

# **The Impact on AMHP Practice and Service Delivery by The Supreme Court Judgment on Deprivation of Liberty: P v Cheshire West and P & Q v Surrey County Council**

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## **Foreword**

***Lyn Romeo, Chief Social Worker (adults) in England & Dr Ruth Allen, Chair of the Mental Health Faculty, The College of Social Work***

The vital role that social workers play in undertaking Approved Mental Health Professional responsibilities and Best Interest assessments under the Mental Health Act and Mental Capacity Act mean that more than ever, social workers must be practicing at the highest standard to ensure that the people they serve have their human rights protected, balanced with care and safety for themselves and others. We work alongside people and their carers to ensure they have every opportunity to live their lives in ways which achieve the outcomes they want for themselves.

This report helpfully highlights the impact that the Supreme Court judgement has had on these key areas of work and recommends action to be taken to ensure that the right conditions for best practice can flourish while ensuring that legal requirements are met.

**Lyn Romeo, Chief Social Worker (adults) in England.**

Social workers and other professionals acting as Approved Mental Health Professionals (AMHPs) and Best Interest Assessors take life-changing decisions every day, protecting the rights of people with mental health problems and ensuring they can access the care and support they need. They work at the intersection of complex law and complex needs. It is work that is sometimes under-appreciated and under-acknowledged within the mental health sector, but the daily decisions made in these circumstances are the backbone of our response to citizens in mental health crisis or acute need.

This paper from the AMHP community of interest within the College of Social Work provides a detailed overview of the challenges and opportunities to protect people's rights using the intersecting legal frameworks of the Mental Health Act 1983 (as amended 2007) (the MHA), the Mental Capacity Act 2005 , Deprivation of Liberty Safeguards 2007 and the new MHA Code of Practice. Many AMHPs and other professionals involved in crisis and acute care will find helpful this review and its recommendations as we work together to make complex areas of law work well for people using services and their families.

**Dr Ruth Allen, Chair of the Mental Health Faculty - The College of Social Work**

**Author**

Emad Lilo is the Vice Chair of The College of Social Work AMHP Community and a board director of the Approved Mental Health Professionals Association (AMHPA). He works at Mersey Care NHS Trust where he provides AMHP practice leadership across the Trust and partner local authorities. He keeps himself well informed of contemporary front line staff issues and challenges by maintaining regular AMHP and BIA practice.

He has 25 years experience in health and social care sectors and has undertaken varied levels of responsibilities as a practitioner, manager, trainer and researcher in both mental health and safeguarding children.

Reform of mental health legislations led to his involvement in the regional and national debates, consultation and practice development such as taking a leading role on the BME Champion project. This was commissioned by Department of Health to assess the impact of the 2007 MHA on BME communities in relation to access to mental health services and Community Treatment Order.

Addressing inequalities to service access by disadvantaged groups including the promotion of service users and carers' involvement and participation in the development of safe, recovery focused and responsive mental health services is at the heart of Emad's day to day practice - He has written and published in collaboration with service users/carers "Service User Guide to The Mental Health & Mental Capacity Acts".

Emad is an honorary lecturer at Liverpool JMU, a visiting lecturer at a number of universities and provides training for hospitals and local authorities where he focuses on MCA, MHA, human rights, social justice and safeguarding. Currently Emad is leading a project funded by the NHS Health education North West, looking at models and good practice examples of integration in mental health.

## **Acknowledgement**

This piece of valuable work required a considerable amount of work, research and dedication. Still, implementation would not have been possible if I did not have the support of many individuals and organisations.

First of all I am thankful to the College of Social Work for its support and commitment for this practitioner led research and workforce development.

It is imperative to convey my sincere gratitude to my colleagues and members of the AMHP Leads Network and the Approved Mental Health Professionals Association (AMHPA) representing AMHP services across England and Wales. Without their active engagement and participation, this work would not have been as thorough and detailed, and thus their support in sharing relevant information has been essential.

I am very grateful to Neil Allen, Barrister Court of Protection and Lecturer at Manchester University. I am extremely thankful and indebted to him for sharing his expertise, his sincere and valuable guidance and encouragement extended to me. Likewise to other leading experts in the mental health, human rights and social justice field, Peter Edwards, Rebecca Fitzpatrick and David Hewitt.

Finally very special thanks to my employer Mersey Care NHS Trust for giving me the facility and time to undertake this valuable work, and my colleagues across the Trust and partner local authorities Liverpool, Sefton and Knowsley.

***This report does not constitute legal advice, which must be sought - if necessary - on the facts of any specific individual case. While care has been taken to ensure it is accurate, up to date and useful, no legal liability will be accepted in relation to it.***

## Glossary

**MHA or Act:** Either used interchangeably meaning the Mental Health Act 1983.

**MHA CoP:** Mental Health Act Code of Practice 2015. Often referred to as revised Code of Practice ('the Code') has been prepared in accordance with section 118 of the Mental Health Act 1983 ('the Act') by the Secretary of State for Health after consulting such bodies as appeared to him to be concerned, and laid before Parliament. The Code came into force on 1 April 2015.

**MCA:** Mental Capacity Act 2005.

**Patient:** The MHA Code of Practice refers throughout to "patients" when it means people who are, or appear to be, suffering from a mental disorder. This use of the term is not a recommendation that the term "patient" should be used in practice in preference to other terms such as "service users", "clients" or similar. It is simply a reflection of the terminology used in the MHA itself.

**Deprivation of Liberty Safeguards (DoLS):** The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.

**Deprivation of Liberty (DoL):** Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is defined through case law.

**AMHP:** A social worker or other professional approved by a local social services authority to act on behalf of a local social services authority in carrying out a variety of functions. The AMHP is warranted, or authorised, to make certain legal decisions and applications under the MHA 1983. Usually this professional will be a social worker who has undertaken additional training to become warranted and the 2007 MHA amended the law to allow other mental health professionals to undertake this role. So it is now possible to see psychiatric nurses, occupational therapists or psychologists become AMHPS. The majority are social workers.

**BIA:** Best Interests Assessor (BIA) for Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS). The role of the BIA is contained in paragraphs 4.58 to 4.76 of the MCA DoLS Code. The BIA needs to decide whether DoL, is occurring, or likely to occur, and, if so, whether the DoL is in the best interests of the person being assessed. The BIA acts on behalf of the Supervisory body.

**Supervisory Body:** The local authority will be the Supervisory Body for people resident in all registered care homes and hospital and the ordinary residence guidelines will be used to determine which local authority has responsibility in a particular situation.

**Managing Authority:** The MCA DoLS Code of Practice defines a Managing Authority as the person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty.

## **Executive Summary**

The Supreme Court judgment (P v Cheshire West and Chester Council and P and Q v Surrey County Council [2014] UKSC 19) has presented new challenges and put enormous pressures on local authorities with the statutory responsibility for providing both Approved Mental Health Professional (AMHP) and Best Interests Assessor (BIA) statutory services. Nonetheless, there is evidence of a tremendous and exceptionally positive response by local authorities and other providers across health and social care in working collaboratively in training, briefings, awareness raising and development of policies and protocols.

The focus of this report is on the MHA and its interface with the MCA, Deprivation of Liberty and the implications of the Supreme Court judgment. The latter has made it clearer and easier for providers and decision makers to identify where a person is being deprived of their liberty.

The 19<sup>th</sup> March 2014, Supreme Court judgment in two cases: P v Cheshire West and Chester Council and P & Q v Surrey County Council, commonly known as “Cheshire West”, has led to a considerable increase in the numbers of people in England and Wales who are considered to be deprived of their liberty for the purposes of receiving care and treatment.

This survey has been undertaken to establish and provide reflection on the impact on AMHP practice and service delivery by the Supreme Court judgment.

It is important to note, whilst we recognise that Deprivation of Liberty occurs in different settings (i.e. hospital, care home, supported living, and even at home), the focus in this report is primarily on the assessment, care and treatment of service users considered for admission to, or already in, an acute psychiatric setting with good practice guidance offered for promoting and safeguarding their rights and recovery.

AMHPs with the responsibility for organising, co-ordinating and contributing to Mental Health Act assessments have been keen to engage with, adapt and gradually welcome and fully embrace the cultural transformation brought about by the judgment.

**The threshold for engaging Article 5 / Deprivation of Liberty was clarified by the judgment ....**

Lady Hale provided the “**Acid Test**” to determine a Deprivation of Liberty (DoL):

- 1) The Person is **not “free to leave”**.

And

- 2) The person is subject to **continuous supervision and control**.

Professionals should “**err on the side of caution**” when determining whether a DoL is occurring.

**The existence of a deprivation of liberty is not dependent on:**

- Whether or not they are complying with the requirement to live in their place of care and or treatment and or support
- Whether or not they are able physically and or cognitively able to undertake the actions necessary to leave their place of care and or treatment and or support
- Whether or not there is total consensus on the person’s place of care or treatment and or support.
- Whether or not they have supported access to universal services and other services such as day services

- Whether or not that support, to access universal services, is required for their own safety
- Whether or not they have unrestricted access to family and other significant others

The judgment is significant as it outlines the test that must be used in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty. It also extends the settings where this could apply. DoLS can be used in a psychiatric and general hospital setting as well as in care homes (where approximately 80% of DoLS authorisations arise) and AMHPs must be able to identify the appropriate legislation to apply.

If a decision maker decides that a person is deprived of their liberty, this can now be authorised by the following 3 routes:

- 1- Detention under the Mental Health Act 1983 (MHA);
- 2- Obtaining authorisation under DoLS;
- 3- (Exceptionally) Obtaining an order from the Court of Protection or inherent jurisdiction of the High Court.

This report identifies a number of contemporaneous issues impacting decision makers (i.e. AMHPs, BIAs, doctors etc.) and service providers:

- Implementation of Cheshire West Judgment – the interface between MHA, DoLS and MCA
- MHA and DoLS - Patients falling between the two legal frameworks;
- Least restrictive principle – application, ethics and whether one legal framework (i.e. DoLS or MHA) promotes it more.
- Objection – definition, manifestation and determining which legal framework to use;

- Misunderstandings across agencies and between professionals in applying the judgment and related legislation (i.e. MCA (with or without DoLS), MHA etc.), resulting in conflict and disputes including delays in decision making.

