act 2003

[5] In England and Wales this includes e.g. treatment for diabetes (Nottinghamshire Healthcare NHS Foundation Trust v MC [2025] 4 WLUK 264); provision of dialysis (A Healthcare v CC [2020] 3 WLUK

applicable in England and Wales is worded differently (*treatment whose purpose is to alleviate, or prevent a worsening of, the mental disorder or any of its symptoms or manifestations*).[6] Wheeler and Ruck Keene[7] provide a useful analysis of the legal situation in England and Wales, pointing out that many court decisions predate the Mental Capacity Act 2005, which provides legal routes to authorise treatment.

Treatment safeguards

In situations of doubt, there is an argument that the choice of which Act to use depends on which one has the better safeguards. For example, treatment under the Mental Health Act, in some situations, requires either written consent or an independent opinion. The equivalent treatment under the AWI Act would not, although could be appealed to a sheriff. But the inconsistency of legislative safeguards should not override the basic requirements and protections of the law.

As an example, the safeguards requiring an independent opinion or expert consent are not in place for amputating a limb due to vascular disease under the AWI Act where the individual lacks capacity to consent. But it would be entirely inappropriate to invoke the Mental Health Act in order to provide an independent opinion, as this is medical treatment for a physical disorder that is unrelated to a mental disorder. It would be for the Scottish Government to address the need for safeguards across the spectrum of health interventions by way of new legislation or amendment of the existing Acts. It would also be good practice for the clinician to consult as widely as possible on such a significant intervention, including obtaining another clinical opinion. We are therefore not convinced that the level of safeguards available under the Mental Health Act should be a consideration in situations of doubt.

Structure of the Commission's opinions

We have based our views on clinical scenarios. All of these are situations brought to our attention. While in some cases, the relevant legislation interface is uncertain, we have given our views on the better option. Where the legislation and the Code of Practice are not clear about what Act should be used, we have come to these conclusions by analysing: (i) with reference to the Code of Practice, is the physical condition an "unrelated physical condition;" and (ii) where the case could be considered self-harm, what is the intention of the patient? If Scottish case law contradicts our position, we will of course review it.

151); and in principle, the administration of a blood transfusion (Nottinghamshire Healthcare NHS Trust v RC [2014] 5 WLUK 45)

[6] s145(4) of the 1983 Act – Note, this definition may be altered by the Mental Health Bill, if passed.

[7] Wheeler, R. Ruck Keene, A. (2021). Compulsory treatment of physical illness under MHA1983. J Med Ethics 2021;0:1–4. doi:10.1136/medethics-2021-107438

When the Mental Health Act is definitely appropriate

In terms of Scottish law, the Mental Health Act, and caselaw from elsewhere[8], the only definite use of the Mental Health Act is to provide artificial nutrition where failure to eat is clearly a consequence of mental disorder. This would include artificial feeding by any route, usually in the case of an individual with anorexia nervosa, but also someone with a severe depressive illness, catatonia or other mental health condition that results in lack of ability to take sufficient nutrition by mouth.

The Mental Health Act is specific about the need for either consent or an independent opinion[9]. We do not interpret artificial hydration as falling within the definition of artificial nutrition, so intravenous or subcutaneous fluid replacement would not be "definitely" covered by the Mental Health Act. Treatment of dehydration as a consequence of mental disorder falls into the "probably covered by the Mental Health Act" category below.

[8] s240 Mental Health (Care and Treatment) (Scotland) Act 2003, and B v Croydon HA [1995] 1 All ER 683 (CA)

[9] s240 Mental Health (Care and Treatment) (Scotland) Act 2003

Situations where the Mental Health Act can be used and where the AWI is also an option

In the following interpretation of the legislation, we have used actual case scenarios and have drawn from existing Commission guidance. There are arguments for using the Mental Health Act, but in all cases, the AWI Act is always an option. In all the following scenarios, we are considering the interface between physical and mental health where the individual is subject to the Mental Health Act. We do not necessarily advise the use of the Mental Health Act for any of these situations where the individual is not subject already to the provisions of that Act.

