

Amending the Mental Capacity Act 2005 to provide for deprivation of liberty

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Introduction

The Government's Mental Health Bill² includes amendments to the Mental Capacity Act 2005 (MCA) intended to remedy the defects in domestic law identified by the European Court of Human Rights (ECtHR) in *HL v United Kingdom* (the Bournemouth case).³ The ECtHR found that where a mentally incapacitated adult had been deprived of his liberty by informal admission to a psychiatric hospital:

- a) the common law doctrine of necessity did not satisfy the "in accordance with a procedure prescribed by law" requirement in Article 5(1) of the European Convention on Human Rights (ECHR); and
- b) pre-Human Rights Act habeas corpus and judicial review proceedings were not capable of performing the court's function under Article 5(4) to review the lawfulness of a deprivation of liberty arising from mental disorder.

The judgment is relevant to anyone who has a mental disorder and is an informal patient in a psychiatric hospital or is resident in a care home, but only if the care regime deprives them of their liberty. The problem for the Government is that some people who may be deprived of their liberty in such circumstances are outside the scope of the Mental Health Act 1983 (MHA) detention powers and are thus caught in what has come to be referred to as the Bournemouth gap.⁴ The most obvious examples are those people who are in psychiatric hospital informally because they are compliant, those in care homes where MHA detention powers cannot be applied, and those in psychiatric hospital who have a learning

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2 Clause 38. In this article references to the Mental Health Bill are to the Bill, without amendments, as introduced in the House of Lords.

3 *HL v UK* (Application 45508/99), judgment was given on 5th October 2004. Reported as *HL v United Kingdom* (2005) 40 EHRR 761.

4 This phrase was first coined following the judgment of the House of Lords in the Bournemouth case (*R v Bournemouth Community and Mental Health NHS Trust Ex p. L* [1998] 3 All. ER 289) where in his speech Lord Steyn had commented adversely on the denial of the safeguards of the Mental Health Act 1983 to compliant incapacitated psychiatric patients. Following the later judgment of the European Court of Human Rights in the case, it is now used to refer to the denial of Article 5 safeguards, whether in hospitals or care homes.

disability which does not fit the statutory definitions of either mental impairment or severe mental impairment and who are thus excluded from detention under section 3 or other longer term sections of the MHA. What is required for all such people, if they are being deprived of their liberty, is an Article 5 compliant legal framework. This is what the Government proposes by way of amendments to the MCA.

During the committee stage of the Mental Health Bill in the House of Lords the responsible minister stated that the purpose of the proposed amendments was not to increase the number of people deprived of their liberty, but rather that the legal position of those necessarily deprived of their liberty will be regularised:

“This is not about taking new powers to detain people. It is about giving safeguards to the most vulnerable in care homes and hospitals who need to have their liberty curtailed and considered and who, in some cases, need to be deprived of aspects of their liberty in order to keep them safe and protected and to provide the highest quality care.”⁵

The people the Government has in mind are cognitively impaired, whether this arises from a learning disability, brain injury or dementia, to a degree which renders them incapable of validly consenting to the care they are receiving.

As will be seen, the new legal regime for such mentally incapacitated people deprived of their liberty is based on different legal criteria for detention, compared with the MHA, and operates according to different procedures. It also provides different safeguards for those who are deprived of their liberty. An important question is whether having two separate regimes for depriving mentally disordered people of liberty will result in inconsistencies and anomalies.

The main justification for two separate regimes is that, compared with MHA detention, the proposed MCA procedures will be less demanding of resources. In its briefing sheet on the proposals the Government says it “has sought to minimise new burdens arising from the safeguards, but some will inevitably arise”.⁶ The extent of the additional demand for resources will be a function of the number of people who come within the MCA deprivation of liberty regime and the average resource burden per case. The former will in large part be dependent on what is meant by deprivation of liberty. In the same briefing sheet the Government says that it “does not consider that deprivation of liberty would be justified in large numbers of cases but recognises that such circumstances may arise”. Coincidentally with the passage of the Bill through the House of Lords, judgment was given in the High Court in a case where, relying on the ECtHR’s judgment in *HL v United Kingdom*, it was alleged that, in breach of Article 5, a mentally incapacitated care home resident (DE) was being deprived of his liberty while being cared for under the common law doctrine of necessity.⁷ As is discussed below,⁸ the analysis of case law under the ECHR which led Munby J to conclude that the regime in the care home deprived DE of his liberty differs from the view expressed by the Government in the draft illustrative code of practice which accompanies the proposals.⁹ If Munby J’s analysis is correct, it must follow that the Government has underestimated the number of mentally incapable people whose care amounts to deprivation of liberty, and the demand for additional resources will be correspondingly greater.

5 Baroness Ashton of Upholland, House of Lords Hansard, 17th January 2007, column 763.

6 Bournemouth Briefing Sheet, Department of Health – November 2006.

7 *JE and DE v Surrey County Council and EW* [2006] EWHC 3495 (Fam).

8 See also Lucy Scott-Moncrieff “Two steps forward, one step back”, in this issue of the *Journal of Mental Health Law*.

9 *The Bournemouth Safeguards: Draft Illustrative Code of Practice*, paragraphs 140-141, published 22.12.06.

This article considers the Government's legislative proposals against the domestic law background, specifically their relationship with existing detention powers in the MHA and the provisions already enacted by Parliament in the MCA which expressly do not authorise deprivation of liberty. Consideration is given to whether the proposed amendments to the MCA create undesirable overlap with the existing detention powers under the MHA.