There will be very few, if any, service users who lack capacity and are in-patients in a psychiatric setting who can be cared for as informal patients. This is due to the nature of care and treatment arrangements within in-patient psychiatric care where arguably the vast majority of patients are deprived of their liberty based on the new Acid Test. It should also be noted that the Care Quality Commission (CQC) which inspects mental health services and monitors the use of the MHA, in its latest 2013/14 report on Monitoring the Mental Health Act, has expressed the view that any incapacitated patient who requires psychiatric admission is likely to satisfy the “Acid Test” for deprivation of liberty.

Decision makers, including AMHPs, must therefore consider the use of either DoLS or MHA. Having said that, applying the least restrictive options should be considered such as the provisions within the MCA in the assessment, care and/or treatment of patients in a psychiatric setting.

This paper identifies a continuing concern surrounding inconsistencies in applying and understanding the MCA. It is imperative that we should not let DoLS and the Supreme Court judgment overshadow and undermine good practice guidance underpinned by the MCA and its empowering principles for the most vulnerable people in our care. The DoLS are part of the MCA and as such rooted in the MCA’s five statutory principles, and the new MHA CoP (2015) provides further guidance to ensure compliance and in embedding it in our practice.

This report will examine the above issues and provide a framework for discussion, guidance and recommendations.

## Recommendations

- 1) AMHPs must be familiar with the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) and must familiarise themselves with the key points from the Cheshire West judgment.
- 2) All service users who may lack capacity to consent to their care/living arrangements/admission to hospital should be assessed. If, on assessment, they do lack capacity it should be considered whether or not they are being deprived of their liberty.
- 3) Further guidance is required to clarify the legal framework governing the admission of incapacitated, non-objecting, compliant patient to psychiatric inpatient care and the use of MCA sections 5 & 6.
- 4) Local authorities should consider increasing AMHP workforce capacity. This is to respond to changing demands, enable access to timely MHA assessments and best practice set out by the MHA guidance and CQC standards.
- 5) To minimise and/or eliminate disputes and conflicts between decision makers and unlawful deprivation or inappropriate use of legislation, supervisory bodies and managing authorities should consider developing joint training and a shared approach in implementing the Cheshire West Judgment and the Acid Test on deprivation of liberty.
- 6) Providers should have policies in place to deal with circumstances where disagreement results in an inability to take a decision as to whether the MHA or DoLs should be used to give legal authorisation to a deprivation of liberty. It is advisable that these policies underpin the working, and facilitate collaboration and cooperation between local supervisory and managing authorities.
- 7) Providers should consider developing and/or updating their existing admission policy to support decision makers in making lawful admission decision informed by case law, guidance and the MCA and its associated principles.
- 8) Hospitals, local authorities and care homes must work together locally to raise awareness and improve understanding of the MCA more widely and embed it in the health and social care culture.

- 9) It is important that decision makers (i.e. AMHPs, BIAs, doctors etc.) have training on the Revised MHA Code of Practice. These professionals should have detailed knowledge of the Code, including its purpose, function and scope. They should be able to identify the legal framework that governs a person's assessment and treatment and authorise any appropriate deprivation of liberty whether under MCA or MHA.

## **1. Introduction**

This is the report of a survey whose purpose is to establish and provide reflection on the impact on AMHP practice and service delivery by the 19<sup>th</sup> March 2014, Supreme Court judgment in two cases: P v Cheshire West and Chester Council and P & Q v Surrey County Council. That judgment, commonly known as “Cheshire West”, has led to a considerable increase in the numbers of people in England and Wales who are considered to be deprived of their liberty for the purposes of receiving care and treatment. The Supreme Court decided that when an individual lacking capacity is under continuous or complete supervision and control and is not free to leave, they are being deprived of their liberty. This is now commonly called the “Acid Test.”

AMHP service providers were invited to report on the following:

- 1) Experience of the impact on AMHP practice and the use of the Mental Health Act since the Supreme Court Judgment;**
- 2) The use of DoLS or MHA or MCA for admitting incapacitated patients to a mental health unit;**
- 3) The use of DoLS or MHA or MCA for the provision of care/treatment to incapacitated patients already in a mental health unit;**
- 4) What training/guidance is or should be made available to improve practice including effective and lawful implementation of the judgment;**

It is hoped the findings will support AMHP service providers to better resource, support and prepare their AMHP workforce to facilitate safe, sound and robust AMHP practice. This is a complex and challenging area of practice, which is at the interface of two legal frameworks. This involves the statutory provisions centred on the Mental Capacity Act 2005 (MCA) (with or without the use of Deprivation of Liberty Safeguards (DoLS)) and Mental Health Act 1983 (MHA). An additional aim is the sharing of good practice examples such as training, guidance and shared protocols across health and social care including AMHP and Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) Best Interests Assessor services.

This survey received positive responses from AMHP services representing 24 local authorities who all freely expressed their views while participating in this study. Therefore this report provides a credible account of the impact of the judgment across the AMHP workforce nationally. It examines the impact of the Supreme Court judgment and provides guidance and good practice examples on the interface between MCA v MHA with recommendations to providers on the implementation of the MCA and future development of the AMHP workforce.

The survey also engaged and incorporated the views of experts in the field. Their contributions offer invaluable clarification on specific guidance and law throughout this report. They are:

**Neil Allen** – Barrister practising at 39 Essex Chambers and a lecturer specialising in mental health and capacity law at Manchester University.

**Peter Edwards** - Director of Peter Edwards Law and the Head of Civil Litigation and Private Client department. He is former President of the Mental Health Lawyers Association.

**Richard Jones** - Honorary Professor of Law at Cardiff Law School. He is the author of Mental Capacity Act and Mental Health Act Manuals.

**Rebecca Fitzpatrick** - Mental Health and Social Care Team Lead, Hill Dickinson Solicitors.

**Niall Fry** – Mental Capacity Act & Deprivation of Liberty Safeguards Lead, Department of Health.

The purpose of this survey report is neither to define Deprivation of Liberty nor to decide which legal framework to use once deprivation is identified. It does, however, provide helpful pointers informed by the MHA Code of Practice (2015), case law, and most up to date guidance issued by providers and the Department of Health.

It is important to note, whilst we recognise that Deprivation of Liberty occurs in different settings (i.e. hospital, care home, supported living, and even at home), the focus in this report is primarily on the assessment, care and treatment of service users considered for admission to, or already in, an acute psychiatric setting with good practice guidance offered for promoting and safeguarding their rights and recovery.

Besides, it is outside the remit of this review to consider the issues of children under 16 years of age, and 16 and 17 year olds. The former are covered by the MHA, parental responsibility and 'Gillick competence'. The latter are of course covered by MHA, MCA but not DoLS and can also be subject to parental responsibility considerations. Both are also, come under the provisions and protection of the Children Acts 1989 and 2004 including the Human Rights Act (HRA) 1998. We do acknowledge children and young people are amongst certain groups of service users that require additional consideration in addition to the general guidance. Therefore to complement this report and for in-depth and up-to-date good practice guidance on the assessment, care and/or treatment arrangements for children and young people we recommend the following:

- Chapter 19 revised MHA CoP (2015): Children and young people under the age of 18.
- Chapter 9 Law Society publication (2015) – Under 18s: Identifying a deprivation of liberty: a practical guide. The guidance was commissioned by the Department of Health and aims to help solicitors and frontline health and social care professionals identify when a deprivation of liberty may be occurring in a number of health and care settings.

The revised MHA CoP has the following Chapters with additional considerations for specific patients:

**Chapter 20: People with learning disabilities or autistic spectrum disorders**

**Chapter 21: People with personality disorders**

**Chapter 22: Patients concerned with criminal proceedings**

## 2. Legal Context

### What is deprivation of liberty?

There is no definition in statute of what constitutes a deprivation of liberty. There is guidance in case law both from England and Wales and the European Court of Human Rights.

### Deprivation of Liberty under Article 5 of European Convention on Human Rights?

- Depends on the particular circumstances of the case.
- “....the starting point must be the specific situation of the individual concerned and account must be taken of the whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question” (para 89, Bournemouth judgment , i.e. H.L. v UK)

### What about restraint?

- “The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance” (para 89, Bournemouth judgment)

The Code of Practice for the Deprivation of Liberty Safeguards (DoLS) sets out a number of factors (alone or in combination) which may indicate that a person is being deprived of their liberty. However it is clear in all the cases that the individual circumstances of that person should be assessed.

### Deprivation of Liberty – Relevant Factors

- Use of restraint, including sedation, particularly when used to secure admission.
- Staff have complete control over care and movement of a person for significant period.
- Staff control treatment and visitors/residence.
- A decision by the care home or hospital that the person would not be allowed to leave – “De facto” detention.

- Refusal of carer's request to discharge patient.
- Unable to maintain social contact.
- Loss of autonomy due to continuous supervision and control.

(Para 2.5 of the DoLS Code of Practice)

The Supreme Court provided further clarification on the 19<sup>th</sup> March 2014, when it handed down its judgment relating to P v Cheshire West and Chester Council and another; P and Q (MIG and MEG) v Surrey County Council [2014] UKSC 19

A deprivation of liberty occurs when:

1. The person is under continuous supervision and control; and
2. Is not free to leave; and
3. The person lacks capacity to consent to these arrangements.

This is referred to as the **Acid Test**. Lady Hale, who provided the Leading Judgment, was clear that disabled people have the same human rights as everyone else. Therefore, what is a deprivation of liberty for a person *without a disability is a deprivation of liberty for a person with a disability*. Stating, “*A gilded cage is still a cage.*”

The judgment further clarified the following factors are **not relevant to** whether there is a deprivation of liberty:

- A mentally disabled person's surroundings are 'relatively' normal;
- He or she does not object to the placement; or
- The arrangements are an appropriate means of achieving the best outcome for the person;

The above factors may justify a deprivation of liberty - but they do not determine whether there has been a deprivation in the first place.

Lady Hale went on further to clarify the position of whether a person is deprived of liberty by stating: “Because of the extreme vulnerability of people like P, MIG and MEG, I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty in their case”

This arguably makes the threshold for DoL low, and should minimise or even eradicate confusion or disputes between decision makers as to whether a person is or likely to be deprived of their liberty (e.g. psychiatrists, AMHPs etc.).

If decision maker/s decides that a person is deprived of their liberty, this can be authorised, by the following 3 routes:

- 1- Detention under the Mental Health Act 1983 (MHA);
- 2- Obtaining authorisation under DoLS;
- 3- (Unusually) Obtaining an order from the Court of Protection.