We consider these situations on a sliding scale from, probably covered by the Mental Health Act to, not covered by the Mental Health Act.

Probably covered by the Mental Health Act: physical illness as a cause of the mental disorder

Case study: Ms A, delirium

Ms A is admitted to hospital under mental health legislation due to a sudden onset of confusion and visual hallucinations. She is found to have a chest infection, and the diagnosis is delirium.

- **Argument for the Mental Health Act:** the chest infection is a direct cause of the delirium. As well as treating the delirium, the Code of Practice is clear that treatment for the underlying cause, i.e. the chest infection, would also be authorised.
- **Argument for the AWI Act:** this Act allows for the treatment of the chest infection. But as Ms A is detained under mental health legislation, treatment for symptoms of delirium, e.g. agitation, hallucinations, is more appropriately given under the authority of the Mental Health Act.
- **Commission's view:** we consider that treatment for the chest infection under the Mental Health Act is appropriate if there are reasonable grounds for believing that the chest infection is a direct cause of the mental disorder. If Ms A had a previous diagnosis or suspicion of dementia, the position is less clear. The chest infection may be contributing to the mental symptoms but may not be a direct cause. On balance, if Ms A has suffered a major change in mental health as a result of the chest infection, we consider the use of the Mental Health Act appropriate to treat the chest infection. Treatment for symptoms of delirium should be given under the Mental Health Act in this situation as she is already detained under mental health legislation. If Ms A is not already detained, then the AWI Act allows for the treatment of the chest infection if she is deemed to lack capacity.

Case study: Mr B, hypothyroidism

Mr B is admitted to hospital under the Mental Health Act with depression, lethargy and persecutory delusions. He is found to have significant hypothyroidism.

As with Ms A, it depends on how sure the clinician can be that the thyroid problem is the cause of the mental symptoms. For example, if Mr B has a history of recurrent depression, the thyroid finding may be contributing to the picture but may not be a direct cause. Again, a major change in mental health that appears attributable to the thyroid findings would make the use of the Mental Health Act appropriate.

Possibly covered by the Mental Health Act: physical illness as a consequence of the mental disorder

Reminder: the Code of Practice states only that self-harm "*may*" be treated under the Mental Health Act. It does not say it *"must"* be treated under that Act. Other than self-harm, there is no other mention of physical illness as a consequence of a mental disorder within mental health legislation. The meaning of self-harm is open to interpretation.

Case study: Mr C, self-harm

Mr C has taken a paracetamol overdose. He refused to stay in hospital and was detained under the Mental Health Act. His paracetamol level is high, but he refuses treatment for this.

- **Argument for the Mental Health Act:** the physical effect of the overdose is a direct consequence of self-harm – Mr C's intention in taking the overdose was to harm himself. This is therefore, according to the Code of Practice, treatable under the Mental Health Act.
- **Argument for the AWI Act:** the Code of Practice for the Mental Health Act is clearer on the cause of the mental disorder being treated under mental health legislation than it is on the consequence of self-harm. It would be equally valid to treat under the AWI Act, if Mr C is deemed to lack capacity.
- **Commission's view:** the Mental Health Act is appropriate here, but use of the AWI Act would not be inappropriate and would be equally valid as above.

Case study: Ms D, low blood sugar

Ms D, detained under the Mental Health Act, has severe depression, wishes to die, and refuses to eat. As a result, her blood sugar becomes dangerously low. She requires intramuscular glucagon to restore blood sugar levels.

- **Commission's view:** as with Mr C, the direct effect of the mental disorder results in the physical disorder (in this case, low blood sugar). There is a precedent court judgement in England (B v Croydon as previously referenced) that the effect of starvation as a result of mental disorder can be treated under mental health legislation. Again, treatment under either Act is equally valid.

Doubtful if covered by the Mental Health Act

In the following scenarios, the physical illness is not in itself a consequence of an act of self-harm. The underlying physical illness is unrelated to the mental disorder. The individual's mental state results in a refusal of treatment for physical illness. We consider two broad categories.

