

CAN THE USE OF THE MENTAL HEALTH ACT BE THE ‘LEAST RESTRICTIVE’ APPROACH FOR PSYCHIATRIC IN-PATIENTS?

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I. INTRODUCTION

In England and Wales, involuntary admissions for assessment or treatment in mental health wards are based on the legal framework of the Mental Health Act 1983 (as amended in 2007) or the Mental Capacity Act 2005, with the Deprivation of Liberty Safeguards introduced in 2007. But what is the “least restrictive” approach and are we truly safeguarding in-patients’ liberty by curbing use of the Mental Health Act in particular groups?

II. WHAT IS LIBERTY IN LAW?

The Human Rights Act 1998 is the source for the legal protection of liberty in English and Welsh law. Article 5 enshrines the right to liberty, stating that no one should be deprived of their liberty unless they meet certain criteria, such as conviction of a crime. Article 5.1(e) includes the following exemption:

‘the lawful detention of...persons of unsound mind, alcoholics or drug addicts...’¹

In 1998, the legal detention of “persons of unsound mind” was solely the province of the Mental Health Act 1983, permitting both detention and treatment without consent of compulsory patients.

However, the 1983 Act did not provide for the treatment of physical health complaints or regulate other life-altering decisions for people unable to give informed consent. From this need and to protect the incapacitated arose the Mental Capacity Act 2005, allowing individuals without capacity to be assessed, treated and accommodated without their agreement – including in mental health units.

It is the Mental Capacity Act that introduced the concept of ‘least restriction’ into the legislation, with its fifth statutory principle:

‘Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.’²

With the substantial amendments to the Mental Health Act in 2007, the concept of ‘minimising restrictions on liberty’³ was added to the guiding principles and the Code of Practice 2008 elaborated further with the Least Restriction Principle:

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¹ Human Rights Act 1998 sch 1 pt 1 Article 5 para 1(e) [<http://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/1/chapter/4>]

² Mental Capacity Act 2005 pt 1 s 1(6) [<http://www.legislation.gov.uk/ukpga/2005/9/section/1>]

³ Mental Health Act 1983 (as amended in 2007) s 118(2B)(c) [<http://www.legislation.gov.uk/ukpga/1983/20/section/118>]

'People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty...'⁴

The Code of Practice was updated in 2015 and the "least restrictive option" was more narrowly defined:

'Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained.'⁵

Due to the use of the word 'lawfully', this tenet implies that any alternative legal framework would be preferable to the Mental Health Act. This reinforces the idea that the Mental Health Act is the most restrictive way a person can be admitted to a mental health unit.

At this time, the Mental Capacity Act was also amended to include the Deprivation of Liberty Safeguards (DoLS). DoLS was designed to plug the so-called 'Bournewood gap'⁶, situations where a person is deprived of their liberty in a hospital or care home but falling outside the scope of the Mental Health Act.

III. DOES ADMISSION TO A MENTAL HEALTH UNIT CONSTITUTE A DEPRIVATION OF LIBERTY?

The Supreme Court judgment on *P v. Cheshire West*⁷ held that there is a deprivation of liberty when the person is under continuous supervision and control and is not free to leave. While the Mental Health Act Code of Practice cautions that blanket or global restrictions on liberty should be avoided, the reality of mental health units is that in-patients are subject to regular checks by staff, their routine is governed by the ward staff, and the door is locked in 58% of cases⁸. The degree or intensity rather than the nature or substance forms the dividing line between a *restriction* on liberty and the more significant *deprivation*, such as under what circumstances a locked door may be opened or the level of observations required.

In *A PCT v. LDV*, the judgement listed three conditions which satisfied a deprivation of liberty:

'(a) an objective element of a person's confinement in a certain limited space for a not negligible time; (b) a subjective element, namely that the person has not validly consented to

⁴ Department of Health. Code of Practice, Mental Health Act 1983. TSO (The Stationery Office), 2008. p. 5

⁵ Department of Health. Code of Practice, Mental Health Act 1983. TSO (The Stationery Office), 2015. p. 22
[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF]

⁶ *HL v. United Kingdom* [2004] ECHR 471 [<http://www.bailii.org/eu/cases/ECHR/2004/471.html>]

⁷ *P v. Cheshire West and Chester Council and P and Q v. Surrey County Council* [2014] UKSC 19 [<http://www.bailii.org/cgi-bin/markup.cgi?doc=/uk/cases/UKSC/2014/19.html>]

⁸ Mental Health Act Commission. *In place of fear? 11th Biennial Report 2003–5*. London: TSO (The Stationery Office), 2005

the confinement in question, and (c) the deprivation of liberty must be one for which the State is responsible.⁹

This means that a capacitous person can accept these restrictions on their liberty via informed consent to an informal admission to a mental health unit. However, a non-capacitous person must be admitted under an appropriate legal framework if the degree or intensity of a restriction of liberty amounted to a deprivation.