The above are the available legal authorities for their detention, in accordance with procedures prescribed by law. Which authority is the most appropriate will depend upon the individual circumstances of the service user and the setting in which they being cared for.

It is essential to be aware of a letter from Niall Fry Mental Capacity Act & Deprivation of Liberty Safeguards Lead of the Department of Health to MCA DOLS leads addressing, amongst other things, palliative care and unconsciousness (January 2015). It conveys the Department of Health view on the application of the **Acid Test** in the palliative care setting, together with confirmation that the department does not consider that 'unconsciousness' would satisfy the mental health requirement for an application under Schedule A1 to the MCA 2005. It has the following 2 areas of guidance/advice:

**1- The Department practice advice on the applicability of the Cheshire West 'acid test' to palliative care:**

- Are they 'free to leave'? Just because they are physically unable to leave of their own accord does not mean they are not free to leave for the purpose of the test – they may for example be able to leave with family assistance;

- Are they under 'continuous control and supervision'? If the individual is in a private room and checked only every few hours then they may not necessarily be under continuous control and supervision.

## **2- Situations where the Department considers there is no deprivation of liberty:**

If a person receiving palliative care has the capacity to consent to the arrangements for their care, and does consent, then there is no deprivation of liberty;

Furthermore, if the person has capacity to consent to the arrangements for their care at the time of their admission or at a time before losing capacity, and does consent, the Department considers this consent to cover the period until death and that hence there is no deprivation of liberty (an exception would be if the person's care package was significantly changed in a manner that imposed significant extra restrictions);

Effectively the letter gives the view that there is no need to use a DoL power if someone has consented to the care plan in advance (e.g. in an advance statement of wishes) when they had capacity (e.g. palliative care/hospices) and that those patients who lose capacity and are unconscious do not have a mental disorder in the meaning of the legislation and so the DoLS framework is not available or appropriate. This is helpful but is only an opinion and is not yet tested in the Courts.

### **Immediate implications of the Cheshire West Judgment on AMHPs**

The judgment is significant as it outlines the test that must be used in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty. It also extends the settings where this could apply. DoLS

can be used in a psychiatric and general hospital setting as well as in care homes (where approximately 80% of DoLS authorisations arise) and AMHPs must be able to identify the appropriate legislation to apply.

***Recommendation: All AMHPs must be familiar with the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) and must familiarise themselves with the key points from the Cheshire West judgment and its implications for their decision making.***

AMHPs in collaboration with other decision makers such as psychiatrists must act to safeguard the rights of vulnerable people and they need to ensure that any deprivation of liberty of a person who lacks capacity to consent to admission is authorised in accordance with one of the above mentioned legal regimes.

There will now be a need to identify those who lack capacity to consent to admission and/or treatment.

***Recommendation: All service users who may lack capacity to consent to their care/living arrangements/admission to hospital should be assessed under MCA. If, on assessment, they do lack capacity it should be considered whether or not they are being deprived of their liberty or would be at risk of being so deprived if admitted informally to hospital.***

There will be very few, if any, service users who lack capacity and are in-patients in a Mental Health Trust who can be cared for as an informal patient relying upon section 131 of the Mental Health Act 1983 and Sections 5 and 6 of the Mental Capacity Act 2005. This is due to the nature of care and treatment arrangements within in-patient psychiatric care where arguably the vast majority of patients are deprived of their liberty based on the new Acid Test.

This view is endorsed by the Royal College of Psychiatrists guidance on the judgment, where it states,

*“An acute psychiatric ward by its nature involves a very significant level of supervision and control and in some settings there are blanket restrictions that apply to all patients whether detained or not.”* (Royal College of Psychiatrists, 2014 p.2).

It should also be noted that the Care Quality Commission (CQC), which inspects mental health services and monitors the use of the MHA, in its latest 2013/14 report on *‘Monitoring the Mental Health Act’*, has expressed the view that any incapacitated patient who requires psychiatric admission is likely to satisfy the “Acid Test” for deprivation of liberty.

Hence decision makers including AMHPs must consider the use of either DoLS or MHA. Having said that, consideration of the use of the least restrictive option should be considered such as MCA, and a full account of this will be provided in this report with recommendations to promote the application of the empowering spirit of the MCA principles.

### 3. Findings and Analysis

In order to examine and explore the impact of the judgment, the survey considered responses from 24 AMHP service providers across England and Wales with regard to the following four topics:

- 1) Experience of the impact on AMHP practice and the use of the Mental Health Act since the Supreme Court Judgment;
- 2) The use of DoLS or MHA or MCA for admitting incapacitated patients to a mental health unit;
- 3) The use of DoLS or MHA or MCA for the provision of care/treatment to incapacitated patients already in a mental health unit;
- 4) What training/guidance is or should be made available to improve practice including effective and lawful implementation of the judgment;

#### 3.1 Experience of the impact on AMHP practice and the use of the Mental Health Act since the Supreme Court Judgment

With the exception of one respondent the remaining 96% of participants reported an increase in the AMHP activities ranging from requests for MHA (AMHPs) and DoLS (BIAs) assessments to general queries and discussion of the judgment interpretation, application and implementation.

***Respondent, "We have seen an unprecedented increase in the number of MHA assessments being requested, and the number of patients being detained as a direct consequence of the CW ruling. We have a dedicated AMHP team who are responding constantly but also using community based AMHPs to meet demand."***

***Respondent, "The increased focus on deprivation of liberty and capacity to consent to admission and treatment has resulted in an increase in requests for MHA assessments coming from the inpatient units."***

***Respondent, " A significant increase in the amount of discussion and debate between AMHPs and psychiatrists on the relative appropriateness of the different legal regimes (particularly with respect to older people's acute psychiatric wards)."***

***Respondent, "The dedicated BIA team has been expanded by recruitment of extra BIAs and admin staff as this is the main point of contact for inquiries. Despite these increases the BIA service cannot adequately respond to the increase in contact and demand."***

***Respondent, "so far we have seen almost a doubling of formal assessments since the Cheshire West ruling. This has meant that our few AMHPs are extremely busy undertaking statutory work and that consequently they are not able to give the time they would otherwise have done to the people on their caseloads. We are looking at alternate ways of delivering the AMHP service as a result but we are only a small unitary authority and a full time AMHP team might not work here as there are days when we have no formal assessments and some where there are between 1 and 3. The two AMHPs who are also BIAs are really struggling..."***

Invariably, it is evident from a number of respondents that there has been a significant impact on AMHPs and service providers. The situation appears to be more challenging for certain local authorities where a large proportion of their Best Interests Assessors for DoLS are drawn from the AMHP service. The levels of activity have led to unprecedented pressure on already limited and stretched AMHP provision across the country. Notwithstanding this, there has been an impressive response by services working collaboratively and in

partnerships with stakeholders including mental health trusts, Higher Educational Institutions (HEIs) (providing BIA training) and legal experts.

***Recommendation: local authorities should consider increasing AMHP workforce capacity. This is to respond to changing demands, enable access to timely MHA assessments and best practice set out by the MHA guidance and CQC standards.***

Consistent with the guidance issued by Department of Health, local authorities have responded by reviewing their allocation of resources in light of the revised test given by the Supreme Court to ensure they meet their legal responsibilities. There has also been a substantial increase of BIA courses delivered primarily by HEIs to meet the demands. In addition some local authorities opted for the development of dedicated BIA teams with clear immediate benefits.

***Respondent, “we have a dedicated team of BIAs (who only do BIA work) who do most of the DoLS work ... These BIAs are not AMHPs. The AMHP service and the DoLS service have different practice managers who are both managed within the MH services by the same Operational manager.”*** As such the impact on the AMHP service capacity is managed more effectively as the functions of AMHPs and BIAs are relatively separated. Overall there has been an increase in training for both BIA and AMHP roles, and increasingly AMHPs are being trained for the BIA role due to their in-depth knowledge and expertise of DoL legislation and associated guidance and policies, including human rights.

Having said that, given the complexity of the interface particularly between the MCA and MHA, there remains a high level of uncertainty.

**Respondent, “Anxiety amongst AMHPs – particularly those who have not undertaken BIA training – about the complexity of the interface between MCA/DoLS and MHA.”**

Therefore it is imperative that all AMHPs should be familiar with the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) and should familiarise themselves with the key points from this judgment (first recommendation above).

The Law Society, in its most recent guidance commissioned by department of health provides the following important pointers to decision makers:

*“Professionals should always remember that authority to deprive someone of their liberty does not, itself, provide authority to provide care and treatment to them. If a person does not have capacity to consent to take decisions in this regard, then it will always be necessary to consider the basis upon which those decisions are being taken by others and their authority for doing so which, will, in general terms, be:*

- *On the basis of the provisions of ss.5-6 MCA 2005, in terms of the delivery of ‘routine’ care and treatment;*
- *On the basis of a court order, where the care and treatment goes beyond the ‘routine;’*
- *In some circumstances, on the basis of the provisions of Part IV of the Mental Health Act 1983 (but only ever in relation to the provision of medical treatment related to the individual's mental disorder).*

*In other words, no one should assume that just because the deprivation of liberty is authorised that this is the end of the story for that individual.”*

(Law Society, 2015 p. 10).

### **3.2 The use of DoLS or MHA or MCA for admitting incapacitated patients to a mental health unit**

The use of the appropriate legislative frameworks, namely the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS), the Mental Health Act or the Mental Capacity Act (MCA) for admitting service users to hospital for care and/or treatment for their mental disorder has received unprecedented debates and examination since the Supreme Court judgment.

When undertaking MHA assessment AMHPs and other decision makers (i.e. doctors) should consider whether the care and/or treatment upon admission amounts to a deprivation or is likely to deprive the patient of their liberty (this is a core element of the assessment). If so, they should consider the use of either the DoLS or MHA. The vast majority of MHA assessments take place in a crisis where decision makers often have to make immediate decisions. A planned piece of work should be undertaken well in advance of admission where DoLS is to be considered – for example where a person is failing to cope in the community but does not need an immediate admission. Therefore MHA has been the most likely legal framework route used in admission following a MHA assessment. This has been reflected by almost all the respondents to this survey.

