
The concept of objection under the DOLS regime

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Introduction

In England and Wales, there are now two regimes under which an adult can be deprived of liberty when receiving mental health treatment: the regime established by the *Mental Health Act 1983* (MHA), and the Deprivation of Liberty Safeguards (DOLS) authorisation regime established by the *Mental Capacity Act 2005* (MCA). Where both regimes might apply to a mentally disordered person in hospital for mental health treatment, a major dividing line between them is the ability of the patient to “object” to being a mental health patient or to being given mental health treatment. If such an objection occurs, a hospitalised patient is ineligible for the DOLS regime and only the MHA regime may be used to authorise the deprivation of their liberty.

This concept of objection is somewhat difficult to grasp. It may not always be clear that a mentally disordered person has objected: where, for example, that person fluctuates between forceful objection and content acceptance of their deprivation of liberty, or where a person only objects following the visitation of an influential family member or friend.

There are other complications of the DOLS regime. The law was plainly intended to provide better procedural protections for patients who would previously have been admitted informally, by filling what is commonly termed the “*Bournewood* gap”.⁴ However, there is some risk that over-reliance on the DOLS regime, which has fewer procedural safeguards for psychiatric patients detained in hospital than the MHA, could lead to a watering down of the protections mental health patients would otherwise enjoy.

It is unclear whether clinicians will find the DOLS regime simpler and more economical to use than the MHA. Some may find the DOLS regime cumbersome and unfamiliar, and, if there is a choice, they may prefer to continue to rely on the MHA, whose process is well-known. Moreover, patients who are not under treatment for mental disorder may have to live within the DOLS regime, when they are deprived of their liberty, regardless of its shortcomings. However, it does not seem to have been any part of the legislative intent, in enacting the DOLS regime, to water down the existing procedural safeguards for

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4. So-called following the case of *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1998] UKHL 24, [1999] 1 AC 458.

patients who would have been detained previously under the MHA.

So it is important to take a consistent and workable approach to the concept of objection, which constitutes one cutting line between the two regimes, to ensure that all compulsory mental health patients receive the benefit of proper procedures and protections. By attempting to better define the test of objection in this article, we aim to make clearer the dividing line between the two enactments, in light of the purpose and context of the DOLS regime.

A background to “objection”

The language of “capacity” and “consent” is familiar to English mental health law. However, a successful application⁵ to the European Court of Human Rights (ECtHR) brought on behalf of HL, who was informally detained in a psychiatric hospital but incapable of giving consent, led to the addition of a new but related concept: the notion of deprivation of liberty, short of confinement under the MHA, which may be authorised under the DOLS regime. But this regime is only available in limited situations. Paragraph 5(4), Schedule 1A MCA provides that a person is ineligible to be subject to a DOLS authorisation where he “objects” either to being a mental health patient, or to receiving mental health treatment.

Previously the House of Lords in *Bournewood*⁶ had considered HL’s position. HL was an autistic middle-aged man being kept at Bournewood Hospital, outside any statutory framework and despite the objections of his community carers. He did not (or could not) request to leave the hospital, nor did he attempt to do so, but he would have been prevented had he tried. The House of Lords (by a majority) concluded this did not amount to detention under the common law, but the ECtHR ruled it was a deprivation of liberty under European human rights law.⁷

The Lords’ judgment may well have been influenced by the fear that sectioning every hospitalised mentally disordered person under the MHA would prove a terrific burden on the resources available to hospitals, Mental Health Review Tribunals (as they were)⁸ and the Mental Health Act Commission (as it was),⁹ as the number of detained patients might nearly treble.¹⁰ In light of the ECtHR decision that English law was insufficient in this domain, the DOLS regime was enacted to protect the liberty interests of such patients. The proper application of this regime permits the deprivation of liberty, by the managing authority of a hospital or care home,¹¹ of a person who lacks the capacity to consent. It now operates alongside the scheme for compulsory treatment found in the MHA.

One circumstance in which a DOLS authorisation may be granted is where an eligible person with a mental disorder requires medical treatment in their best interests, but does not have the capacity to consent to the deprivation of their liberty for that purpose.¹² The need for authorisation appears to fulfil the requirement in article 5(1)(e) of the European Convention on Human Rights that mentally disordered persons may only be deprived of their liberty “in accordance with a procedure prescribed by law”, while the availability of review by the Court of Protection¹³ meets the requirement in article 5(4)

5. *HL v United Kingdom* (2005) 40 EHRR 32.

6. *Above* n 4.

7. *HL*, *above* n 5, [90].

8. Now replaced in England by the First-Tier Tribunal (Mental Health), established by the Tribunals, Courts, and Enforcement Act 2007.

9. The Mental Health Act Commission was abolished by the

Health and Social Care Act 2008, and its functions subsumed within the Care Quality Commission.

10. *Bournewood*, *above* n 4, 481-2.