The final part of the article questions the Government's approach to demarcating the boundary between the two detention regimes. It proposes that if MCA detention were confined to those who lack capacity and do not object to their care, compliance with Article 5 could be achieved more simply and at less cost than under the Government's proposed amendments to the MCA.

Historical background

If the proposed amendments to the MCA are a response to the ECtHR's decision in the *Bournewood* case, the case itself arose from the application of legal principles which had been developed in the course of modernising English mental health law during the twentieth century. Those principles determined where the line was to be drawn between psychiatric patients whose hospital care warranted the use of legal powers of detention and patients for whom such powers were not considered necessary.

The first significant legislative step in this process was section 1 of the Mental Treatment Act 1930, which followed a recommendation made in 1926 by the Royal Commission on Lunacy and Mental Disorder.¹⁰ It provided for voluntary admission by allowing a person who was capable of expressing his or her wishes to make a written application to be admitted to a psychiatric hospital. Having been admitted on that basis the patient was entitled to discharge him/herself on giving 72 hours' notice.

The operation of this provision was considered by the Royal Commission on the Law relating to Mental Illness and Mental Deficiency (the Percy Commission) whose recommendations formed the basis for the Mental Health Act 1959.¹¹ Their main criticism was that the capability threshold for voluntary admission was too high with the consequence that powers of compulsion still had to be used in some cases where the patient was not unwilling to be admitted:

*"Because no one may be a voluntary patient unless he can give positive evidence of his willingness to be so, some patients who are not considered capable of giving a valid signature on the application form ... may only be admitted under the [involuntary] certification procedures, even though they are not positively unwilling to be admitted and even if they could in fact be treated and cared for without powers of detention."*¹²

The Percy Commission's most important proposal for reform of mental health law was that there should in future be a presumption in favour of informal admission and treatment. This placed the onus on the psychiatric patient positively to opt out of informal care, by objecting to it, thus to opt into a regime of compulsion. They saw this as placing psychiatric treatment in the majority of cases on the same foundation as other forms of medical treatment and they hoped that it would reduce the stigma associated with treatment for mental disorder.

¹⁰ *Report of the Royal Commission on Lunacy and Mental Disorder* Cmd. 2700.

¹² *Ibid.* paragraph 218.

¹¹ *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954 – 1957*. Cmnd. 169.

“We therefore recommend that the law and its administration should be altered, in relation to all forms of mental disorder, by abandoning the assumption that compulsory powers must be used unless the patient can express a positive desire for treatment, and replacing this by the offer of care, without deprivation of liberty, to all who need it and are not unwilling to receive it.”¹³

We recommend that all admissions except under compulsory procedures should be arranged in the same way as admissions to general hospitals, with no application form to be signed by the patient and no statutory requirement for any fixed notice of any intention to leave.”¹⁴

In referring to deprivation of liberty, the Percy Commission equated this with the use of coercion against the wishes of the patient; if he or she did not object, there was no deprivation of liberty and therefore no need to use legal powers of compulsion.

As enshrined in practice under the Mental Health Act 1959, and later under the MHA, the crucial distinction was between the unwilling patient, in respect of whom admission could only be under compulsory powers of detention; and all other psychiatric patients, who were to be admitted and treated without the use of formal powers. In deciding whether to use compulsory powers, it was not necessary to consider the patient’s mental capacity. The sole question was as to the patient’s volition.

Even if the basis for the distinction was clear, its application was not always straightforward. It was sometimes difficult to know how much weight to give to what a mentally disordered person said or did if no clear purpose or intention, amounting to unwillingness, could readily be discerned. This is well illustrated by paragraph 19.27 of the current MHA Code of Practice:

“The safety of informal patients, who would be at risk of harm if they wandered out of a ward or mental nursing home at will, should be ensured by adequate staffing and good supervision. Combination locks and double handed doors should be used only in units where there is a regular and significant risk of patients wandering off accidentally and being at risk of harm. There should be clear policies on the use of locks and other devices and a mechanism for reviewing decisions. Every patient should have an individual care plan which states explicitly why and when he or she will be prevented from leaving the ward.

Patients who are not deliberately trying to leave the ward, but who may wander out accidentally, may legitimately be deterred from leaving the ward by those devices. In the case of a patient who persistently and/or purposely attempts to leave a ward or mental nursing home, whether or not they understand the risk involved, consideration must be given to assessing whether they would more appropriately be formally detained under the Act in a hospital or a mental nursing home registered to take detained patients, than remain as informal patients.”¹⁵

This contemplates that it is compatible with informal status for a patient to be prevented from leaving the ward, provided that their leaving the ward is not persistent and/or purposeful. Such patients, most of whom are elderly and suffering from dementia, are regarded as not unwilling to receive hospital care.

Bournewood and the doctrine of necessity

HL, a profoundly autistic middle-aged man, was admitted to Bournewood hospital in July 1997. As he did not object or resist, the consultant psychiatrist in charge of his treatment saw no need to use MHA powers – so she admitted him informally.

The consultant psychiatrist’s interpretation of the law was ultimately upheld by the House of Lords in a

13 *Ibid.* paragraph 291.

14 *Ibid.* paragraph 300.

15 *Code of Practice Mental Health Act 1983*, Department of Health and Welsh Office, 1999.

unanimous decision the following summer.¹⁶ While there had been some understandable vagueness in the Percy Commission's report about the legal basis for admitting and treating a patient who did not express any wishes in the matter, all five Law Lords were clear that the correct legal description of HL was that he lacked capacity and that the necessary powers arose under the common law doctrine of necessity. Specifically, he lacked capacity to make the relevant treatment decisions arising from the consultant psychiatrist's clinical opinion that he needed to be admitted to Bournwood hospital for assessment and treatment of a mental disorder. The doctrine of necessity conferred on those caring for him all necessary powers to act in what they considered to be his best interests. Since the common law provided for this situation there was no need, and therefore no legal justification, for using compulsory powers under the MHA. Such powers were to be used only where there was no other lawful means of admitting and treating a patient.