***Respondent, “The MCA has not been used for admitting someone to a mental health unit, because the rationale for admission includes treatment, or assessment for treatment, making the MHA the most appropriate legislation to use.”***

***Respondent, “We have had a limited number of DOLS requests for MH admissions, nearly all detained under MHA. MCA not being used.”***

**Respondent, “We know from the DoLS service that the DoLS procedures are not being used prospectively to admit persons to psychiatric wards and that their use tends to be retrospective once the person is in hospital.”**

**Respondent, “Like other authorities we have a marked increase in DoLS activity since the ruling including those informally admitted to hospital. There has been a rise in the number of older people lacking capacity admitted under the MHA“**

**Respondent, “in terms of using MHA and/or MCA for admitting patients to a mental health unit, it seems that more frequently the MHA is used as often the person is resistant to admission and meets the criteria for detention under the act.”**

It would appear the option of using the least restrictive admission under the MCA (i.e. Sections 5 & 6) has almost ceased with the only informal or voluntary (section 131 MHA) admissions being where people are capable of understanding their need for care and treatment in a mental health unit (i.e. the care/treatment regime does not amount to a deprivation of liberty or if it does, they can consent to the restrictions amounting to a deprivation of liberty). Respondents provided a clear rationale for the use of MHA, which reflects common current practice to ensure service users are afforded the necessary safeguards; however, there remains a concern regarding consideration of less restrictive options.

Arguably to ensure good practice, we still need to consider whether the care and treatment can safely and appropriately be provided in a less restrictive manner that will not give rise (or likely) to a deprivation of liberty. In this situation the service user should not be detained under the MHA or DoLS.

***Respondent, "New admissions of incapacitated patients to a MH unit are now almost invariably under the auspices of the MHA. This is partly due to this being the most appropriate statute in most cases but also a marked reluctance on the part of the NHS Trust to admit using MCA even in those cases where it might be more appropriate."***

Therefore given the stigma associated with deprivation of liberty including promotion of recovery, decision-makers including AMHPs should continue being proactive in considering informal admission where the care and/or treatment may not be a deprivation of liberty. For example, by admitting the service user to hospital who has capacity and not objecting under section 131 MHA or seldom if he/she lacks capacity and also not objecting, under sections 5&6 MCA where the care and treatment will not involve a deprivation of their liberty (further analysis to follow).

Objection is another significant area of practice that has led to extensive debates, and at times disputes and/or confusion between decision makers. In addition once a patient is admitted informally both the MHA and DoLS become available. Objection and the availability of legal frameworks for patients already admitted to psychiatric unit will be examined in section 3.3 below.

Whilst the revised MHA Code of Practice came into force on the 1<sup>st</sup> April and is largely helpful and provides good guidance in relation to the interface between MCA and MHA, there are certain statements which I will refer to here which have divided commentators and practitioners alike, with potential implications for AMHPs as well as other decision makers' practice.

13.35 *"...sections 5 and 6 of the MCA cannot be relied on if the overall care package, including any proposed measures of restraint and/or proposed restrictions on movement, will give rise to a 'deprivation of liberty'. A deprivation of liberty will engage article 5 of the ECHR and must be specifically*

*authorised under the MCA by a DoLS authorisation or a Court of Protection order, or otherwise made lawful by way of detention under the Act." And secondly*

*13.53 "First, a person who lacks capacity to consent to being accommodated in a hospital for care and/or treatment for mental disorder and who is likely to be deprived of their liberty should never be informally admitted to hospital (whether they are content to be admitted or not.)"*

This appears to suggest that this person can never be ADMITTED informally. As discussed earlier, it is rare or almost impracticable to initiate a DoLS authorisation in the community during a MHA assessment. The absolute earliest that any authority to detain under the DoLS could be initiated is on admission, with an urgent authorisation granted by the hospital which will be the managing authority under the DoLS regime.

Therefore, does this mean that EVERY incapacitated person (in relation to ability to consent to admission) must always be detained under the Mental Health Act in order for them to be admitted, irrespective of their level of compliance? And where does that leave AMHPs in the community when making decisions in relation to admitting compliant incapacitated patients? These questions were raised for discussion on Mental Health Law Online.

Professor Richard Jones responded to the online debate by writing, "In my opinion, compliant mentally incapacitated patients can continue to be admitted informally under the authority of ss.5 and 6 of the MCA.

After admission, they can be assessed to see whether they satisfy the Acid Test. In any event, I do not see how the use of the MHA can be justified in anticipation of a possible future deprivation of liberty."

Second commentator stated, “I completely agree with you (referring to the above statement). Outwith 'elective admissions' to psychiatric wards (somewhat a rarity I would have thought) the admission of a 'non-objecting' person who nevertheless lacks capacity to grant a valid consent is usually going to be via an informal route and the appraisal of whether authorisation is required would be made 'post arrival'. Its also apparent (to me at least) that the two Acts have different thresholds post the SJ judgment and use of the MHA to achieve 'apriori authorisation' will often not be justified as the person may well not meet the (MHA) criteria for detention...”

Third commentator, “I agree with all of you and am glad it is not just me who was puzzled by this guidance.”

Separately, I sought the opinion of other leading experts in the field, by asking the question, does the guidance within the revised Code of Practice means under no circumstances can a patient be admitted informally under the MCA sections 5 and 6, even in an emergency?

Neil Allen replied and said, “If I lack capacity and need to be admitted to a psychiatric ward to treat my mental disorder, if I object or would object if able to, use the MHA. If I am non-objecting, use MCA 5-6 to take me there and urgent DOLS with request for standard DOLS.... In deciding whether I object or would object, if in doubt Code says err on the side of caution (i.e. consider me to be objecting).” Neil is a Barrister at the prestigious 39 Essex Street Chambers and lecturer at Manchester University.

Whilst another leading mental health solicitor Peter Edwards, commented, “It is likely that the acid test will always be met and I think this is one of the most important ripple MHA effects of Cheshire West. The informal incapacitated patient is, on the whole, a thing of the past. It might be possible to authorise the DoL using the AM principles under the MCA.” He concurred with the

opinion stated above by the barrister, “An emergency would not be a DoL.” Peter Edwards is the Director of Peter Edwards Law and the Head of Civil Litigation and Private Client department. He was until recently the President of the Mental Health Lawyers Association and the president of the Mental Health Charity, Imagine.

Peter Edwards makes reference to the AM case which was considered by Mr Justice Charles in August 2013, *AM v SLAM*. It attempted to start clarifying the decision making process that an AMHP or a Best Interests Assessor has to make when deciding between the Mental Health Act and the Mental Capacity Act.

It was being argued on AM’s behalf that her stay in hospital could be covered by Sec.5 of the Mental Capacity Act, and that an authorisation under the DoLS could be issued if it was considered that there was a deprivation of liberty.

It was the view of the Judge that the entire process of deciding between the MCA or the MHA hinges on S.131 MHA. Mr Justice Charles stated: “The application of s.131 MHA and ss.5 and 6 of the MCA to the assessment and treatment of a compliant incapacitated patient work together.”

The judgment goes on to outline the three stages in the decision making process:

1. Is there a need to admit the patient? And if so, does the patient have the capacity to consent to informal admission under S.131 MHA?
2. Can the hospital rely on the MCA alone to assess and treat the patient?
3. If the MCA could be used, “How should the existence of a choice between reliance on the MHA and the MCA (with or without DoLS) be taken into account?”

AM's representatives argued that in her case DoLS should be used, but Mr. Justice Charles made it clear that "the correct position is that there may be cases in which a compliant incapacitated person may properly and lawfully be admitted, assessed or treated and detained under Part II MHA when he or she could be assessed or treated pursuant to s. 131 MHA and ss 5 and 6 MCA and be the subject of the DoLS." The judge further clarified this by referring to paragraphs 4.21 of the 2008 MHA CoP and 4.48 of the DoLS CoP, where the codes offer helpful examples.

Para 4.21 of the 2008 MHA CoP provide the following examples of when the MCA is not appropriate:

*"Whether or not the deprivation of liberty safeguards could be used, other reasons why it may not be possible to rely on the MCA alone include the following:*

- 1. The patient's lack of capacity to consent is fluctuating or temporary and the patient is not expected to consent when they regain capacity. This may be particularly relevant to patients having acute psychotic, manic or depressive episodes;*
- 2. a degree of restraint needs to be used which is justified by the risk to other people but which is not permissible under the MCA because, exceptionally, it cannot be said to be proportionate to the risk to the patient personally; and*
- 3. There is some other specific identifiable risk that the person might not receive the treatment they need if the MCA is relied on and that either the person or others might potentially suffer harm as a result."*

Para 4.48 of the DoLS CoP basically consolidates and echoes 2008 MHA CoP guidance:

*"Even where a person does not object and a deprivation of liberty authorisation is possible, it should not be assumed that such an authorisation is invariably the correct course. There may be other factors that suggest that the Mental Health Act 1983 should be used (for example, where it is thought likely that the person*

*will recover relevant capacity and will then refuse to consent to treatment, or where it is important for the hospital managers to have a formal power to retake a person who goes absent without leave)."*

A third contribution came from Rebecca Fitzpatrick who leads the mental health and social care team at Hill Dickinson Solicitors. She responded to my query concerning Para 13.35 of the new MHA CoP by stating, "I think this is where the disquiet/confusion/debate is coming from and the Code doesn't fully deal with this type of situation. I agree with Richard Jones that for short periods you could potentially rely on s.4 & 5 to get the person to hospital or alternatively the common law – this is often the case in acute hospitals where a person needs a short period of emergency assessment and treatment at A&E (or for example people coming round from anaesthetic lack capacity can often be aggressive and disorientated and might need to be effectively deprived of their liberty for very short periods to keep them safe) but a formal DoL authorisation will not be required (as no requirement for a standard authorisation as per 6.3 of Code)."

Rebecca Fitzpatrick whose solicitor's firm provides regular legal advice to Mersey Care NHS Trust, reflected further and said, "I also wondered about those patients whose capacity fluctuates and agree to a care plan in advance that they should be admitted informally if they are not obviously objecting for a short period to stabilise their mental health – surely that would be less restrictive in accordance with the least restrictive principle than slapping a section or a DoL on them & in accordance with their views and wishes? I do worry that the pendulum has swung a bit too far the other way so that we are now in a situation where the Cheshire West case has had the effect of whole groups of patients being placed on section without perhaps sufficient scrutiny of their individual circumstances in some cases."