11. *Mental Capacity Act 2005, Schedule A1, para 2.*

12. *Mental Capacity Act 2005, Schedule A1, Part 3.*

13. *Mental Capacity Act 2005, s 21A.*

that the legality of the person's detention must be readily testable by a court.

The applicability of the DOLS regime centres on various inclusion and exclusion criteria. The inclusion criteria¹⁴ are the mental health requirement, the mental capacity requirement, the best interests requirement and the age requirement. Under the exclusion criteria, a person does not qualify for a DOLS authorisation in certain circumstances. This includes where the person objects to being a mental health patient or to being given mental health treatment, or where some competing legal regime applies (the eligibility requirement);¹⁵ and where they have made a valid advance decision that contradicts the intervention, or the proposal to deprive them of liberty would conflict with a valid decision of a donee acting under a lasting power of attorney or of a deputy appointed by the Court of Protection (the no refusals requirement).¹⁶ The tests for eligibility, in particular, are complex, with their detail being explained in a separate Schedule 1A to the MCA.¹⁷

Objection will arise as an issue where a person is within the scope of the *Mental Health Act 1983* (by virtue of a mental disorder and meeting the other criteria for detention), but is not currently the subject of a compulsory treatment regime whereby they are deprived of liberty. Ineligibility by objection is not a simple matter of objecting to a deprivation of liberty, however. Rather, where a DOLS instrument would otherwise authorise a person to be deprived of liberty as a mental health patient, and that person objects either to that status or to treatment arising from that status, the person will be ineligible to be treated under the DOLS regime. An objection of that kind, then, makes a person ineligible only where the purpose of a DOLS authorisation would be treatment for mental disorder.

There is no need for a person to have the capacity to object: the eligibility criteria treat a person as if they had such capacity.¹⁸ Lack of capacity to consent to a deprivation of liberty is already a requirement of a DOLS authorisation; requiring an objection to be made with capacity would create an unobtainable exception.

Objection to what?

As noted above, for an objection to be an effective limit on DOLS eligibility, it must be an objection to being a mental health patient, or to receiving mental health treatment. A "mental health patient" is defined as a person accommodated in a hospital for the purpose of being given treatment for a mental disorder, while "mental health treatment" is simply medical treatment for mental disorder received as a "mental health patient".¹⁹ The definition of the latter is explicitly subsumed into the former; the grounds of objection, then, are largely interchangeable. Objection will not exclude a person from the scope of the DOLS regime when they are deprived of liberty for mental health treatment in another type of facility (such as a private care home),²⁰ or where the treatment is not for the person's mental disorder but for some unrelated medical condition²¹ which is not a symptom or manifestation of a mental disorder.²²

14. *Mental Capacity Act 2005, Schedule A1, para 12(1)*.

15. *Mental Capacity Act 2005, Schedule A1, para 12(1)(e) and Schedule 1A*.

16. *Mental Capacity Act 2005, Schedule A1, paras 12(1)(f) and 18-20*.

17. *Mental Capacity Act 2005, Schedule 1A*.

18. *Explanatory Notes to the Mental Health Act 2007, para 204*.

19. *Mental Capacity Act 2005, Schedule 1A, para 16(1)*.

20. *W Primary Care Trust v TB* [2009] EWHC 1737 (Fam), [39].

21. *GJ v The Foundation Trust and Ors* [2009] EWHC 2972 (Fam), [2010] Fam 70, [128].

22. *See the definition of 'treatment' in Mental Health Act 1983, s 145(4)*.

Objection to treatment does not affect DOLS authorisations granted for reasons other than treatment for mental disorder, so long as the deprivation of liberty is in the best interests of the person and all the other inclusion criteria for a DOLS authorisation have been met. The purpose of objection is therefore to exclude a patient from the DOLS regime, and to require their treatment under the MHA hospital treatment regime, *where a person is otherwise eligible for both regimes*. So a person's objection will only exempt them from eligibility under the DOLS regime when their deprivation of liberty for treatment for mental disorder under the MHA is currently occurring or feasible: that is, they currently meet the criteria for compulsory treatment for mental disorder under that Act.