1. Refusal of treatment as an act of intentional self-harm.
2. Refusal of treatment as a result of mental disorder where harm will result, but where intentional self-harm is not the primary motivation.

Refusal of treatment as an act of self-harm

Case studies: Mr E, Ms F and Ms G, refusal of treatment as an act of self-harm

Mr E has moderate learning disability and epilepsy. He was admitted to hospital under the Mental Health Act depressed, not eating and having seizures as a result of not taking his anti-convulsant medication. His mother died recently. He is regarded as having an abnormal grief reaction. He refuses his anticonvulsant medication because he wants to die and join his mother. He is regarded as lacking capacity to make that decision. Anti-convulsant medication is being given covertly.

There is a complex interplay in that further seizures are likely to worsen his mental state. In addition, his refusal of physical healthcare to prevent seizures can be seen as self-harm. His intention in refusing the anticonvulsant medication is to harm himself. Again, noting the complexity, epilepsy is not a consequence of the mental disorder, although his refusal to take treatment for it is a result of his mental state, and can be seen as an act of intentional self-harm.

Ms F has a depressive disorder and is on long-term hormonal treatment for breast cancer. She refuses this treatment because she wants to die. Her intention in refusing the treatment is to harm herself.

Ms G has diabetes and an emotionally unstable personality disorder. She refuses insulin as an act of self-harm with the intention of becoming seriously unwell or ending her life. Her intention in refusing insulin is to harm herself.

- **Argument for using the Mental Health Act:** in each case, the adverse consequence of the untreated underlying physical illness arises from refusing treatment as an act of self-harm and is therefore in line with the Code of Practice.
- **Argument for using the AWI Act:** in each case, the underlying physical disorder is unrelated to the mental disorder. Whilst symptoms of the physical disorder are manifesting due to a refusal of treatment (which could be seen as an intentional act of self-harm), the physical disorder that requires treatment exists independently of the mental disorder, and is not the direct cause of the

mental disorder (albeit that in the case of Ms G, poor diabetic control may contribute to the worsening of her mental state).

- **Commission's view:** the Mental Health Act would be appropriate for detaining the individual and treating the mental health component in these cases. Whilst the refusal of such treatment could be seen as a means of self-harm, the underlying physical illness exists independently of the mental disorder. Code of Practice This differs from e.g. Ms G intentionally misusing insulin as a means of self-harm, as the misuse of insulin (and the adverse consequences of that) are caused by Ms G actively taking the insulin, which she is doing because of a mental disorder. As a result, our view is that the AWI Act should be used in preference to the Mental Health Act where the individual refuses treatment for physical illness as a means of self-harm. While the argument is not clear-cut, opening the door to mental health legislation being used to authorise treatment for an unrelated physical disorder, where there is a refusal of that treatment, could stretch the definition of "treatment for mental disorder" beyond the intention and wording of the Mental Health Act and Codes of Practice.

Refusal of treatment as a result of mental disorder where harm will result, but where intentional self-harm is not the primary motivation

Case study: Ms H, influence of mental disorder, anorexia nervosa and diabetes

Ms H has anorexia nervosa, and also diabetes. She refuses insulin because she knows it will result in weight gain. Without insulin, her blood sugar will rise, risking her overall health and possibly worsening her mental state. Additionally, she will not gain weight, also jeopardising her physical and mental health.

This is different from Ms G above. While death or serious illness may be the outcome, the primary intention is to prevent weight gain (rather than death), and the primary motivation is irrational fear of gaining weight.