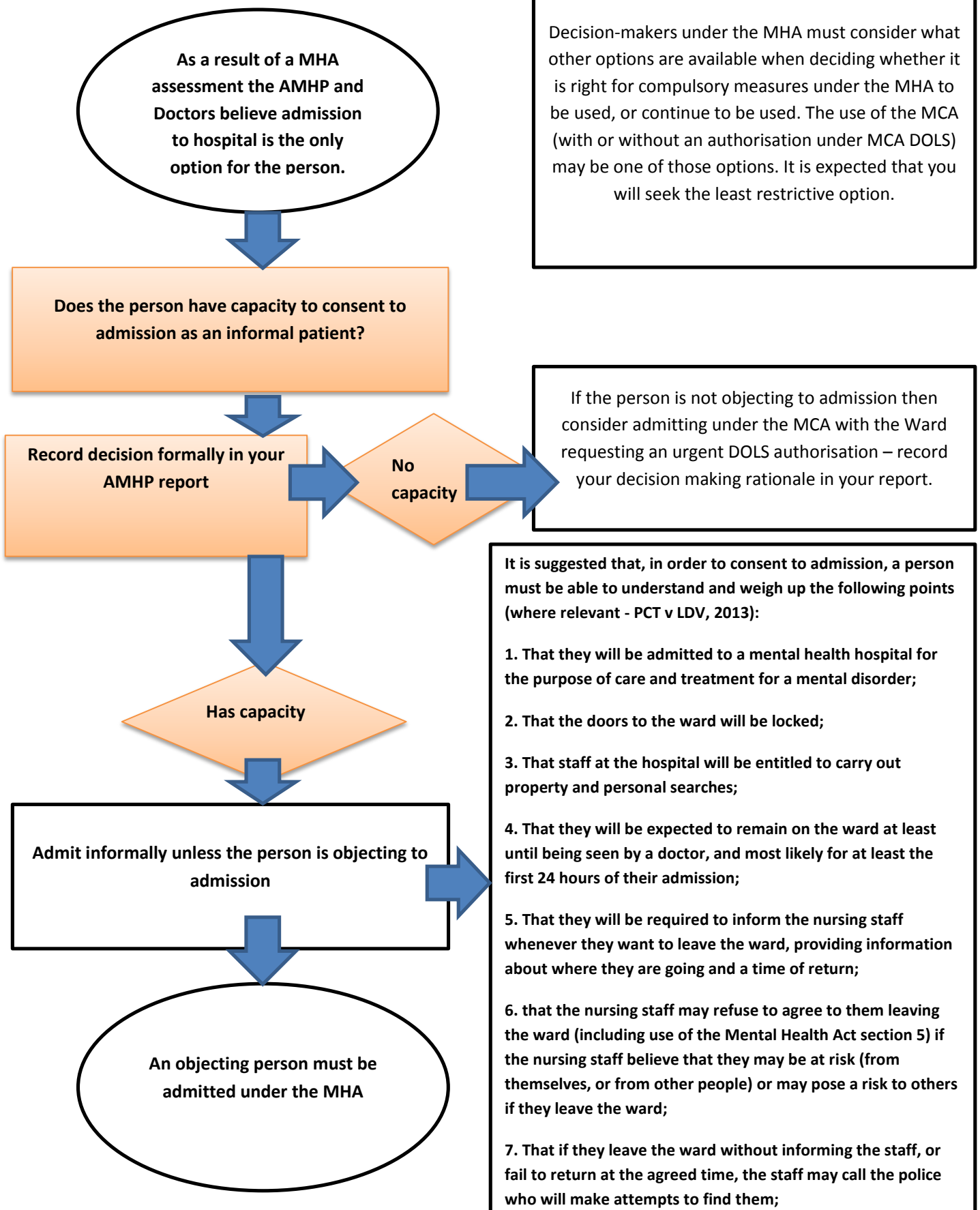
"The other area of uncertainty is what does "not free to leave" mean exactly – more guidance on this as well as the meaning of "objecting" would be useful!

What about people who are incapable of leaving because they are in a persistent vegetative or minimally conscious state and all involved agree the placement is in their best interests? - I know that is outside the remit of this survey report but is an interesting question that hasn't yet been clarified by the courts."

Rebecca Fitzpatrick is ranked Tier 1 in the categories of mental health law and court of protection work in Chambers & Partners Guide to the UK legal profession. She dealt with the first Supreme Court case to consider the Mental Capacity Act *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.

An excellent guidance on the interface between MCA and MHA has been developed by Surrey County Council, and shared by their AMHP Lead with the AMHP Leads Network, in response to my query via the network. It provides very helpful step-by-step approach to AMHPs and other decision makers on the use of MCA (with or without an authorisation under DoLS) and the MHA. It does again support the views of commentators thus far, that if the person being assessed is not objecting and lacks capacity to consent to their admission, assessment and/or treatment for mental disorder in a psychiatric setting, decision makers could consider admission under MCA with the ward requesting an urgent authorisation; see Figure 1, p35 below.

**Figure 1: MCA v MHA Guidance**



It is imperative to make a note of the guidance published in April 2015 by the Law Society. The guidance was commissioned by the Department of Health to assist those professionals most directly concerned with commissioning, implementation and oversight of arrangements for care and treatment of individuals who may lack the capacity to consent to such arrangement. Its purpose is to provide practical assistance in identifying whether they are deprived of their liberty, and hence to ensure that appropriate steps can be taken to secure their rights under Article 5 ECHR. However, the principal aim of the guidance is to assist in identifying a deprivation: it does not address in detail how that deprivation ought to be authorised. Nor does the guidance consider the law regarding the right to challenge a deprivation of liberty under Article 5(4) ECHR.

Specifically the guidance states, *“If the patient either cannot or does not consent to their admission, assessment and/or treatment for mental disorder in the psychiatric setting, and that admission, assessment and/or treatment will involve a deprivation of their liberty, then authority will be required under one of four routes:*

- *The provisions of the MHA 1983;*
- *DOLS, i.e. the provisions of Schedule A1 Mental Capacity Act 2005 (“DOLS”);*
- *(Unusually) by way of an order made under the inherent jurisdiction of the High Court;*
- *(Unusually) by way of an order made by the Court of Protection.”*  
(Law Society, 2015 p.52)

As stated earlier the decision as to which legal framework to use is outside the scope of this guidance. Nonetheless, it provides the most comprehensive and up to date case law written by authors, who are all prominent lawyers who (in different contexts) advise upon and act in cases involving questions of deprivation of liberty.

And finally I had the following response from the Department of Health about my enquiry relating to Paragraphs 13.35 and 13.53 of the MHA CoP:

“It will almost always be in the person's best interests to give urgent treatment without delay.

The DoLS Code of Practice also states,

- At para 6.3: "an urgent authorisation should not be used where there is no expectation that a standard deprivation of liberty authorisation will be needed"

- At para 6.4: " Similarly, an urgent deprivation of liberty authorisation should not be given when a person is, for example, in an accident and emergency unit or a care home, and it is anticipated that within a matter of a few hours or a few days the person will no longer be in that environment"

Although this contribution by Department of Health is helpful, there remains widespread interpretations and debates of the application of Paragraphs 13.53 and 13.35 of the CoP. Hence the following recommendation

***Recommendation, “Further guidance is required to clarify the legal framework governing the admission of incapacitated, non-objecting, compliant patient to psychiatric inpatient care and the use of MCA sections 5 & 6.***

It would appear, and this remains to be clarified in the fullness of time, that the intention of the Code, is to prompt decision makers (i.e. AMHPs, doctors, etc.) to consider the care and treatment of a patient upon admission and whether it will or be likely to give rise to deprivation of liberty. Arguably it is an approach that promotes patients rights being assessed under the MHA and highlights the implications and seriousness of unlawful deprivation of liberty. Moreover, in relation to the purpose and legal status of the Code, it is clearly stated in its introductory chapter that AMHPs alongside other decision makers should follow it as statutory guidance on how they should proceed when undertaking duties under the Act. As departures from the Code could give rise to legal

challenge, reasons for any departure should be recorded clearly (MHA CoP, Para V).

Interestingly survey participants did not provide comment on the conveying arrangements for service users being admitted to psychiatric hospital. This is an issue which sometimes can cause conflict across health, social care and other public service agencies (i.e. ambulance, police, local authorities, NHS etc.) and between decision makers, particularly for service users who lack capacity. The following clarification by the Law Society offers very helpful guidance:

*“Transporting a person who lacks capacity from their home, or another location to a hospital by ambulance in an emergency will not usually amount to a deprivation of liberty. In almost all cases, it is likely that a person can be lawfully taken to a hospital or care home by ambulance under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.*

*The DoLS Code suggests that there may be exceptional circumstances where taking a person to a hospital or a care home amounts to a deprivation of liberty. We suggest that the following situations which include, but go beyond those discussed in the Code, may give rise to the need to seek authorisation to ensure that the measures taken are lawful:*

- Where it is or may be necessary to arrange for the assistance of the police and/or other statutory services to gain entry into the person's home and assist in the removal of the person from their home and into the ambulance;*
- Where it is or may be necessary to do more than persuade or provide transient forcible physical restraint of the person during the transportation;*
- Where the person may have to be sedated for the purpose of transportation;*  
*or*
- Where the journey is exceptionally long.”*

(Law Society, 2015 p.37).

In conclusion the Revised MHA Code of Practice emphasises, in relation to capacity specifically, that professionals need to be aware that service users with a mental disorder, including those liable to be detained under the MHA, do not necessarily lack capacity. The assumption should always be that a patient subject to the MHA has capacity, unless it is established otherwise in accordance with the MCA. It emphasises that healthcare providers have a legal duty to care for and treat service users who lack capacity in accordance with the MCA, when it applies. Failure to do so could result in enforcement action being taken by the Care Quality Commission (CQC).