Objection is therefore a critical factor in determining whether a person is treated under the hospital treatment regime of the MHA, or under a DOLS authorisation, with the former having primacy.²³ Obviously there could be scope for overlap between the two regimes, but it was made clear in *GJ v The Foundation Trust*, a detailed judgment of the Court of Protection,²⁴ that decision-makers should not approach the MHA and DOLS schemes as equal alternatives but should recognise and give effect to the primacy of the MHA.²⁵ We take this principle of primacy to mean that all patients who would previously have been treated under the MHA hospital treatment regime should continue to be treated under it, with the DOLS regime reserved firstly for non-objecting mental health patients who would previously have fallen into the *Bournewood* gap,²⁶ and secondly for patients whose donee or deputy has "made a valid decision to consent to each matter" to which the patient objects.²⁷

Points of difference between the DOLS and MHA regimes

Some groundwork is necessary before difficult cases of objection can be addressed. When defining the boundary between the DOLS and MHA regimes, it is important to bear in mind the different legal consequences of treatment under these regimes. Jones has briefly described some of the distinctions between the two regimes, concluding that, where there is a choice between the two, the latter is preferable.²⁸

Some of Jones' points are worth expanding upon. He correctly states that the protections relating to treatment contained in Part IV of the MHA are not replicated in the MCA.²⁹ These protections are not insignificant: they concern such matters as the special regime governing electro-convulsive therapy,³⁰ and they require a clinician to certify in writing the capacity and the consent of a patient after three months of compulsory pharmacological treatment, or to obtain a second opinion from a doctor appointed for the purposes of Part IV of the Act.³¹ In contrast, the MCA provides that decisions as to medical treatment³² may be made by a court order or by an appointed deputy,³³ or by a person holding a lasting power of

23. *GJ*, above n 21, [58]; see also *Mental Capacity Act* 2005, s. 28.

24. See Allen, Neil "The Bournewood Gap (As Amended?): *GJ v Foundation Trust* [Commentary]" (2010) 18 *Med L Rev* 78, 82.

25. *Above* n 21, [65].

26. Whether or not HL actually fell into the part of the Bournewood gap that is now filled by the DOLS regime is a valid point of contention: see Allen, n 24, 84.

27. Where the donee or deputy does consent to this, the patient may be deprived of liberty under the DOLS regime: *Mental Capacity Act* 2005, Schedule 1A, para 5(5).

28. Jones, Richard "Deprivations of Liberty: Mental Health Act or Mental Capacity Act?" (2007) *J Mental Health L* 170, 172-3; see also Jones, Richard *Mental Capacity Act Manual* (3rd ed, Sweet & Maxwell, London, 2008), 2-030.

29. *Ibid*, 172.

30. *Mental Health Act* 1983, s 58A(1).

31. *Mental Health Act* 1983, s 58.

32. *Mental Capacity Act* 2005, s 17(1)(d).

33. *Mental Capacity Act* 2005, s 16(2).

attorney, as long as the person lacks the capacity to make a treatment decision; or by a clinician or carer where the person lacks capacity and the actions taken are in the best interests of that person.³⁴ The specific treatment protections under the MHA regime are not replicated. This difference is symptomatic of the different intended applications of the two enactments: the MHA is aimed at providing compulsory mental health treatment for mentally disordered persons, whereas the MCA is intended to provide substitute decision-making for a range of personal decisions based on lack of capacity, including decisions about medical treatment, living arrangements, and property and welfare issues.³⁵ It therefore has a broader focus than the MHA, but offers fewer specific procedural protections concerning psychiatric treatment.

Jones also claims that the mental health patient's nearest relative "has no role to play under the MCA",³⁶ compared to the significant protective powers available to a nearest relative (NR) formally designated for a compulsory patient under the MHA. While it is true that this NR has no specific function under the MCA (since the NR's formal role is confined to the context of the MHA), there is still provision for the compulsory appointment of a relevant person's representative (RPR) whenever a DOLS authorisation is made.³⁷ The NR under the MHA will normally be the closest relation of the patient,³⁸ whereas the RPR may be some other family member, friend or carer.³⁹ An NR is designated by virtue of their familial relationship, and has a number of powers under the MHA, but has few particular requirements to fulfil: they are not obliged by law, for instance, to consider whether they should exercise all their powers. The RPR, on the other hand, must be able to keep in contact with the relevant person and be willing to be their representative;⁴⁰ they must act in the person's best interests;⁴¹ and can be selected by a relevant person with the capacity to do so.⁴² A NR can be replaced where they are incapable of exercising their powers, or act unreasonably or irresponsibly, or are deemed "unsuitable" for the role, but they can only be replaced by court order,⁴³ whereas the RPR can be replaced by the supervisory body for certain reasons, without application to a court.⁴⁴

As a whole, then, the RPR appointment appears to be better considered, and have more immediate oversight, than the appointment of an NR. However, the NR's specific powers to direct the discharge of a patient from compulsory assessment or treatment⁴⁵ are not granted to the RPR. As above, this reflects the broader focus of the MCA.

Perhaps the most striking point Jones makes about the MCA is the lack of automatic judicial oversight of long-term deprivation of liberty, compared with the position under the MHA.⁴⁶ This conflicts with the claim made by Bartlett that the MCA provides better protection of patients' rights because it provides for

34. *Mental Capacity Act 2005*, s 5(1).

35. See also Richardson, Geneva "Mental Capacity at the Margin: The Interface between Two Acts" (2010) 18 *Med L Rev* 56, 57.