- **Argument for the Mental Health Act:** her refusal of insulin treatment can be seen as an act of self-harm, so treatment under this Act accords with the Code of Practice. Additionally, the effect of raised blood sugar is likely to cloud her judgement more and could therefore be a cause of her mental disorder.
- **Argument against the Mental Health Act:** diabetes is neither a direct cause of the mental disorder nor a consequence of intentional self-harm. The physical disorder (diabetes) is unrelated to the mental disorder. Ms H's refusal of treatment is driven by a fear of gaining weight as a result of anorexia-related thought processes, but this is not the same as intentional self-harm. The resultant high blood sugar may contribute to a worsening of her mental state, but it is not a direct cause of the mental disorder.
- **Commission's view:** in England and Wales, mental health law could be used to administer insulin in this situation according to interpretation of the law by the

courts[10]. See also the previous reference to the review by Wheeler and Ruck Keene. The current phrasing of the Scottish legislation and Code of Practice would be less likely to support such use of the Mental Health Act. Again, while not clear-cut, we consider treatment with insulin would be more appropriately given under the AWI Act.

Case studies: Ms I and Mr J

Ms I has a chronic psychotic illness. She also has a basal cell carcinoma on her face. Without treatment, this is likely to spread locally and could seriously damage her health. She refuses treatment because she believes the lesion gives her special psychic powers. She is considered to lack capacity to consent.

Mr J has grandiose beliefs arising from a manic episode. He believes God will cure him of any illness and refuses treatment for ongoing serious health conditions, including heart failure.

In each of these cases, we consider the AWI Act the correct way to authorise treatment. While harm may result from a refusal of treatment, this does not appear to us to fall within the category of intentional self-harm. While accepting that there is a lack of legal clarity here, we do not believe it was Parliament's intention that mental health legislation should be used to treat physical illnesses such as these.

Summary of the Commission's views on treating the consequences of self-harm

The Code of Practice states that self-harm as a consequence of mental disorder may be treated under the Mental Health Act. In the case of an act of intentional self-harm, e.g. an overdose, the Mental Health Act may be used, but the AWI Act may also be appropriate. In other cases, as described here, it appears progressively less appropriate to use the Mental Health Act.

[10] Nottinghamshire Healthcare NHS Foundation Trust v MC [2025] EWHC 920 (Fam)

Not covered by the Mental Health Act

Case study: Mr K, side effects of treatment for mental disorder

Mr K is subject to treatment under the Mental Health Act and is prescribed antipsychotic medication e.g. for schizophrenia. He develops significant side effects with stiffness and tremor consistent with Parkinsonism. He is reluctant to accept treatment for this and is considered incapable of making this decision as a result of his mental state. Without this treatment, he is at risk of falls, and his immobility will hamper recovery.

- **Argument for the Mental Health Act:** the physical disorder is caused by the mental disorder, because his treatment has unwanted side-effects.
- **Argument against the Mental Health Act:** it is too great a stretch to go from "treatment for mental disorder" to "treatment of a physical disorder that is a side effect of treatment for mental disorder", especially as this refusal of treatment is less likely to be interpreted as intentional "self-harm" in terms of the Code of Practice.
- **Commission's view**: the Commission has generally taken the view that treatment for adverse effects of antipsychotic medication is not a treatment for mental disorder. Sister organisations in other jurisdictions have taken a different view. We know of no applicable case law in this area. Our present view is that this is not a scenario where the Mental Health Act is appropriate. The same would apply to lithium-induced hypothyroidism. The situation may be complicated if the adverse effects of medication worsen the individual's mental state, but as this is not a direct cause of the mental disorder, we do not think the Mental Health Act an appropriate way to authorise treatment.

Case study: Ms L, possible cancer and lack of capacity to understand

Ms L has advanced dementia. She had a suspicious breast lump that could be cancer. She resists investigation or treatment, but she cannot understand what she is being told about the lump.

We see this as clearly being the AWI Act as appropriate, with the least restrictive intervention. Lack of capacity to understand information about diagnosis and treatment cannot be interpreted as intentional self-harm.

Additional consideration where the AWI Act is preferred

While it is recognised that force or restraint can be used under the Mental Health Act (although not specified in law and subject to good practice guidance only), there is uncertainty under the AWI Act. This is dealt with under our *Right to treat* good practice guidance. Again, we emphasize that implied authorisation of forcible treatment under the Mental Health Act, along with the treatment safeguards under part 16 of that Act, should not be a consideration in the choice of which Act to use. Practitioners should always consider the criteria and principles underpinning both laws.