***Respondent, "Misunderstanding of the MCA is a challenge. This has been causing disputes and fallouts between professionals and services. Practitioners continue to make best interests decisions on behalf of people who possess capacity to make the decisions for themselves. There is still a culture in health where staff presume that the person lacks capacity because they have dementia, learning disability or a mental health diagnosis. Or just totally ignore the MCA if patients are sectioned, it's wrong! I think we have made some strides as AMHPs and social workers, but I guess other professionals across the wider health and social care spectrum still struggle with understanding and applying the spirits of the Mental Capacity Act."***

### **3.3 The use of DoLS or MHA or MCA for the provision of care/treatment to incapacitated patients already in a mental health unit**

**Respondent, “AMHPs are occasionally placed in a dilemma when the doctor assessing mental disorder for the purposes of DoLS assessment states that an assessment under the MHA should be used, but when the MHA assessment takes place, the doctor involved in that assessment feels that detention under MHA is not appropriate. “**

**Respondent, “I don't think that prior to the Chester West Ruling DoLS was used enough, we have one referral last year but the BIA felt the person had capacity. However since the ruling there has been confusion about when to apply it. Recently some clients were taken off their Section and to be referred to the DoLS service under an urgent authorisation as it was stated that this was the least restrictive, however the psychiatrist felt they weren't eligible because they should be detained under the MHA. This has happened several times and left people neither detained or under Dols, as when we sent out an AMHP for the MHA, it was decided the clients weren't detainable and should be under DoLS.”**

**Respondent, “Although there has been an increase in the use of DoLS for inpatients since the ruling, the interface between DoLS and MHA is a long standing issue with occasional tensions between AMHPs who wish to ensure the least restrictive option and medical staff who may be unsure or lack confidence in making decisions about treatment of incapacitated patients.”**

**Respondent, “More general terms it may be beneficial to have more guidance about what actually constitutes ‘objection’ on the part of an informal incapacitated patient on a mental health ward. There seems to be some differing opinions on this and when it is appropriate to dispense with DoLS and move into MHA territory.”**

***Respondent, “There seems to be a particular sticking point around what constitutes an ‘objection’ when considering Eligibility.”***

The survey participants in their commentary above have highlighted a number of the most pressing contemporaneous issues, which are summarised below:

- Implementation of Cheshire West Judgment – the interface between MHA, DoLS and MCA;
- MHA and DoLS - Patients falling between the two legal frameworks;
- Misunderstandings across agencies and between professionals in applying the judgment and related legislation resulting in conflict and disputes including delay in decision making;
- Least restrictive principle – application, ethics and whether one legal framework (i.e. DoLS or MHA) promotes it more;
- Objection – definition, manifestation and determining which legal framework to use;

To address these points, I will start by identifying the categories of patients based on legal framework governing their care and treatment arrangements, then an examination of the criteria and the appropriate choice of which legal framework to apply, i.e. MHA or DoLS. The issues of objection and least restrictive principle will be integral to the discussion with further guidance and helpful pointers.

It is now accepted that there are four broad categories of patients:

- Voluntary (has capacity to consent to admission) patients admitted under S131 of the MHA
- Detained patients admitted under S2/3 etc. of the MHA
- Informal (lack capacity) patients admitted via the best interest decision making process and Sections 5 and 6 of the MCA

- Patients subject to DoLS sections 4A and 4B and Schedules A1 and 1A of the MCA

The Supreme Court judgment no longer allows for the category of informal patient where that patient meets the “Acid Test”. They must either be:

- Admitted under S2/3 (etc.) of the MHA or
- Subject to DoLS (Sections 4A and 4B of, and Schedules A1 and 1A to, the MCA).

Professionals must take into account the following:

Admission under the MHA or DOLS:

If:

- The patient lacks capacity to consent to these arrangements, and
- The assessment and proposed treatment is wholly or partly for mental disorder, and
- The patient meets the criteria under S2 or S3 of the MHA, and
- The patient does not object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder.

Then practitioners will have a choice between the two regimes (Para 13.49, MHA CoP 2015)

Figure 2, page 43 below, is an option grid from the MHA CoP summarising the availability of the Act and of DoLs where a deprivation of liberty has been identified for a mental health patient, accommodated in hospital for the purpose of treatment for a mental disorder.

**Figure 2: Options grid summarising the availability of the Act and of DoLS**

	Individual <b>objects</b> to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder	Individual <b>does not object</b> to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder
Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	<b>Only the Mental Health Act is available</b>	The Mental Health Act is available. Informal admission might also be appropriate. Neither DoLS authorisation nor Court of Protection order available
Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment	<b>Only the Mental Health Act is available</b>	The Mental Health Act is available. DoLS authorisation is available, or potentially a Court of Protection order

Admissions must not fall between the two statutory regimes. Para 13.60 MHA CoP states, *“In the relatively small number of cases where detention under the Act and a DoLS authorisation or Court of Protection order are available, this Code of Practice does not seek to preferentially orientate the decision-maker in any given direction. Such a decision should always be made depending on the unique circumstances of each case. Clearly recording the reasons for the final decision made will be important. The most pressing concern should always be that if an individual lacks capacity to consent to the matter in question and is deprived of their liberty they should receive the safeguards afforded under either the Act or through a DoLS authorisation or a Court of Protection order.”* The option of considering to refer a case to the Court of Protection should be an absolutely last resort, and an application to the Court should really only be made if decision makers have found it impossible to determine the capacity or best interests of a service user in relation to a particular decision.

**Respondent, *It is also likely that we may see a rise in the use of DoLS for people who are no longer liable for detention under the MHA or who are in medical units but who cannot be discharged due to problems with identifying suitable move on placements or delays in arranging robust support on return home.***

Para 13.2 MHA CoP provides further guidance, that practitioners should be able to identify the legal framework that governs a patient's assessment and treatment journey and authorise any appropriate deprivation of a patient's liberty whether the MCA or Mental Health Act (the Act). The legal framework is not static and may change as the patient's circumstances and needs change.

Therefore, if the MHA Section is terminated then there should be a consideration to put a DoLS in place with immediate effect. (I.e. no longer meet MHA Criteria), and a patient on a psychiatric ward could be supported under the DoLS regime under the following circumstances:

- They lack capacity to consent to their admission and/or treatment
- They do not object to their admission and/or treatment
- The admission is primarily for welfare reasons
- The patient is no longer receiving treatment for their mental disorder as defined by MHA s145

Furthermore, onward DoLS planning should form part of discharge planning process. For example, where a patient is being discharged to 24-hour care and the care and treatment is or likely to amount to deprivation of liberty. Having said that, patients who are non-compliant whilst awaiting discharge and still subject to treatment (i.e. for mental disorder or related to it) – and treatment covers a wide range of activity - and this should be delivered under the Mental Health Act (Joint Cheshire West and Chester & Cheshire and Wirral Partnership NHS Foundation Trust Briefing, 2014).

The MHA Code provides further guidance in favour of using the MHA over DoLS where a patient deprived of their liberty may regain capacity or may have fluctuating capacity. Such a situation is likely to indicate use of the Act to authorise a deprivation of liberty should be preferred over use of a DoLS (MHA CoP, 13.54).

As regards which regime is the least restrictive, MHA CoP is very clear that professionals should apply the criteria governing each legal framework and not assume one regime is “less restrictive” than the other. It is the care plan which imposes the restrictions, not the procedural safeguards. Para 13.58 MHA CoP states, *“The choice of legal regime should never be based on a general preference for one regime or the other, or because one regime is more familiar to the decision-maker than the other. Such considerations are not legally relevant and lead to arbitrary decision-making. In addition decision-makers should not proceed on the basis that one regime is generally less restrictive than the other. Both regimes are based on the need to impose as few restrictions on the liberty and autonomy of patients as possible. In the particular circumstances of an individual case, it may be apparent that one regime is likely to prove less restrictive. If so, this should be balanced against any potential benefits associated with the other regime. ”*

***Recommendation: To minimise and/or eliminate disputes and conflicts between decision makers and unlawful deprivation or inappropriate use of legislation, supervisory bodies and managing authorities should consider developing joint training and a shared approach in implementing the Cheshire West Judgment and the acid test on deprivation of liberty.***

***Recommendation: Providers should have policies in place to deal with circumstances where disagreement results in an inability to take a decision as to whether the MHA or DoLS should be used to give legal authorisation to a deprivation of liberty. It is advisable that these policies underpin the working,***

***and facilitate collaboration and cooperation between local supervisory and managing authorities.***

In relation to objection and determining which legal framework to apply, the threshold for objection within the Code is set very low, consistent with the Cheshire West Judgment. The Code makes a reasonable attempt to provide guidance to decision makers, where it states in Para 13.51

*“Whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects, the reasonableness of that objection is not the issue. In many cases the patient will be perfectly able to state their objection. In other cases the relevant person will need to consider the patient’s behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. In deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting.”*

Moreover, it is imperative when decision makers assess a person’s capacity to consent to admission to hospital ‘it is not necessary for the person to comprehend every detail of the issue’ (Macur J in *LBL v RYJ* [2010] EWHC 2660), but rather that they are able to comprehend and weigh the salient details relevant to the decision.

It is suggested that, in order to consent to admission, a person must be able to understand and weigh up the following points (where relevant):

1. That they will be admitted to a mental health hospital for the purpose of care and treatment for a mental disorder;
2. That the doors to the ward will be locked;
3. That staff at the hospital will be entitled to carry out property and personal searches;
4. That they will be expected to remain on the ward at least until being seen by a doctor, and most likely for at least the first 24 hours of their admission;

5. That they will be required to inform the nursing staff whenever they want to leave the ward, providing information about where they are going and a time of return;

6. That the nursing staff may refuse to agree to them leaving the ward (including use of the Mental Health Act section 5) if the nursing staff believe that they may be at risk (from themselves, or from other people) or may pose a risk to others if they leave the ward;

7. That if they leave the ward without informing the staff, or fail to return at the agreed time, the staff may call the police who will make attempts to find them;

This is a list based on the findings in *A PCT v LDV* (2013), with some additional elements, which is being used by some service providers to offer guidance for decision makers considering admission of a person with capacity to consent (e.g. refer to figure 1).