36. Jones, above n 28, 172.

37. *Mental Capacity Act 2005*, Schedule A1, para 139(1).

38. In some instances, however, the application of the detailed provisions of s 26 *Mental Health Act 1983* may not have precisely this effect.

39. *Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008* (SI

2008/1315), regs 5(1), 6(1), 8(1).

40. SI 2008/1315, reg 3(1).

41. SI 2008/1315, reg 13(g).

42. SI 2008/1315, reg 5(1).

43. *Mental Health Act 1983*, s 29.

44. SI 2008/1315, reg 13.

45. *Mental Health Act 1983*, s 23(2). The nearest relative's direction for discharge can, however, be barred by the patient's responsible clinician on specified grounds: *Mental Health Act 1983*, s 25(1).

46. Jones, above n 28, 172.

an independent assessment of a patient's best interests.⁴⁷

These statements cannot both be right: the true position may be closer to that described by Jones. Bartlett claims that "meaningful safeguards to detention" in the MHA regime are "triggered by the patient", so will not be effective where a patient has no ability to ask for a review.⁴⁸ This is questionable. While a patient *can* trigger review by the Tribunal,⁴⁹ hospital managers are also under a duty to refer cases to the Tribunal where a patient's case has not been brought to the attention of the Tribunal in the first six months of detention under Part II,⁵⁰ or where the patient's case has not been considered by the Tribunal for three years.⁵¹ An NR of a patient detained for treatment may also apply for review when their direction for discharge has been barred by the relevant clinician.⁵² There may be some delay before the tribunal hearing occurs. But, as these provisions show, not all meaningful safeguards to detention are triggered by the patient. Some safeguards can be, and sometimes must be, triggered by others.

Bartlett also says the best interests assessors are an "independent party" reviewing the condition of the patient.⁵³ But, while the best interests assessor will never be the professional with day-to-day care of the relevant person,⁵⁴ they may well be a colleague of that professional, employed in the same Trust. A person is barred from performing the role of best interests assessor when they have a financial interest in the managing authority,⁵⁵ when they are a relative of the relevant person,⁵⁶ and when they are employed by the supervisory body and that body and the managing authority are the same.⁵⁷ But that is not sufficient to ensure assessors are completely "independent" of the professionals who provide the patient's day-to-day care. They may be independent of the relevant person so far as normal care decisions are concerned, but they may still have a close working relationship with the professional with day-to-day responsibility for that person's care. In contrast, the Tribunal is a judicial body, assessing each case objectively as an outside party, so is more independent than a best interests assessor.

In light of these differences between the two regimes, it might be thought that the MHA regime has certain procedural advantages for mental health patients. When discussing the concept of objection, which forms one boundary for the mental health patient between the two schemes, these advantages should be kept in mind.

Economic issues

In addition, the differences between the regimes raise questions of cost. There is an economic justification for using the regime with lower compliance costs. It is not entirely clear which regime will entail the lower costs, particularly as the statutory duty to provide after-care for patients treated under the MHA⁵⁸ has no equivalent for patients under the DOLS regime.⁵⁹ But the financial implications of using the MHA regime for all informal patients were strongly emphasized in the *Bournewood* litigation.⁶⁰ It is clear that

47. Bartlett, Peter "Civil Confinement" in Gostin, Lawrence et al. (eds) *Principles of Mental Health Law and Policy* (Oxford University Press, Oxford, 2010), para 12.228.

48. *Ibid.*

49. *Mental Health Act 1983*, s 66(1)(i).

50. *Mental Health Act 1983*, s 68(2).

51. *Mental Health Act 1983*, s 68(6).

52. *Mental Health Act 1983*, s 66(1)(ii).

53. *Above n 47.*

54. *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (SI 2008/1858), reg 12(1).

55. SI 2008/1858, reg 11.

56. SI 2008/1858, reg 10.

57. SI 2008/1858, reg 12(2).

58. *Mental Health Act 1983*, s 117.

59. Jones, *above n 28*, 173.

60. *Above n 4.*

the MHA is intended to have primacy over the DOLS regime,⁶¹ and that persons subject to the MHA enjoy greater procedural safeguards. So, who should be treated for mental disorder under the possibly cheaper, but less procedurally rigorous, DOLS regime?

The answer, if one emphasizes the value of due process to detained patients, would be those patients least likely to benefit from the additional procedural protections of the MHA regime. Such patients would normally be suffering from a long-term mental disorder, with little likelihood of recovery or improvement in their condition, so that the focus of clinicians is more on palliative than curative care.⁶² Some suitable examples of such mental disorders may be degenerative conditions such as dementia, serious intellectual or learning disabilities, or permanent brain injuries caused by alcohol abuse, traumatic brain injury or cerebral hypoxia. Patients with conditions that tend to have a fluctuating course, on the other hand, such as schizophrenia, or disorders of mood or affect, or other psychotic conditions, may be less suited to the DOLS regime.