The House of Lords' decision arguably left the legal landscape unchanged. The Percy Commission's presumption in favour of informal care for the 'not unwilling' had prevailed. The analysis in terms of capacity and incapacity appeared only to clarify the meaning of that phrase. Both the Mental Health Act Memorandum and Code of Practice were amended to make explicit that 'not unwilling' encompassed a patient who gives capable consent to admission, and also a patient who is mentally incapable of consent but not objecting to entering hospital.¹⁷

The Code and Memorandum now implied four categories of patient: with capacity and consenting; with capacity and not consenting; without capacity and not unwilling; and without capacity and objecting. In order to know in which category any particular patient belonged it was first necessary to assess their capacity to consent to admission and treatment, where previously it had been sufficient merely to ascertain whether or not they were objecting to admission. There is no reason, however, to believe that this new analysis made any difference to the practice of those assessing patients for admission under the MHA. The crucial distinction remained that between the objecting or unwilling patient (with or without capacity), whose lawful admission requires the use of MHA detaining powers, and everyone else for whom informal admission is lawful.

Bournwood and deprivation of liberty

In the domestic courts there was a division of opinion among the judges as to whether, for the purpose of the habeas corpus proceedings, HL was detained while he was an informal patient in Bournwood hospital. All three Court of Appeal judges, together with two of the five Law Lords, concluded that he was detained. The remaining three Law Lords and the first instance judge were of the contrary view.

Among the judges who found that HL was detained, the crucial point was that he was not free to leave Bournwood hospital. The Court of Appeal defined the test as:

*"a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving."*¹⁸

In the House of Lords, Lord Nolan agreed with the Court of Appeal on the question whether HL was detained, and he explained the context:

16 *R v Bournwood Community and Mental Health NHS Trust* Ex p. L [1998] 3 All. ER 289

17 See Paragraph 295 of the revised Mental Health Act 1983 Memorandum on Parts I to VI, VIII and X, Department

of Health, 1998, and Para 2.7 of the 1999 revision of the MHA Code of Practice. .

18 *R v Bournwood Community and Mental Health NHS Trust, ex parte L* [1998]1 All ER 634 at page 639.

*"[He] was closely monitored at all times so as to ensure that he came to no harm. It would have been wholly irresponsible for those monitoring him to let him leave the hospital until he had been judged fit to do so."*¹⁹

Lord Steyn memorably described as a 'fairy tale' the contention that HL was free to leave Bournemouth:

*"In my view [HL] was detained because the health care professionals intentionally assumed control over him to such a degree as to amount to a complete deprivation of his liberty."*²⁰

The question whether or not HL was deprived of his liberty was ultimately not determinative, as both Lord Nolan and Lord Steyn found, with their three colleagues, that those responsible for admitting and treating him had acted lawfully under the doctrine of necessity.

When the case reached the ECtHR the questions were: first, whether in terms of Article 5 HL was deprived of his liberty; and second, if so, whether the doctrine of necessity provided the necessary Article 5 safeguards against arbitrary detention. In the judgment which it gave in 2004 the Court concluded, essentially on the same basis as Lord Steyn, that HL was deprived of his liberty:

"The Court considers the key factor in the present case to be that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements ...

More particularly, ... his responsible medical officer (Dr M) was clear that, had the applicant resisted admission or tried to leave thereafter, she would have prevented him from doing so.

*Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave."*²¹

On the second question, whether the deprivation of liberty was "in accordance with a procedure prescribed by law" as required by Article 5(1), the Court found that it was not. The basis for this conclusion was not so much that the doctrine of necessity was imprecise and uncertain but rather that "the further element of lawfulness, the aim of avoiding arbitrariness, has not been satisfied". The Court found that the application of the doctrine of necessity in HL's case lacked sufficient procedural safeguards:

*"In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. There is no requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attach to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention. The nomination of the representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 [Mental Health] Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities."*²²

Before discussing the Government's legislative response, the judgment's immediate implications for practice under the MHA should be noted, particularly given that by 2004 the Human Rights Act 1998 (HRA) was in force. If we return to the example of the patient who is prone to wander and who, for his or her own safety, is to be prevented from leaving the ward, we can see that the guidance in paragraph

19 *R v Bournemouth Community and Mental Health NHS Trust, ex parte L (Secretary of State for Health and others intervening)* [1998] 3 All ER 289 at page 302

20 *Ibid.* at page 307.

21 *HL v United Kingdom* (2005) 40 EHRR 761, at pages 792 – 793.

22 *Ibid.* page 800.

19.27 of the Code fails to direct the reader to the crucial question which is whether the patient is being deprived of liberty. If the answer is in the affirmative, the HRA directs that, if possible, the deprivation of liberty be made compatible with the Article 5 “in accordance with a procedure prescribed by law” requirement. Moreover, given the Court’s finding that HL was deprived of his liberty, though he neither wandered nor objected, the question whether the admission of a not unwilling patient amounts to a deprivation of liberty now has to be asked in every case. The effect of the ECtHR’s judgment should have been to change practice in this respect. One might have expected as a consequence that MHA powers would have been used in some types of case where in the past admission and treatment would have been under common law, but this appears not to have happened. The best explanation for this is that practitioners have not been clear about what amounts to a deprivation of liberty where the patient is not objecting to or resisting admission.