The Law Society in their latest earlier mentioned guidance, has the following comprehensive set of questions for front line mental health practitioners that may help them establish whether an individual is deprived of their liberty in a psychiatric context:

*“• Is the door to the ward or unit locked? Does the patient either know the code or have a swipe, and is he or she able to make use of it to come and go as he or she pleases?*

*• Can the patient leave the ward at any time or are there any conditions the person is required to adhere to?*

*• How easy is it for the patient to go outside and get access to fresh air?*

*• What if any steps would be taken by staff if the patient were to announce their intention to leave the ward a) temporarily or b) permanently?*

*• Is the patient able to access all areas of the ward when they wish to?*

*• Can the patient prepare any refreshments for themselves?*

- *Is the patient able to access items for leisure activities when they wish, such as: games consoles, books, means of listening to music, art, craft or writing equipment, the internet?*
- *What observation levels is the patient on and how are they monitored?*
- *Is the patient prescribed medication? If so, can they consent to such medication, and what is its purpose? Is it to control their behaviour?*
- *To what extent is the patient required to adhere to a timetable?*
- *Does the ward have a period of “protected time” when visitors cannot come onto the ward?*
- *How easy is it for the patient to use the phone in private?*
- *What are the visiting hours?*
- *Is the patient ever nursed alone and if so in what circumstances?*
- *Is the patient ever secluded? If so, why and for how long on each occasion? Is seclusion regularly used?*
- *Is restraint ever used and in what circumstances? How often is it used?*
- *Are there any sanctions used if the patient’s behaviour is cause for concern? If so what are they and why?*
- *Does the patient manage his or her own finances? If not, who does, why, and under what authority?*
- *Could any of the liberty - restricting measures be dispensed with and if so how?”*

(Law Society, 2015 p 63)

***Recommendation: Providers should consider developing and/or updating their existing admission policy to support decision makers in making lawful admission decision informed by case law, guidance and the MCA and its associated principles.***

There remains a concern about the continuing lack of understanding and awareness of the MCA, which is often a potential barrier to good practice and disputes between AMHPs and other decision makers. The MHA with its revised CoP as well as DoLs are both set firmly within the empowering ethos of the MCA. They encourage all health and social care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty. This was reiterated at a recent MCA seminar on February 2015 hosted by Lyn Romeo, Chief Social Worker (adult) England. An explicit message from both the Chief Social Worker and Niall Fry, MCA and DoLs Lead, department of health, that:

*“We should not let DoLS overshadow/detract good practice guidance underpinned by the MCA”*

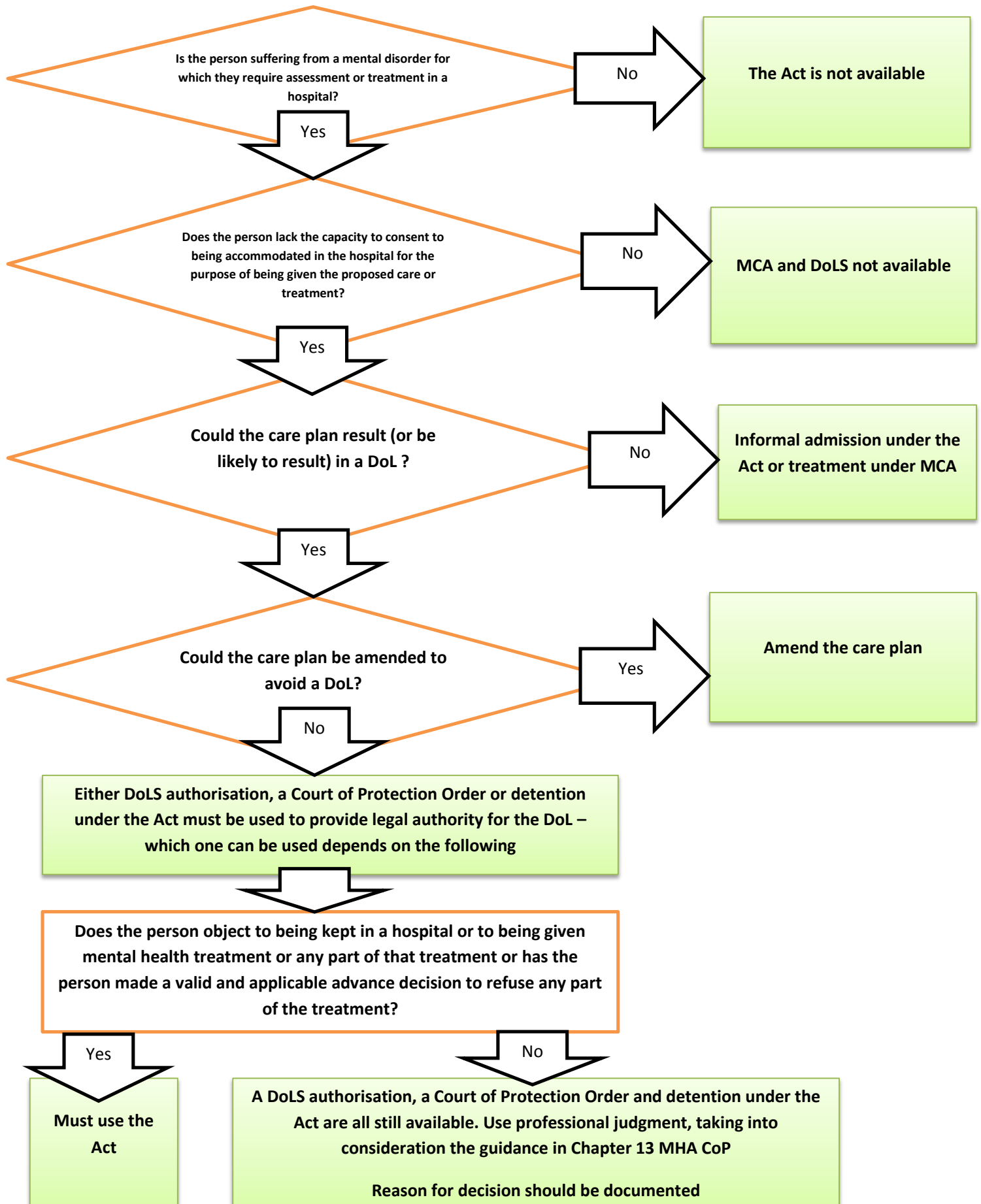
Therefore ***Recommendation: Hospitals, local authorities and care homes must work together locally to raise awareness and improve understanding of the MCA more widely and embed it in health and social care culture.***

The DoLS are part of the MCA and as such rooted in the MCA's five statutory principles. The DoLs only apply to people who lack capacity to consent to accommodation in a care home or hospital where care and/or treatment provided in that accommodation amounts or is likely to amount to a deprivation of liberty. The DoLS authorisation does not itself authorise care or treatment, only the deprivation of liberty that results from the implementation of the proposed care plan. As such, all necessary care or treatment should be provided in accordance with the MCA.

The MHA, on the other hand, does not regulate care or treatments that are unrelated to mental disorders. Hence in those circumstances the MCA can be relied upon in relation to specific decisions, that the patient lacks capacity to consent to.

The MHA CoP provides a very helpful flowchart (see Figure3, page 51), which describes the key decision-making steps when determining whether the MHA and/or the MCA will be available. The flowchart does not replace careful consideration by decision-makers of all relevant circumstances in individual cases. AMHPs and other decision makers should use their professional judgment within the framework of the legislation (MHA CoP, 13.62).

**Figure3: Deciding whether the Act and/or MCA will be available to be used**



### **3.4 What training/guidance is or should be made available to improve practice including effective and lawful implementation of the judgment**

**Respondent, “The County Council is providing training as well as one day of the AMHP training will focus on this. The Partnership Trust has also provided training. In addition briefing sheets and information from legal departments have been sent out to AMHPs, psychiatrist, nursing staff and wards.”**

**Respondent, “The LA has circulated guidance to its own staff and Care home and Hospital providers. New BIAs training courses are being organised but unless there is some change agreed at a national level my Local authority like all authorities will increasingly be unable to meet timescales for authorisations and emergency authorisations will inevitably extend to their maximum”**

**Respondent, “We have had some very good training under our AMHP refresher training arrangements with the local AMHP University training provider and with our legal advisers who are a private firm to whom we have outsourced this function. Good training has also been delivered to senior staff in the NHS Trust we work with in integrated teams, but the interpretation of some staff is less informed than we would hope for when trying to use the most appropriate statute in each case.”**

**Respondent, “The ruling and subsequent high profile of DoLS has increased the chances of debates on MHA and MCA interface and reduced the chances of illegal admissions.”**

The judgment has presented new challenges and put enormous pressures on local authorities with the statutory responsibilities of providing both AMHP and BIA services. Nonetheless, there is evidence of tremendous and

exceptional response by LAs and other providers across health and social care in working collaboratively in training, briefings, awareness raising and development of policies and protocols. The focus is on the MCA and its interface with MHA, deprivation of liberty and implications of the Supreme Court judgment. The latter has made it clearer and easier for providers and decision makers to identify where a person is being deprived of their liberty.

AMHPs with the responsibility for organising, co-ordinating and contributing to Mental Health Act assessments have been keen to engage with, adapt and gradually welcome and fully embrace the cultural transformation brought about by the judgment. This is evident where AMHPs work within localities where providers (both health and social care) jointly work effectively, linking regionally and nationally in promoting and implementing good practice. There are many examples of joint training and development of policies and procedures that support decision makers from diverse backgrounds and facilitate shared understanding and approach in applying the Supreme Court Judgment.

**Recommendation: It is important that decision makers (i.e. AMHPs, BIAs, doctors) have training on the Revised MHA Code of Practice. These professionals should have detailed knowledge of the Code, including its purpose, function and scope. They should be able to identify the legal framework that governs a person's assessment and treatment and authorise any appropriate deprivation of liberty whether under MCA or MHA.**

#### **4. Conclusion**

It is evident from all the respondents that there has been significant impact on AMHPs and service providers, but the situation appears to be more challenging for certain local authorities where a large proportion of their Best Interests Assessors for DoLS are drawn from the AMHP service. The levels of activity have caused unprecedented pressure on already limited and stretched AMHP services across the country. Notwithstanding this, there has been impressive response by services in working collaboratively and in partnerships with stakeholders including mental health trusts, HEIs and legal experts. Consistent with the guidance issued by Department of Health, local authorities have responded by reviewing their allocation of resources in light of the revised test given by the Supreme Court to ensure they meet their legal responsibilities. There has been a substantial increase in the number of BIA courses delivered primarily by HEIs to meet the demands. In addition some local authorities opted for the development of a dedicated BIA teams with clear immediate benefits. The impact of the latter will arguably require further review and monitoring.

Clearly there have been landmark changes impacting AMHP practice and the local authorities on behalf of which the professionals act, as result of the Cheshire West Judgment and more recently the implementation of the Revised MHA CoP in April 2015. Both of which have been helpful developments in clarifying very complicated case law on deprivation of liberty. The AMHPs and their local authority employers have welcomed these changes by embedding them in their practice and service delivery.

However, there remain barriers and challenges in fully implementing these changes arising from the bewildering, complex and bureaucratic DoLS framework and its interface with other legislations governing deprivation of liberty that has been explicitly reported by both the House of Lords post-legislative scrutiny report on the MCA and the Cheshire West Supreme Court judgment. This has led the government to task the Law Commission to look for a framework that is simpler, while still protecting the rights of vulnerable

people with mental health problems and those who lack capacity. The Law Commission is expected to publish a consultation paper in the summer of 2015 and their final report and draft legislation in summer 2017.