The meaning of “objection”

The MHA Code of Practice offers some guidance on the meaning of objection. The matter should be considered, it says, “in the round, taking into account all the circumstances, so far as they are reasonably ascertainable”, and “the reasonableness of [the] objection is not the issue”.⁶³ In addition, both this Code⁶⁴ and the MCA⁶⁵ specifically mention the need to consider the patient’s behaviour, wishes, feelings, views, beliefs, and values, so far as they can be ascertained. The Code adds that a person is to be taken as objecting when there is reason to think they would object, if able to do so;⁶⁶ refusal through an applicable advance directive is to be considered an objection;⁶⁷ it is sufficient if the patient objects to some, though not all, elements of their mental health care;⁶⁸ and the need for restraint of the patient to protect others is a strong indicator that the MHA should be used.⁶⁹ But can we take the matter further?

Objection is objectively assessed

First, it cannot be the case that the existence of an objection can be established purely subjectively: that is, it should not be viewed solely from the perspective of either the subject of a DOLS authorisation or the staff member administering the treatment. A patient’s subjective intention to object may not be sufficiently obvious to be recognised by a particular DOLS assessor. Alternatively, a particular staff member might not recognise the manifestation of an objection when the person is acutely psychotic or of a changeable disposition. But the actual views of the patient or staff member should not necessarily be definitive, in either case. The proper assessment of objection must be objective, viewed from the point of view of a reasonable and fair-minded observer looking on.

Such an observer should not be fixed with an in-depth knowledge of the objector’s psychiatric history. This avoids the sort of subjective assessment of objection that a carer may be prone to making, such as a determination that there has not been a *proper* objection in law, due to the mental state of the objector.

61. GJ, above n 21.

62. *We do not mean palliative in the sense of treatment for an illness causing death, but merely in the sense of treatment for an illness from which significant recovery is unlikely.*

63. Department of Health Code of Practice: Mental Health Act 1983 (2008) (MHA Code of Practice), para 4.19.

64. *Ibid.*

65. Mental Capacity Act 2005, Schedule 1A, para 5(6).

66. MHA Code of Practice, above n 63, para 4.19.

67. *Ibid*, para 4.20.

68. *Ibid.*

69. *Ibid*, para 4.21.

Capacity to object is irrelevant. A reasonable observer must be able to recognise the behaviour constituting an objection, without reflecting on the capacity of a person to object, or any deficit in the mental processes of an objector as a result of mental disorder.

It is clear too that an effective objection need not be a verbal one. In determining whether a person has objected, eligibility assessors are required to take into account the person's *behaviour*, as well as their wishes, feelings, views, beliefs and values. These latter views will normally require communication through language, either verbally or otherwise, but the concept of behaviour clearly encompasses all the responses of a person to their deprivation of liberty, including physical responses. The DOLS Code of Practice is effectively making the same point when it says that the necessity for physical restraint may indicate that an objection is occurring.⁷⁰

An assessor should look at the totality of the person's behaviour to determine whether objection has cumulatively occurred, rather than considering whether each of a series of isolated incidents is sufficient. A parallel can be drawn with the cumulative effect principle applied by the ECtHR to determine whether a deprivation of liberty has occurred, which takes into account all the elements of a person's living conditions.⁷¹ The cumulative approach in this case would take into account the duration, persistence and character of the behaviour.

This approach provides a helpful framework for assessment, but there must still be some threshold for objection generally agreed upon for consistency to be achieved. Situations of objection are limited only by the variety of human behaviour, so no bright line may exist. But by illustrating difficult cases, where assessors may struggle to determine whether an objection has occurred in light of the practical and legal consequences of the choice between regimes, we hope to make this boundary clearer.

Borderline cases of objection

An objection may be difficult to discern, but a DOLS assessor should have no trouble recognising a clear and persistent verbal objection. In *Re DE*,⁷² for example, the man made his desire to leave "perfectly clear"⁷³ by repeated objections to the deprivation of his liberty. Over a seven-day period in November 2005, DE's objections were recorded by care home staff five times, and included statements such as "You are holding me against my civil rights, all I want to do is be with my wife"; in conversation with his advocate, "come and get me, I want out of here"; and in conversation with his wife, "I'm coming home ... I am bloody coming home".⁷⁴

However, some scenarios are not so clear-cut. People whose resolve fluctuates, between plain objection to a deprivation of liberty at some times and ambivalence or acceptance at others, are not so clearly classed as objectors. Less still are those without faculties of speech or movement. An inability to communicate feelings verbally, combined with an inability to make controlled movements indicative of a desire or attempt to leave a place, would make objection very difficult. Some individuals may be so profoundly disabled that there is no feasible way for them to object to a deprivation of liberty.