Summary

When the Mental Health Act is *definitely* appropriate:

- Artificial nutrition where refusal to eat is caused by mental disorder e.g. anorexia, catatonia.
- *NB* Artificial hydration e.g. IV fluids is *not* covered in the same way.

When the Mental Health Act is *probably* appropriate:

- Physical illness *causing* mental disorder e.g. hypothyroidism causing depression.
- AWI Act remains an alternative.

When the Mental Health Act is *possibly* appropriate:

- Physical illness *as an action of self-harm* due to mental disorder e.g. paracetamol overdose, refusal to eat causing hypoglycaemia.
- Can also be validly treated under the AWI Act.

When it's *doubtful* that the Mental Health Act is appropriate:

- Refusal of physical health treatment as a form of self-harm e.g. refusing epilepsy medication, insulin, or cancer therapy due to depressive intent.
- Mental Health Act may be used for detention and treating mental disorder, but AWI Act preferred for treating physical health issue.
- Refusal driven by mental disorder but not intended as self-harm e.g. diabetes refusal in anorexia, psychotic delusions preventing cancer treatment.
- Use of AWI Act strongly favoured.

What is *not covered* by the Mental Health Act:

- Treating side effects of psychiatric medication e.g. Parkinsonism from antipsychotics.
- Physical illness in someone with advanced dementia who resists investigation but cannot understand the implications e.g. possible cancer.
- Use of AWI Act only.

Additional considerations

Force and restraint are more clearly permitted under the Mental Health Act, but the Commission cautions against choosing legislation based on availability of coercive powers or safeguards. Clinicians should take note of Commission guidance on the use of force and restraint for physical healthcare.[11]

[11]Good practice guide, *Right to treat*: https://www.mwcscot.org.uk/node/509

When in doubt, practitioners should seek legal advice and consider both the principles and criteria of the relevant Acts.

Decision tree for which Act to use (see also: diagram 1)

Step 1: is the treatment for a mental disorder itself, including symptoms and behavioural consequences?

If yes, use the Mental Health Act.
If no, go to step 2.

Step 2: is the physical illness the direct cause of the mental disorder? e.g. delirium from chest infection, hypothyroidism causing depression.

If yes, treatment would be authorised under the Mental Health Act.
If no, go to step 3.

Step 3: is the physical illness a consequence of the mental disorder? e.g. self-harm, refusal to eat leading to hypoglycaemia.

If yes, treatment may be given under the Mental Health Act, but the AWI Act is also an option. If urgent, common law necessity may apply.
If no, go to step 4.

Step 4: is the refusal of treatment itself an act of intentional self-harm? e.g. refusing insulin or cancer treatment with the stated wish to die.

If yes, while the MHA could be argued, the Commission's view is that the AWI Act is usually the more appropriate route. If urgent, common law necessity may apply.
If no, go to step 5.