Hence the AMHP workforce is likely to have to embrace further changes in the next 2-3 years in addition to recently mentioned landmark developments.

Whatever changes may come our way, the AMHPs as important decision makers have demonstrated that they are at the forefront in embedding them. They continue focusing on the vulnerable people being assessed under the MHA by placing them at the heart of their practice.

AMHPs in their interventions always endeavour to honour wherever possible and pay due considerations to the wishes, feelings, beliefs and values of service users and their family, carers and significant others. They are at the forefront of decision makers, in protecting the rights of mental health service users subject to the powers of MHA, ensuring their human rights are safeguarded and promoting their recovery and independence.

## 5. Bibliography

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[The letter from Niall Fry of the Department of Health to MCA DOLS leads addressing, amongst other things, palliative care and unconsciousness \(January 2015\)](#)

[The letter from the Chief Social Worker, Lyn Romeo, on the MCA 2005 and the vital role of social workers \(January 2015\)](#)

## Useful Website Resources

[www.mentalhealthlawonline.co.uk](http://www.mentalhealthlawonline.co.uk)

Extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983.

[www.mclap.org.uk](http://www.mclap.org.uk)

This website maintained by Alex Ruck Keene, is borne out of a desire to promote better, clearer thinking amongst lawyers, policy-makers and professionals as to the operation of the MCA 2005.

<http://thesmallplaces.wordpress.com>

The Small Places is a Blog site written by Lucy Series, a researcher at the Centre for Health and Social Care Law at Cardiff Law School. Lucy's research interests include legal capacity and human rights, especially in health and social care services. She is currently working on a project about the Court of Protection.

[www.scie.org.uk](http://www.scie.org.uk)

The website of Social Care Institute for Excellence includes good practice guidance in a number of areas relating to mental capacity and related law, including a *directory* of mental capacity resources.

[www.themaskedamhp.blogspot.co.uk](http://www.themaskedamhp.blogspot.co.uk)

The blog written by the Masked AMHP with case law updates and reflection on current mental health practice and developments.

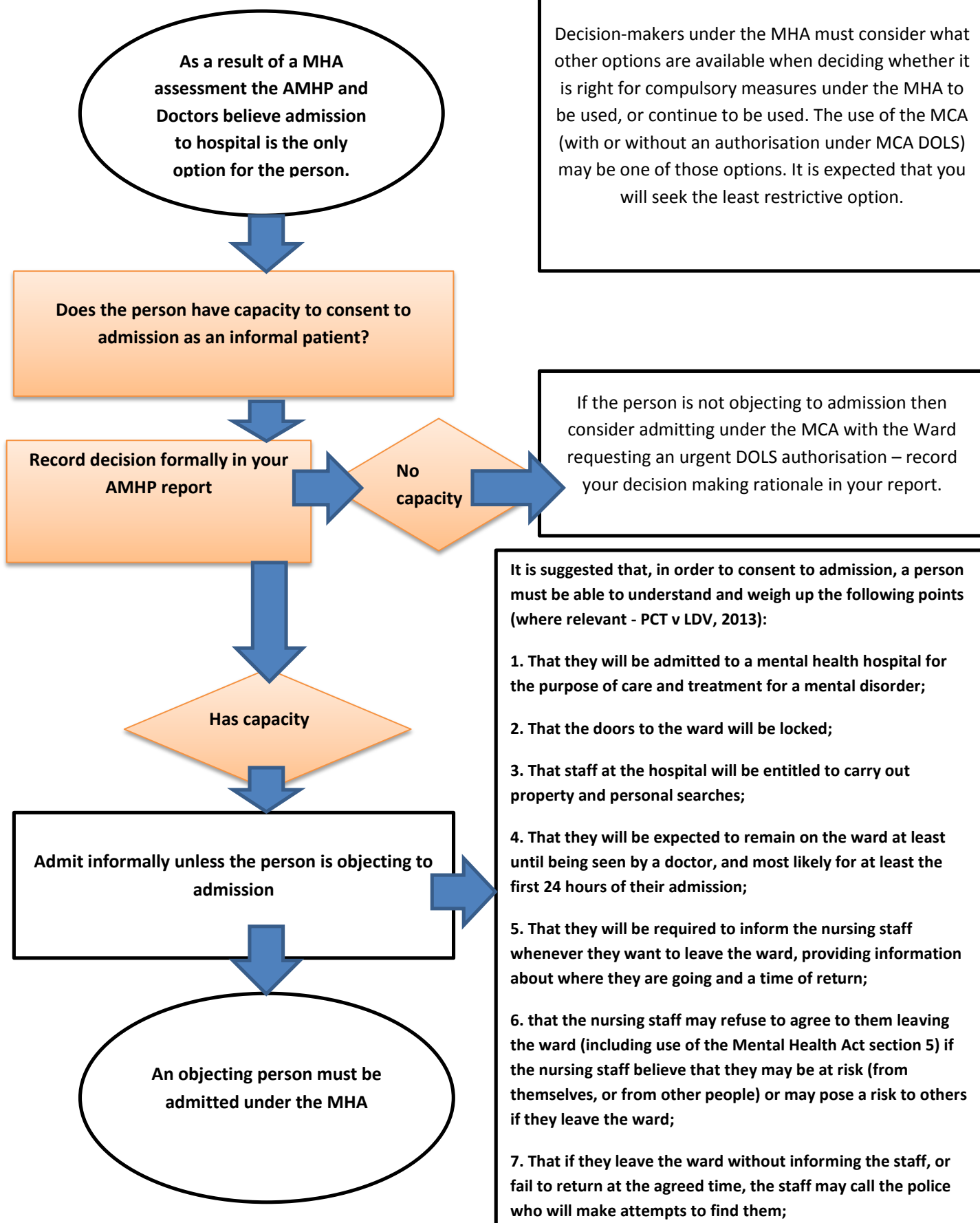
## **6. Appendix**

**Figure 1: MCA v MHA Guidance**

**Figure 2: Options grid summarising the availability of the Act and of DoLS**

**Figure 3: Deciding whether the Act and/or MCA will be available to be used**

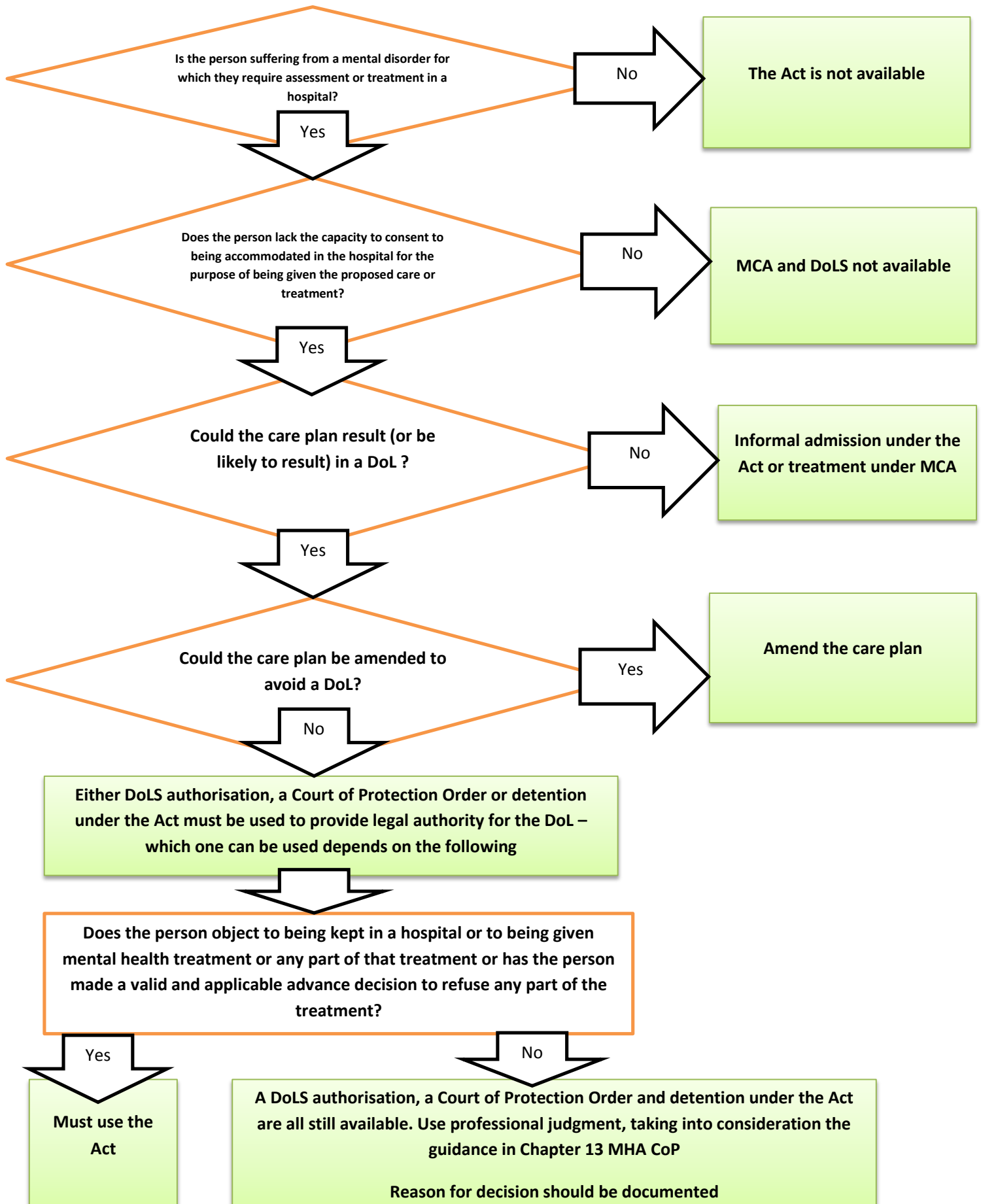
Figure 1: MCA v MHA Guidance



**Figure 2: Options grid summarising the availability of the Act and of DoLS**

	Individual <b>objects</b> to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder	Individual <b>does not object</b> to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder
Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	<b>Only the Mental Health Act is available</b>	The Mental Health Act is available. Informal admission might also be appropriate. Neither DoLS authorisation nor Court of Protection order available
Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment	<b>Only the Mental Health Act is available</b>	The Mental Health Act is available. DoLS authorisation is available, or potentially a Court of Protection order

**Figure3: Deciding whether the Act and/or MCA will be available to be used**



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