As these scenarios show, the inquiry requires us to consider the practical realities of objection. A broad

70. Ministry of Justice *Deprivation of Liberty Safeguards Code of Practice* (2008), para 2.13.

71. *Guzzardi v Italy* (1980) 3 EHRR 333, [95].

72. *Re DE; JE v Surrey County Council* [2006] EWHC 3459, [2007] 1 MHLR 39.

73. *Ibid*, [112].

74. *Ibid*, [90].

interpretation of the concept may result in a considerable increase in the number of detained patients under the MHA, necessitating greater spending on psychiatric hospitals, assessment and administrative personnel, and on the Tribunal. An overly strict approach to objection, however, might see clinicians increasingly opt for DOLS authorisations over the MHA, which may result in a lower standard of patient protection and less specificity of powers than is available under the more specialised MHA regime.

The problem of “fluctuating” objection

A variable mental state due to mental disorder may lead to a fluctuating state of objection, with a person expressing a strong objection to treatment or deprivation of liberty at one time, and ambivalence or acceptance at another. Contradictory statements or behaviour from day to day, or even over shorter periods, may evidence such fluctuation. A variable mental state may be due to the natural course of the person’s mental disorder, or could develop through ineffective treatment or non-compliance with treatment, or simply through change of attitude towards their position.

Approaches taken to the problem of fluctuating capacity provide a possible parallel. DOLS patients will normally lack the capacity to make decisions relating to their care, but may enjoy periods where that capacity is present. Use of the MCA where consent to treatment is likely to be refused when the person regains capacity is not advised.⁷⁵

The DOLS Code of Practice gives some guidance on how to deal with such a problem, suggesting a balance must be struck between the need to terminate a DOLS authorisation where a person has capacity, and the time and resources spent where a DOLS authorisation is regularly reviewed, terminated and re-applied for due to fluctuating capacity.⁷⁶ The test for capacity recommended by the Code to preserve this balance is “consistent evidence of the regaining of capacity on a longer-term basis.”⁷⁷

The test for objection should be somewhat similar, but while consistency of conduct is important in determining whether an objection has occurred, testing whether that conduct has continued “on a longer-term basis” would not sit well with the underlying presumptions of the eligibility requirement. Capacity to object is assumed. It is the conduct, not the mental state of the objector, which is assessed. Where sufficient, that conduct is presumed to constitute a competent objection. The time period for an effective objection, then, need only be long enough to show that the person’s objection to deprivation of liberty is settled and unlikely to change in the short term. Consistency of objecting conduct over several days should, in most cases, be of a sufficient duration cumulatively to constitute an objection in law, even where a person has demonstrated a changeable resolve.

This test fits well with cases where a person is already deprived of liberty, but what of the case where a DOLS authorisation is applied for in advance? It may be difficult for an assessor to gather data indicating a consistent objection over a sufficient time course where a patient is not already resident in hospital. The information of family, friends or carers is not necessarily reliable. Objecting conduct or compliance during past admissions may be relevant, but the assessor is permitted to take into account past behaviour of a proposed patient “only so far as it is still appropriate to have regard to [it].”⁷⁸

Given the difficulties in gathering information that would indicate such an objection, it would seem

75. *MHA Code of Practice*, above n 63, para 4.21.

76. *Above* n 71, para 8.22.

77. *Ibid*, para 8.23.

78. *Mental Capacity Act 2005, Schedule 1A*, para 5(7).

prudent that a proposed patient should be taken to object wherever an assessor knows of evidence that they are objecting at the time of assessment or prior to it. If this is inconsistent with that person's compliant behaviour during a prior period of assessment or treatment, then that prior behaviour should be disregarded as per para 5(7) of the eligibility test.⁷⁹ Such an approach, while rather cautious and likely to lead to use of the MHA regime, better protects a proposed patient's rights when they are initially deprived of liberty through use of a more robust regime. It may also be the most economical approach, despite the concerns of the Bournemouth interveners:⁸⁰ incorrect use of the DOLS regime may later necessitate an admission under the MHA, unnecessarily complicating the administrative process by invoking both regimes in succession.

Advance decisions

It is clear that an advance decision to refuse treatment⁸¹ made with capacity will preclude treatment under the MCA so long as the advance decision remains valid at the time the necessity for treatment arises.⁸² Other than in respect of ECT in non-emergency situations,⁸³ an advance decision will not prevent compulsory treatment under the MHA regime.⁸⁴ This is, in effect, another distinction between the two regimes for mental health treatment.

Influence or free-will?

Another difficult case arises where a person who would not normally object to a deprivation of liberty shows a great attachment to, or dependence on, a family member or carer, and so may be influenced by them to attempt to leave the facility connected to their DOLS authorisation, or to vocalise a previously unheard objection. Such behaviours would normally be sufficient to constitute an objection in law so long as the person does not have a history of fluctuating between objecting behaviour and acceptance of their deprivation of liberty, as discussed above. Where the behaviour only arises briefly after a family visitation or other forms of influence, though, can it really be said to be an objection? And what if a previously contented person begins to persistently object to their deprivation of liberty over a longer period of time, following a meeting with his or her immediate family?