Proposed amendments to the Mental Capacity Act 2005

The Government’s considered response to the ECtHR’s judgment is to amend the MCA so as to create a new regime for deprivation of liberty to sit alongside existing MHA detention powers. The proposed new MCA deprivation of liberty regime both sets legal criteria and creates a new statutory procedure for depriving a mentally incapacitated person of liberty. The criteria are to be found in six qualifying requirements:

- (a) *The age requirement:* P has reached the age of 18.
- (b) *The mental health requirement:* P is “suffering from mental disorder (within the meaning of the Mental Health Act, but disregarding any exclusion for persons with learning disability).”²³
- (c) *The mental capacity requirement:* P “lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital or care home [i.e. that in which he is to be/is being deprived of his liberty] for the purpose of being given the relevant care or treatment.”
- (d) *The best interests requirement:* P satisfies four conditions:
 - i) That he is, or is to be, a detained resident.
 - ii) That it is in P’s best interests for him to be a detained resident.
 - iii) That, in order to prevent harm to P, it is necessary for him to be a detained resident.
 - iv) That it is a proportionate response to—
 - (a) the likelihood of P suffering harm, and
 - (b) the seriousness of that harm, for him to be a detained resident.
- (e) *The eligibility requirement:* P is not ineligible to be deprived of his liberty under the MCA. Ineligibility would arise if he were detained or detainable under the MHA (see below).

23 The relevant exclusion is to be found in clause 2 of the Mental Health Bill which defines learning disability as a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning. It further provides that in relation to detention for treatment a person shall not be considered by reason of that disability to be suffering from mental disorder “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct”. The effect of disregarding this exclusion is that people with learning disability who are excluded from detention under treatment sections of the MHA will be detainable under the MCA if they lack capacity.

- (f) *The no refusals requirement*: P has not made a valid advance decision and there is not some other valid decision, of a donee of a lasting power of attorney or a deputy appointed by the Court of Protection, which conflicts with the decision made by D.

These requirements add to the *substantive safeguards* that are already to be found in the MCA. First, the definition of mental disorder is not in the MCA, which instead relies on the concept of mental incapacity alone. The mental disorder requirement is needed to comply with ECtHR case law which says that a deprivation of liberty by reason of unsoundness of mind must be based on medical evidence of mental disorder.²⁴ Second, the mental capacity requirement is helpful in directing D to the issue in relation to which P's capacity has to be determined, but it does not add anything of substance to the capacity test in the unamended MCA. Third, the best interests requirement, when taken together with section 4 of the MCA, appears to have much the same effect as section 6 of the MCA in relation to restrictions on liberty. However, unlike section 6 it refers not to what D reasonably believes but to P's best interests as an objective state of fact, which is established by the best interests assessment.

In responding to the Bournewood judgment, the Government has emphasised the need for *procedural safeguards* and it has expressly sought to cover each of the points of criticism made by the ECtHR. The proposed safeguards have a number of elements.

- i) The requirement, except in cases of urgent necessity, to obtain an authorisation for a deprivation of liberty from the appropriate supervisory body.

The duty to apply to the supervisory body for a standard authorisation is placed on the hospital or care home where it is proposed that P will reside or, in some cases, is already residing. As an interim measure an emergency authorisation, lasting no longer than seven days, can be given by the managing authority of the hospital or care home if there is an urgent need for P to be a detained resident and an application has been made for a standard authorisation.

A standard authorisation, with a maximum duration of twelve months, will only be granted if the assessments obtained by the supervisory body show that all six qualifying requirements are satisfied. The supervisory body is then bound to give the authorisation. The supervisory body, which for a hospital admission is the responsible PCT and for a residential care home is the local authority, selects the people to carry out the assessments. There must be at least two assessments, including one by a doctor which deals with the mental health requirement and one by someone other than a doctor which deals with the best interests requirement.²⁵ Regulations may make provision for the selection and eligibility of people to carry out assessments, covering their experience, qualifications and any connection they may have with the supervisory body or the relevant hospital or care home.

- ii) The requirement for the appointment of a representative for the person who is being deprived of liberty.

The duty to appoint a representative for the patient, "as soon as practicable after a standard authorisation is given", is imposed on the supervisory body. Before appointing someone as representative for P it must appear to the supervisory body that the person would, if appointed, maintain contact with P; represent P in matters relating to the deprivation of liberty arising from P's residence in the hospital or care home; and support P in relation to those matters. Regulations may provide for how the representative is to be

²⁴ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387.

²⁵ *The Bill does not prescribe which of the other requirements each of the assessments must cover, provided that taken together they cover all the requirements.*

selected and by whom, although the actual appointment is made by the supervisory body.²⁶ The draft code of practice identifies the best interests assessor as having a pivotal role in determining whether P or P's attorney or deputy have selected someone who would be eligible to act as P's representative; and, if not, to consider recommending such a person.²⁷

- iii) The requirement for periodic reviews to determine whether the grounds justifying deprivation of liberty still obtain.

When the period authorised by the current standard authorisation is due to expire, the managing authority of the hospital or care home must seek a fresh authorisation from the supervisory body. The process is essentially the same as for a new standard authorisation. In addition, the supervisory body will be bound to review the authorisation if requested to do so, for example by the managing authority or by the patient's representative. If the review shows that there have been relevant changes the supervisory body must obtain such further assessments as may be necessary.