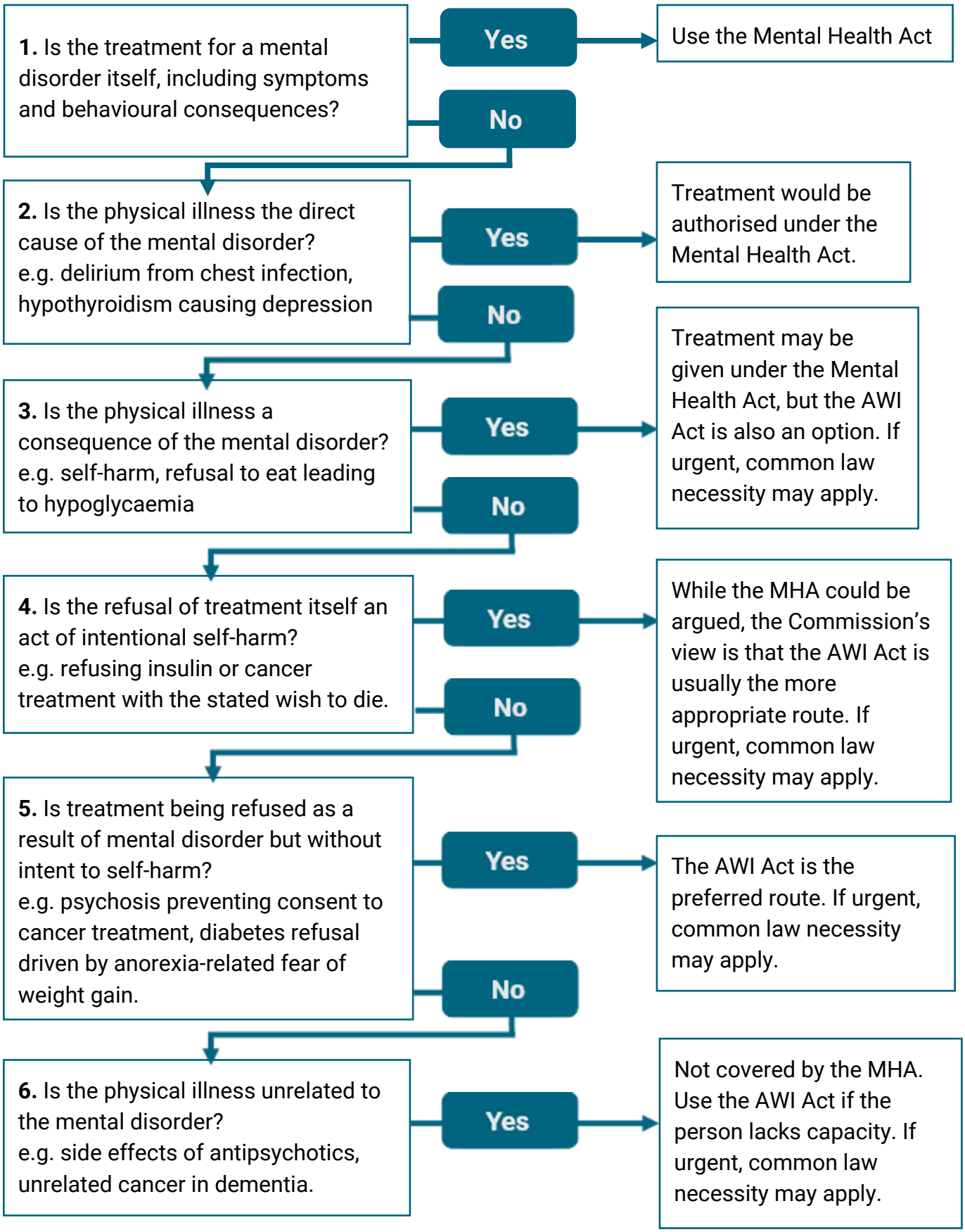
Step 5: is treatment being refused as a result of mental disorder but without intent to self-harm? e.g. psychosis preventing consent to cancer treatment, diabetes refusal driven by anorexia-related fear of weight gain.

If yes, the AWI Act is the preferred route. If urgent, common law necessity may apply.
If no, go to step 6.

Step 6: is the physical illness unrelated to the mental disorder? e.g. side effects of antipsychotics, unrelated cancer in dementia.

If yes, this is not covered by the Mental Health Act. Use the AWI Act if the person lacks capacity. If urgent, common law necessity may apply.

Diagram 1: decision tree for deciding which Act to use



Conclusion

There is no blanket rule mandating use of the Mental Health Act for treating physical illness in detained individuals. The AWI Act is always an option, and in most cases it is the more appropriate route, especially when the physical illness is unrelated to the mental disorder. Artificial nutrition remains the one clear example where the Mental Health Act explicitly applies.

Clinicians should prioritise the individual's needs, the intention behind refusal of treatment, and the nature of the physical illness, not simply the presence of detention under mental health legislation.

As our remit does not cover giving specific clinical or legal advice, it would be advisable to seek a local second opinion and advice from the Central Legal Office or relevant legal team (where appropriate) for complex situations. Having said that, we are willing to discuss individual situations, and we hope this guidance will be helpful in this difficult area.

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