One solution to these problems has been to prevent influence over a person by stopping visitation by influential people. The care facilities in both *Bournemouth*⁸⁵ and *DE*⁸⁶ took this step, but this is an unattractive approach to the problem. Preventing a person from having contact with their family, friends and carers, simply to avoid the implementation of a more complex legal regime for their compulsory care, would not be a sufficient reason to limit the person's right to respect for private and family life contained in art 8(1) of the ECHR. Limiting visitation under the MHA to prevent "incitement to abscond"⁸⁷ is justifiable, as the MHA provides a stringent legislative process under which compulsory treatment is permitted for legitimate ends, to which the patient's objection to deprivation of liberty is not relevant. But prevention of objection (and the need to invoke the MHA regime) by an informal method, where a person is subject to the DOLS regime, is not a legitimate limitation under art 8(2) ECHR. Assuming that

79. *Ibid.*

80. *Above n 4*, 481-2.

81. *Mental Capacity Act 2005*, ss 24-26.

82. *Mental Capacity Act 2005*, Schedule A1, para 19.

83. *Mental Health Act 1983*, s. 58A (2), (5)(c).

84. Fennell, Philip "Mental Capacity" in Gostin, Lawrence et al. (eds) *Principles of Mental Health Law and Policy* (Oxford University Press, Oxford, 2010), para 4.86.

85. *Above n 4*.

86. *Above n 73*.

87. *MHA Code of Practice*, above n 63, para 19.13.

visitation will occur, then, we should determine what constitutes an objection from an impressionable or dependent patient.

A good approach may be to assess whether the patient's behaviour is sufficient to cumulatively indicate a settled objection, as we have done with the problem of fluctuating objection. Applying this test to the case of brief objecting behaviour following each family visit, it is unlikely that an objection in law will be found. Such short-term complaints may in fact represent a longing for family, carers or close friends, rather than an objection to treatment or to being a mental health patient. Wishing that one could live with family is not equivalent to objecting to a deprivation of liberty; a person subject to a DOLS authorisation may be resigned to its necessity, while strongly desiring that the situation could be different. Persistent objecting behaviour, on the other hand, must be treated as objection in law, even if it only arises following the influence of a family member.

Carers may seek to curtail more than just influential visitors to prevent objection. Locking doors to prevent a person from leaving, or the persistent use of restraint, may prevent behaviour indicative of an objection, but the person may still be objecting nevertheless. A person may be unmanageable without such measures being taken, but the need for the carer's behaviour may be indicative of an objection in law.

Delusional reasons for being in hospital

A further difficult scenario may arise wherein a patient has delusional reasons for staying in hospital – solely to escape their persecutors, for instance. The patient may make it quite clear that the only reason they agree to stay in the hospital is their physical safety, not their need for treatment. Should that be treated as implicit objection? Perhaps not, if they have not actually expressed the desire to leave. The matter should clarify itself, in any case, when they are asked to take medication. At that point, should they refuse to take it, as required, they could be considered to object to their mental health treatment, requiring activation of the MHA.

Inability to object and objection by proxy

Critically incapacitated patients deprived of liberty for mental health treatment under the MCA may be unable to express their wishes or feelings, or their views, beliefs and values, or to express their views meaningfully in their behaviour. This could prevent an eligibility assessor from determining whether or not they object. This raises the problem of objection by proxy, if some other person concerned for the patient nevertheless believes they can perceive signs of objection from the patient that others cannot read.

First, the matter might be taken up by any donee or deputy of the patient, who might both seek to withdraw any consent they had previously given to the person's treatment as a mental health patient, and argue – simultaneously – that the patient is now to be understood as objecting to that treatment – an argument that, if accepted in total, would render the patient ineligible for further treatment under the DOLS regime.⁸⁸ But whether the patient is *really* to be taken as objecting in such cases – in the necessary *legal* sense – could still be an open question, and the regime confers no express authority on a donee or deputy to make that decision, or to object definitively for the patient by proxy.

88. *Mental Capacity Act 2005, Schedule 1A, para 5(4) and (5).*

Nevertheless, it might seem a reasonable proposition that other people whose concern for the patient is formally recognised by law should be able to object on behalf of a person without the ability to do so: that is, an objection might be made by a donee, a deputy, a relevant person's representative (RPR), an independent mental capacity advocate (IMCA), a guardian or an immediate family member who would be designated the NR under the MHA – even if these possibilities are not expressly provided by the MCA.