- iv) The right, conferred on both the patient and the representative, to apply to the Court of Protection to challenge the deprivation of liberty.

Both P and his or her representative have the right of application to challenge a standard authorisation. The detained person also has the right to apply to the Court to challenge an urgent authorisation. In determining any such application, the Court will have to decide whether P meets the six qualifying requirements.

Defining deprivation of liberty

The substantive requirements and procedural safeguards apply only in cases where P is to be, or is already, deprived of liberty. The Bill contains an interpretation provision which falls short of a definition of deprivation of liberty: "In this Act, references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention."²⁸

The draft illustrative code of practice makes clear that "a person may only be deprived of their liberty in their own best interests and when there is no less restrictive alternative." The proposed safeguards exist for those cases "where deprivation of liberty is an unavoidable necessity... Every effort should be made to prevent deprivation of liberty becoming unavoidable."²⁹ It goes on to suggest how this is to be achieved. Those involved in the provision of residential accommodation should "to the greatest possible extent that safety considerations will allow, seek to operate care regimes that promote a person's control over their daily living and maximise their autonomy ... This will both reduce the likelihood of deprivation of liberty arising, and enhance their quality of life."³⁰ There follows a section on best practice to avoid deprivation of liberty by ensuring that alternatives to admission to hospital or residential care are considered, that any restrictions placed on the person while in hospital or residential care are kept to the minimum necessary and that proper steps are taken to help the person retain contact with family, friends and carers.³¹

26 *The patient's representative is distinct from the Independent Mental Capacity Advocate (IMCA) who under the MCA will be appointed in certain circumstances where there is no family member or carer to consult in relation to decisions affecting a mentally incapacitated person.*

27 *The Bournewood Safeguards: Draft Illustrative Code of Practice, paragraphs 140-141, published 22.12.06.*

28 *Mental Health Bill, Schedule 8 para 10(5)*

29 *The Bournewood Safeguards: Draft Illustrative Code of Practice. Para 8*

30 *Ibid para 9*

31 *Ibid para 11*

The reason given in the draft illustrative code for not including a definition of deprivation of liberty in the Bill is that “it is not possible to state that a particular measure would or would not constitute a deprivation of liberty in ECHR terms in every case. It will be necessary to consider all the factors involved on an individual basis.” However, there are features which according to the draft code may be relevant in an individual case. One of those is that the person is prevented from leaving the hospital or care home and another is the choices they are free to make while they are there:

“The person is not allowed to leave the facility

If a person is, or would be, prevented from leaving the facility at all, whether by distraction, locked doors or restraint, that would be a relevant factor in considering whether or not there is deprivation of liberty. However, restrictions placed for the person’s protection would not necessarily amount to deprivation of liberty in the absence of other restrictions, for example if they are only able to leave when accompanied by a friend, family member or carer, or are not allowed to leave in the middle of the night.

A person is not deprived of their liberty simply because they lack the physical ability to leave, or the mental capacity to form a genuine intention to leave. But such a person could still be deprived of their liberty if-

- *Family, friends or carers, who might reasonably expect to take decisions under the Mental Capacity Act 2005 in relation to the person, are prevented from moving them to another care setting or from taking them out.*
- *They are given no (or very limited) opportunity temporarily to go outside of the home or hospital (escorted or otherwise) even though that is physically possible and it seems likely that they would enjoy it, it would reduce their distress or anxiety, or would otherwise be beneficial.*

The person has no or very limited choice about their life within the care home or hospital

For example, where they can be within the facility, what they can do, whom they can associate with, when and what to eat. This could equally apply if choices were available but the care given to the person did not enable them to exercise that choice. If a person is not allowed any freedom of movement within the unit they are probably deprived of their liberty. Regular use of medication or seating from which a person cannot get up in order to control a person’s behaviour and movement may constitute deprivation of liberty. Restrictions which are unavoidable in a group living situation, and which apply to all residents, would be unlikely in themselves to constitute a deprivation of liberty but this would depend on the context and the extent of other restrictions imposed on the person concerned.”³²

In their legislative scrutiny report on the Mental Health Bill,³³ the Joint Committee on Human Rights commented unfavourably on this guidance, preferring Munby J’s analysis of deprivation of liberty in *JE* and *DE v Surrey County Council and EW*.³⁴

*“We consider that deprivation of liberty is a less flexible and elusive concept than might be thought from the draft illustrative guidance. Since we posed this question to the Government, Munby J has delivered judgment in *JE* and *DE v Surrey County Council and EW*, holding that the crucial issue in determining whether there is a deprivation of liberty is not so much whether the person’s freedom within the institutional setting is curtailed, but rather whether or not the person is free to leave.”³⁵*

The Joint Committee also commented critically on the complexity of the Bournemouth safeguards and

³² *Ibid* para 28

³⁴ [2006] EWHC 3495 (Fam)

³³ Joint Committee on Human Rights, *Legislative Scrutiny: Mental Health Bill, Fourth Report of Session 2006-07*, HL Paper 40 HC 288 (published 4th February 2007)

³⁵ *Ibid* page 30

questioned “whether they will be readily understood by proprietors of residential care homes, even with the benefit of professional advice.” Together with other commentators, they favour the inclusion in the amended MCA of a definition that is clear and simple to operate. The advantage of their preferred definition is that it requires only a single question to be asked: whether P is free to leave the place of residence. If not, there is a deprivation of liberty.³⁶