IV. CLINICAL CONSEQUENCES: LEGISLATION IN ACTION

What does this mean for clinicians when a person is assessed for admission to a mental health unit? Is informal admission always less restrictive of a person's liberty than detention under the Mental Health Act, as the revised Code of Practice would have us believe?

In 2013, I evaluated use of emergency medical detention – Section 5(2) – on two adult in-patient wards in South West London and St George's Mental Health Trust. Of 527 admissions, 75 patients were detained under Section 5(2). 35 patients were detained within 72 hours of admission. On closer examination, these patients fell into two categories: non-capacitous and non-consenting.

By examining these groups in further detail, we can understand the pitfalls of shunning detention under the Mental Health Act at admission for the capacitous, reluctant patient and the non-capacitous, compliant patient.

V. THE CAPACITOUS, RELUCTANT PATIENT

Outside the legal frameworks of the Mental Health Act and the Mental Capacity Act/Deprivation of Liberty Safeguards, valid informed consent is required for an admission to a mental health unit.

The Deprivation of Liberty Safeguards Code of Practice 2008 identified a non-exhaustive list of factors that point towards a deprivation of liberty. These include that the person is admitted for care and treatment of a mental disorder, they will be subject to supervision and use of medication to control their mental state, that their property may be searched, and that staff must grant permission to use the door.¹⁰ These form a familiar list to the in-patient psychiatrist and, while the judge in *A PCT v. LDV* was careful not to be proscriptive of what was required for informed consent, he pointed to understanding these factors as being integral to the process.

If an assessed person is not keen on admission, she may be persuaded by a loved one or professional. Persuasion is an important tool for a psychiatrist, but only if the person can freely make either an affirmative or negative decision. If the only acceptable outcome is agreement, this steps over the line into coercion. If the person

⁹ *A PCT v. LDV, CC & B Healthcare Group*. [2013] EWHC 272 (Fam) para. 13 [<http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWHC/Fam/2013/272.html>]

¹⁰ Department of Health. Mental Capacity Act 2005, Deprivation of liberty safeguards, Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. TSO (The Stationery Office), 2008, p. 17

refuses to come in, but agrees when the issue of detention is raised, the Mental Health Act Code of Practice is clear:

'The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)'¹¹.

The reality of a locked door in an inpatient mental health unit is also an important aspect of consent. Admission to an acute mental health unit stems from a risk to self or others. If someone at such risk then asks to leave the unit, they will be subject to assessment by a nurse and then probably a doctor. In the *Bournewood* judgment, Lord Steyn stated:

'if "L" had shown any sign of wanting to leave, he would have been firmly discouraged by staff and, if necessary, physically prevented from doing so. The suggestion that "L" was free to go is a fairy tale.'¹²

For how many informal in-patients is this true? My audit of Section 5(2) use indicates their number may be significant, particularly as it does not account for those successfully persuaded to stay without resorting to legal detention.

In *Storck v. Germany*, the Court ruled there had been a deprivation of liberty where a person had initially consented to admission, agreeing with the Bremen Regional Court's assertion:

'Even assuming the applicant's initial consent, it would have lapsed by the applicant's uncontested attempts to escape.'¹³

Patients who repeatedly ask to leave and are repeatedly persuaded to stay may not be trying to pick the lock, but they are expressing their desire to escape the confines of the unit and they are being denied without a formal right of appeal.

There is also the question of advocacy. Who can give informal in-patients advice on their rights under these circumstances? If the person was detained under the Mental Health Act, she could access an Independent Mental Health Advocate (IMHA) and free legal advice. If she was treated under the Mental Capacity Act, with or without DoLS, she would have an Independent Mental Capacity Advocate (IMCA) to promote her best interests and would also be entitled to free legal advice for appealing. However, non-Tribunal Legal Aid is means-tested in England – though Wales provides an IMHA service to all its in-patients. While wider mental health advocacy technically exists, it is significantly under-resourced. Advocacy is only guaranteed in England with a legal detention.

¹¹ Department of Health. Code of Practice, Mental Health Act 1983. TSO (The Stationery Office), 2015. p. 116
[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF]

¹² L, In re [1998] UKHL 24 [<http://www.bailii.org/uk/cases/UKHL/1998/24.html>]

¹³ *Storck v. Germany* [2005] 43 EHRR 96 [<http://www.bailii.org/cgi-bin/markup.cgi?doc=/eu/cases/ECHR/2005/406.html>]

VI. THE NON-CAPACITOUS, COOPERATIVE PATIENT

In the case of a non-capacitous, cooperative patient, potentially either the Mental Health Act or the Mental Capacity Act could be used. As both have 'least restrictive' clauses, how does the assessing team decide which route to take?