An IMCA, for instance, might be particularly apt for this role, as they are required to ascertain the wishes, feelings, beliefs and values of the patient⁸⁹ with regard to care decisions, and these are the same elements to be considered when assessing eligibility.⁹⁰ Moreover, the RPR is specifically designated as the person's representative for certain purposes. However, even permitting those performing such recognised roles to object definitively on behalf of the patient would seem to run against the larger scheme of the MCA, which already includes a clear review structure.

An RPR can apply for compulsory review of a DOLS authorisation by the supervisory body that issued it,⁹¹ and can apply to the Court of Protection for a ruling on the validity of a DOLS authorisation (under s 21A MCA), and does not require the permission of the Court to proceed.⁹² These powers allow the RPR to have a DOLS authorisation reviewed by the issuing authority or an independent judicial body. It would not make sense to permit an RPR to stand in the shoes of a patient to make an objection as well, as that would clearly end the authorisation and undercut the established processes of review or judicial oversight.

An IMCA has the same right to challenge a care decision as a person interested in a patient's welfare or engaged in their care.⁹³ But this confers no formal power. Presumably, it means the IMCA can assist or represent the RPR or an interested party (such as a family member or close friend) in their communication with the supervising authority or an application to the Court of Protection. But there is no automatic right to apply to the supervising authority or Court for review, as no formal role is contemplated for family or friends of a patient besides that of the patient's RPR. An interested person can make an application to the Court of Protection, but permission to proceed will depend on the person's connection to the detained patient, the reasons for the application, the benefit to the patient, and whether the benefit can be achieved in any other way.⁹⁴

Given this review process, which centres on the RPR's powers to apply for automatic review, it would be unusual to permit the RPR, IMCA or any other person to definitively object as well and so undercut the RPR's established statutory role. However, the RPR and IMCA are clearly contemplated as having some degree of input on the matter of objection. The RPR's role is to "represent the relevant person in matters relating to, or connected with, the deprivation of liberty"⁹⁵ generally. The IMCA's role is even more specific, as described above.

Where a person is unable to express an objection due to severe impairment, then, the RPR or IMCA will not have the power to object definitively. However, their statutory roles, and those of others in similar positions, suggest that any conclusion they might reach about the patient's views or wishes should be strongly persuasive in a determination of whether a DOLS authorisation should be granted.

89. *Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006* (SI 2006/1832), reg 6(5) (b).

90. *Mental Capacity Act 2005, Schedule 1A, para 5.*

91. *Mental Capacity Act 2005, Schedule A1, para 102.*

92. *Mental Capacity Act 2005, s 50(1A); The Court of Protection Rules 2007, r 51(2A).*

93. *SI 2006/1832, reg 7(2).*

94. *Mental Capacity Act 2005, s 50(3).*

95. *SI 2008/1315, reg 12(1)(a)(ii).*

MHA primacy as an underlying principle

The case of GJ⁹⁶ touches on an important principle, which we have reflected throughout the examples discussed above. The DOLS regime was not intended to diminish the use or importance of the MHA, but to increase the protection afforded to incapacitated persons who would not previously have been treated under the existing legislation, but under common law justifications. The MHA has a position of primacy over the MCA, as the Court of Protection has made clear, and where there is a choice between the two regimes (as there may be where an incapacitated patient meets the civil commitment criteria), decision-makers should “take all practical steps to ensure that that primacy is recognised and given effect to.”⁹⁷ This is particularly relevant “in areas of doubt”.⁹⁸ This leads easily to a general rule that eligibility assessors should follow where there is uncertainty as to whether an objection has occurred: *when in doubt as to whether an objection has occurred, use the MHA regime.*⁹⁹ This is quite different from saying that one should always use the MHA regime when its elements are satisfied, because then all other people who fall “within the scope of” the MHA,¹⁰⁰ and are deprived of liberty, but are clearly not objecting, would have to be brought under the MHA as well, even though that is not the intention of the statutory scheme.

The MHA and DOLS regimes exist to provide procedural protections for mental health patients. In light of the non-consensual nature of the mental health treatment, there may be considerable value for patients in the safeguards provided, so their treatment may be properly tested, and endorsed or rejected, according to a rigorous process. Patients will have differing requirements, depending on the nature of their mental disorder. Approaching the choice between regimes with the primacy of the MHA in mind ensures that patients who will most benefit from its procedural protections are not deprived of liberty under lesser safeguards. Likewise, a generous approach to objection where doubt exists will result in a more comprehensive and specialised legal approach to the mental health treatment of the objecting person.

The principle of primacy accorded to the MHA therefore gives the DOLS regime a secondary role, primarily focused on the long-term treatment of patients with enduring mental disorders who lack capacity but clearly do not object to their hospital-based mental health care.

96. Above n 21.

97. *Ibid.*, [65].

98. *Ibid.*

99. This principle is also reflected in the MHA Code of Practice, above n 63, para 4.19.

100. Mental Capacity Act 2005, Schedule 1A, para 2, Case E.