If this definition were to be inserted in the MCA it would surely increase the number of people subject to the new deprivation of liberty regime, as compared with the Government’s prediction that there will not be a “large number” of cases. It would include every mentally incapacitated person who would be prevented from leaving the premises where they are being provided with residential or hospital care. The Joint Committee’s definition, derived from *Munby J*, is much the same as that formulated by the Court of Appeal in the *Bournewood* case. According to evidence submitted by the Mental Health Act Commission to the House of Lords in that case, the Court of Appeal judgment would have resulted annually in an additional 48,000 MHA detentions.³⁷ To this figure would have to be added the considerably larger number of mentally incapacitated people who are resident in care homes, and thus outside the scope of MHA detention powers, but who are deprived of liberty in the sense that they would be prevented from leaving.³⁸

Deprivation of liberty and the use of the Mental Health Act 1983

The Government considers it would be undesirable if there was overlap between the MHA and MCA detention powers such that on a case by case basis a choice had to be made as to which was the more appropriate legal regime. Its solution is that the new MCA powers are to be used only in circumstances where existing MHA powers are not available.

Schedule 7 of the Mental Health Bill inserts a new schedule 1A in the MCA: “Persons Ineligible to be Deprived of Liberty by this Act”. In giving precedence to the 1983 Act, this schedule includes not only the obvious case of people who are already detained pursuant to an application or order under the MHA, it also excludes from detention under the MCA people who are “within the scope of the Mental Health Act”. Paragraph 12 of the schedule defines what is meant by being within the scope:

“(1) *P* is within the scope of the Mental Health Act if—

- (a) an application in respect of *P* could be made under section 2 or 3 of the Mental Health Act,
- and

36 This is consistent with what in *JE and DE v Surrey County Council and EW Munby J* referred to at paragraph 77 ii) b) of his judgment as the necessary objective element in a deprivation of liberty: “In the type of case with which I am here concerned, the key factor is whether the person is, or is not, free to leave ...”.

37 Lord Goff summarised the evidence provided by the Mental Health Act Commission: “First and foremost, the effect of the [Court of Appeal’s] judgment is that large numbers of mental patients who would formerly not have to be compulsorily detained under the 1983 Act will now have to be so detained. Inquiries by the commission suggest that ‘there will be an additional 22,000 detained patients resident on any one day as a consequence of the Court of Appeal judgment plus an additional 48,000 admissions per year under the Act’ (written submission para 3.4). This estimate should be set against the background that the

average number of detained patients resident on any one day in England and Wales is approximately 13,000.”

38 In respect of what is the largest group, people suffering from dementia, a recent study estimates that in the UK there are currently 424,378 people with late-onset dementia who are living in private households and a further 244,185 living in care homes. (Dementia UK – A report into the prevalence and cost of dementia prepared by the Personal Social Services Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King’s College London, for the Alzheimer’s Society, 27th February 2007). Given that residence in a care home is usually associated with greater deterioration of functioning in a progressive condition, it seems reasonable to assume that, for their own safety, the majority of such people are not free to leave the care homes where they are residing.

- (b) *P could be detained in a hospital in pursuance of such an application, were one made.*
- (2) *The following provisions of this paragraph apply when determining whether an application in respect of P could be made under section 2 or 3 of the Mental Health Act.*
 - (3) *If the grounds in section 2(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 2(3) of that Act have been given.*
 - (4) *If the grounds in section 3(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 3(3) of that Act have been given.*
 - (5) *In determining whether the ground in section 3(2)(c) of the Mental Health Act is met in P's case,³⁹ it is to be assumed that the treatment referred to in section 3(2)(c) cannot be provided under this Act [i.e. the MCA]."*

The object is to capture established practice under the MHA and to prevent any change that would result in people being detained under the MCA in future in circumstances where currently they would be detained under the MHA. If, on the other hand, someone would not now be detained under the MHA, but is nonetheless being deprived of liberty, the MCA is to be used. For example, a person who lacks capacity and does not object to hospital admission would not now be detained under the MHA. It is proposed that in future such a person, if deprived of liberty, would be detainable under the MCA. It is not clear, however, that Schedule 1A will have the result intended by the Government. Arguably, the effect of paragraph 12(5) of the schedule is that anyone who is deprived of liberty in a psychiatric hospital is detainable under the MHA and should be so detained rather than being deprived of liberty under the proposed MCA provisions. The only exception to this would appear to be people whose mental disorder excludes them from detention under section 3 and other treatment sections because of the restricted definitions of the classified forms of mental disorder currently to be found in section 1(2) of the MHA.⁴⁰

If we return again to the wandering patient and the guidance in paragraph 19.27 of the MHA Code of Practice, the question being addressed there is whether such a person is to be understood as objecting to being in hospital – the test being whether they are persistently and/or purposely trying to leave. If, however, deprivation of liberty does not, in such a case, depend on the person's intentions but solely on whether, regardless of their intentions, they would be allowed to leave, the guidance can be of no assistance. It cannot in any case provide the answer to the question whether, assuming there is a deprivation of liberty, it could lawfully be under the MHA. It is not possible to identify any provision in the MHA which precludes its use in such circumstances. The point is made succinctly in the current edition of the Mental Health Act Manual: "An assessment for the sectioning of a mentally incapacitated person who is compliant to being in hospital should be made if the patient is being deprived of his or her liberty as a failure to detain the patient under [the MHA] would violate the patient's right under Art. 5 of the ECHR."⁴¹ Once it is accepted that it would be lawful to detain such a person under the MHA, the effect of paragraph 12(5) of schedule 1A is that they are *within* the scope of the MHA and thus excluded from the proposed MCA deprivation of liberty regime. This is apparently not the Government's intention. The Bournemouth Briefing Sheet says: "The new [MCA] procedure cannot be used to detain people in hospital for treatment of mental disorder in situations where the Mental Health Act could be used instead

39 Section 3(2)(c) says: "it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section."

40 In the Mental Health Bill the exclusion of certain people with learning disability from detention under treatment sections of the MHA is continued - see footnote 23 above.