It is extremely unlikely that the Mental Capacity Act can stand alone here. Consider the restrictions on liberty that must be endured by the capacitous in-patient for informal admission. However, with the person under consideration unable to understand these restrictions or evaluate the risks of defying them, the degree and intensity is liable to increase. Will the door be opened and the person allowed to leave unescorted if they cannot comprehend why they are in the unit? In such situations, the Deprivation of Liberty Safeguards must be applied.

In *AM v. SLAM NHS Foundation Trust*, the judgment considered the non-capacitous, compliant patient eligible for admission under either the Mental Health Act or the Mental Capacity Act/DoLS regime. The Mental Health Act's 'necessity test' means that DoLS has 'effective priority' if the assessment and treatment can be carried out under the Mental Capacity Act framework. However, Judge Charles took care to highlight that

'authorisation of a detention under DOLS will not inevitably be less restrictive'¹⁴.

The DoLS process involves the hospital manager granting the unit an urgent authorisation to admit the patient and at the same time applying for a standard authorisation from the supervisory body (the local authority in England). This urgent authorisation requires one person to request it, rather than the recommendations of two Section 12 doctors and the agreement of an Approved Mental Health Practitioner.

The supervisory body then has 21 days to arrange the assessment. Compare that to the 7-day guidance for a Section 2 appeal. If the supervisory body goes on to make the authorisation, it can last up to 12 months, and, in the interim, review is at the discretion of the supervisory body and the hospital. The person subject to the authorisation can ask for a review, and legal challenges can be mounted through the Court of Protection, but these are expensive and long-winded routes.

The idea of introducing a tribunal-like system for DoLS was considered by the House of Lords in their Mental Capacity Act and DoLS review but they decided that an increased number of hearings would require the composition of the tribunals to be modified, risking loss of expertise and greatly increasing costs¹⁵.

Thus, is the Mental Capacity Act/DoLS path less restrictive than the Mental Health Act, with its time-limited detentions, right of appeal and relatively easy access to First

¹⁴ *AM v. (1) South London & Maudsley NHS Foundation Trust and (2) The Secretary of State for Health* [2013] UKUT 0365 (AAC) para. 68(ii) [<http://www.bailii.org/cgi-bin/markup.cgi?doc=/uk/cases/UKUT/AAC/2013/365.html>]

¹⁵ Select Committee on the Mental Capacity Act 2005. *Mental Capacity Act 2005: post-legislative scrutiny*. (HL 2013-14 139) [<http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm>]

Tier Tribunals and Managers' Hearings? It is far from inevitable that DoLS is less restrictive than the Mental Health Act.

The rapidly deteriorating patient who lacks capacity is also of concern. If he is admitted informally to an acute in-patient ward – as a purported 'least restrictive option' – what happens if he becomes unsafe in the open ward environment? To be transferred to a Psychiatric Intensive Care Unit (PICU), a patient must be detained under the Mental Health Act¹⁶. Waiting for a Mental Health Act Assessment prolongs the time spent by the person in an unsafe environment, with unnecessary danger to himself, other patients and staff. In my service evaluation, I identified 6 patients who proceeded rapidly to PICU from an informal admission, 4 within 24 hours of admission.

VII. CONCLUSIONS

With legislative emphasis on the 'least restrictive option', assessing healthcare teams consider avoiding use of the Mental Health Act is the least restrictive route. However, with the reluctant, capacitous patient or the non-capacitous, compliant patient, this may not be the case in actuality.

For the capacitous patient who wants to leave, the responsible clinician must be confident that consent is truly informed and the right to leave more than a 'fairy tale' for informal admission to avoid an unlawful deprivation of liberty. For the non-capacitous, compliant patient, the Mental Capacity Act and DoLS path can only be considered the least restrictive option once the Mental Capacity Act and DoLS have a robust appeal and review framework and the potential need for PICU has been negated or appropriately addressed. The Law Commission's consultation on DoLS suggest that it is not fit for purpose and are proposing replacing the system with 'Protective Care'¹⁷, which may provide a framework that is less restrictive than the Mental Health Act in actuality rather than in theory.

Assessment under the Mental Health Act in these complex cases may, in fact, be the least restrictive option and in the person's best interests.

¹⁶ Department of Health. *Mental Health Policy Implementation Guide, National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments*. TSO (The Stationary Office), 2002. [<http://napicu.org.uk/wp/wp-content/uploads/2013/04/2002-NMS.pdf>]

¹⁷ Law Commission. *Mental Capacity and Deprivation of Liberty, A Consultation*. TSO (The Stationary Office), 2015. [http://www.lawcom.gov.uk/wp-content/uploads/2015/07/cp222_mental_capacity.pdf]