41 Mental Health Act Manual, Richard Jones, Thomson, Sweet & Maxwell, 10th ed. 2006 page 23.

if they are thought to object to detention for the purposes of such treatment. This will mean that people who object will be treated in broadly the same way as people with capacity who are refusing treatment for mental disorder and who need to be detained as a result.⁴² The implication is that people who do not object will not be detained under the MHA, but instead will be deprived of their liberty under the MCA. If the Government does not want such people to be detained under the MHA it may have to make clear in the legislation which classes of people with mental disorders who are deprived of liberty fall to be dealt with under the MHA and MCA respectively.

What of the person with dementia who, albeit mentally incapacitated, does object to the hospital regime and subsequently to the residential care home? According to the Government, such a person is clearly *within* the scope of the MHA where admission to hospital is being considered or is effected. With the move to residential care, even though still objecting, he or she is clearly *outside* the scope, for the simple reason that the MHA is not capable of authorising a deprivation of liberty outside hospital. Such a person would therefore move from one legal regime to another at the point of leaving hospital. It is difficult to identify any principled reason why a different regime, with different legal criteria and procedural safeguards, should apply according only to the place of detention.

Another example is a person with what the Mental Health Bill defines as a learning disability: “a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning”. If that person’s learning disability is not “associated with abnormally aggressive or seriously irresponsible conduct on his part”, he or she will be detainable under section 2 of the MHA for a maximum of 28 days but thereafter, assuming a lack of capacity, will be detainable in hospital only under the MCA,⁴³ regardless of his or her attitude to being in hospital and to the treatment being offered. The explanation for this is historical and may now appear anachronistic, the policy aim having been to avoid the use of formal legal powers in relation to most people with a learning disability who require in-patient psychiatric treatment. If that same individual objects to care in a nursing home he or she will, of course, be detainable only under the MCA.

Discussion

The following criticisms can be made of the Government’s proposals:

- 1) The two detention regimes, respectively under the MHA and MCA, are designed for different purposes but in drawing the boundary between them the Government has not taken this into account. Instead the Government has sought, while not changing the scope of MHA detention powers, to create by amendments to the MCA a residual regime for deprivation of liberty outside the MHA. A consequence of the Government’s proposals is that the same individual can move between the two regimes, by reason only of considerations such as the place of detention or a technical definition of mental disorder in the MHA, where there is no change in the individual’s mental condition or attitude to receiving care. Moreover, the distinction between those within and outside the scope of the MHA is less clear than the Government has assumed. This may lead to inconsistencies in practice.
- 2) Another consequence of the Government’s approach is that the new MCA detention regime has to cover a wide range of people who have in common only that they are in need of care in a

⁴² *Bournemouth briefing sheet, Department of Health – November 2006.*

⁴³ *The Government would presumably say, additionally, that MHA detention would only be available in such a case if the patient was objecting.*

hospital or other residential setting and they lack capacity to consent to it. If the proposed MCA powers were to be confined to those patients who are compliant with their care and whose mental incapacity is associated with a significant degree of cognitive impairment, it is arguable that a less complicated, and potentially less costly, regime would suffice to satisfy the Article 5 “in accordance with a procedure prescribed by law” requirement. This is of particular relevance because it appears that the Government has underestimated the number of mentally incapacitated people who are necessarily being deprived of their liberty and therefore the total cost of the new deprivation of liberty regime.

In relation to the first criticism, the MHA and MCA detention regimes are designed for different purposes. They have different legal criteria for detention and different procedural safeguards. As the historical background demonstrates, the essence of detention under the MHA is that the State takes away an individual’s liberty against that person’s will. The MHA, reflecting ECHR norms, sets a risk threshold before the state can legitimately intervene and it provides the individual with recourse to the mental health review tribunal to challenge the judgments of the professionals, whether about the presence or nature of a mental disorder or the risks associated with it. The tribunal has to consider the proportionality of any deprivation of liberty by balancing the risks, including to the patient himself, against the loss of liberty which detention necessarily entails. From the individual’s point of view, the desired outcome in such proceedings is the recovery of liberty: the freedom to choose whether to remain in hospital or to return home.

The proposed MCA regime serves a different purpose, particularly if deprivation of liberty is equated with the individual not being free to leave the place where residential care is being provided. If for such an individual, like HL in the Bournemouth case, it would, as Lord Nolan said, be “wholly irresponsible ... to let him leave”,⁴⁴ it is difficult to envisage how there could be a successful challenge to such a deprivation of liberty. There may of course be instances where the professionals get the judgment wrong, such that it would be safe for the person to be free to leave; but where the mental incapacity is associated with significant cognitive impairment it is unlikely that there would be many such cases. Different considerations will arise in cases such as HLs where at all times there was available a better alternative to hospital care. However, it would surely be a mistaken view to see this as an Article 5 issue equivalent to the patient detained under the MHA who asserts the right to return home. For someone like HL, the question whether to remain in hospital or to return home is essentially a judgment made by others about his best interests. It is not about deprivation of liberty, as presumably he would not be free to leave wherever he was being properly cared for, for the reason given by Lord Nolan. Within the framework of the MCA, the question as to an incapacitated person’s place of residence would normally be considered applying the principles and procedures in the main body of the Act, rather than through the proposed new deprivation of liberty regime.

It is no doubt true that many of those who are detained under the MHA, including those with mental illnesses such as schizophrenia who are not cognitively impaired, lack capacity at the point of admission. What they have in common is that they object to being in hospital or to receiving treatment. To a greater or lesser degree they assert the right to be free to make their own choices. The MHA is undoubtedly the appropriate legal framework for such people. It is no less appropriate because they happen to be in a nursing home rather than a hospital or because they have a learning disability which is not associated with “abnormally aggressive or seriously irresponsible conduct”. The first element of a coherent approach to

⁴⁴ Per Lord Nolan – see footnote 20 above.

the ECtHR's judgment in the *Bournewood* case would be to bring within the MHA all those who object to the care regime which deprives them of their liberty. This would mean extending MHA detention to settings other than hospitals, possibly through an enhanced MHA guardianship regime.

The second element would be to exclude from detention under the MHA all those who do not object to the care regime which deprives them of their liberty. It is accepted that it may sometimes be difficult to know whether a person is or is not objecting but this is something which, as now, could be the subject of guidance in a code of practice.

The third element would be to include within the MCA a definition of deprivation of liberty of the kind proposed by the Joint Committee on Human Rights. People who lack capacity and are deprived of liberty because of mental disorder, but who do not object or resist, would come within a new MCA detention regime.

Turning to the second criticism, in seeking to ensure that the new MCA regime complies with the Article 5 "in accordance with a procedure prescribed by law" requirement, the Government's approach has been to meet the criticisms made by the ECtHR in the *Bournewood* case. Its proposed procedural safeguards mirror those criticisms. The Government appears to have assumed that in drawing attention to the lack of specific procedural safeguards in connection with HL's admission to *Bournewood*, the ECtHR intended to lay down minimum standards for an Article 5 compliant procedure in cases where deprivation of liberty arises from mental disorder. This would be a misreading of a judgment in which the Court also commented favourably on what was then the Mental Capacity Bill and is now the MCA:

*"The Court notes, on the one hand, the concerns about the lack of regulation in this area expressed by Lord Steyn [and others]. On the other hand, it has also noted the Government's understandable concern to avoid the full, formal inflexible impact of the 1983 [Mental Health] Act. However, the current reform proposals set out to answer the above-mentioned concerns of the Government while at the same time making provision for detailed procedural regulation of the detention of incapacitated individuals."*⁴⁵

If the Government had started from the position that the proposed MCA detention powers would only apply to people who are compliant and whose mental incapacity is associated with significant cognitive impairment, it could then have asked both what was desirable to safeguard their interests and what was minimally necessary to comply with the Article 5 "in accordance with a procedure prescribed by law" requirement.

The aim is to ensure that decision-making which leads to an individual being deprived of liberty is not arbitrary. As was acknowledged by the ECtHR in *Bournewood*, the decision-making framework of the MCA, as now enacted, goes considerably further than common law to reduce the risk of arbitrariness. If it were felt that decisions resulting in deprivation of liberty raise issues requiring special consideration, the provisions already enacted in section 6 of the MCA, which deal with restraint, provide a model for incorporating additional substantive safeguards in relation to decision-making under the MCA. Many of the points of criticism in the ECtHR's judgment in *Bournewood*, such as the exact purpose of admission and the requirement for a continuing clinical assessment of the persistence of a mental disorder, could be incorporated into the MCA by way of safeguards for decisions resulting in deprivation of liberty. Additional safeguards could include an explicit proportionality requirement and other matters pertinent to such a decision. It is difficult to see that anything more is needed. Such matters would have to be considered as part of the decision-making process under the MCA which leads to the incapacitated

45 *HL v United Kingdom* (2005) 40 EHRR 761, page 801.

person being placed in hospital or residential care and would be covered in the resulting care plan. There should not normally be any need for further medical or other assessments specifically for the purpose of compliance with Article 5.

As to formal procedural safeguards, if the MCA deprivation of liberty regime were to be reserved for people with significant cognitive impairment who do not object to their care, less stringent and complex safeguards would be needed than those now proposed by the Government. There are only two essential requirements. First, to identify, record and notify the registration body whenever a mentally incapacitated person is being deprived of their liberty by a public authority in circumstances where the person is not objecting. If the legal test under the MCA for deprivation of liberty is whether they would be prevented from leaving the hospital or care home, this should present few difficulties to mental health professionals and care providers. The second requirement, in order to comply with Article 5(4) of the ECHR, is that the person deprived of liberty, or someone else on their behalf, must have the opportunity to challenge the deprivation of liberty by an application to the Court of Protection. This entails the appointment of a representative by a body which is independent of the place of detention. There would need to be a procedure for identifying the most suitable person to act as representative. This would usually, though not invariably, be a family member.

Conclusion

The Government's response to the problems thrown up by the *Bournewood* case in the ECtHR is limited and pragmatic. While recognising the necessity to regularise the legal position of people who are unlawfully being deprived of liberty under common law powers, it does not wish to extend the full MHA detention regime to everyone who may be deprived of liberty. It therefore proposes to fill the *Bournewood* gap but to leave the scope of MHA detention powers unchanged. There are serious disadvantages in approaching law reform in this way. Legislation which is not underpinned by clear principles and legal definitions is likely to result in unforeseen consequences, for example an increased number of detentions of compliant patients under the MHA. By failing to define who will come within the proposed new MCA provisions, it risks creating an unnecessarily complex and costly detention regime under the MCA with little discernible benefit to the people whose interests it is intended to protect.