

# Deprivation of liberty: Mental Capacity Act safeguards versus the Mental Health Act<sup>†</sup>

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**Summary** The Mental Capacity Act deprivation of liberty safeguards have been criticised for their complexity and unclear interface with existing mental health law. The new legislation, which was implemented in April 2009, is likely to pose a challenge to clinical teams.

**Declaration of interest** None.

The Mental Capacity Act deprivation of liberty safeguards<sup>1</sup> were introduced via the Mental Health Act 2007 amendments<sup>2</sup> on 1 April 2009. The new legislation has implications for practice in psychiatric and general hospitals, and particularly in care homes, where there are high numbers of individuals who lack capacity to make decisions about admission and treatment.<sup>3,4</sup>

The safeguards have been introduced in response to the European Court of Human Rights judgment of *HL v. UK*, known as the 'Bournewood case'.<sup>5</sup> The European Court of Human Rights concluded that common law, which had been widely used to hold and treat patients lacking capacity, was inadequate to satisfy the European Convention of Human Rights.<sup>6</sup> Specifically, it contravenes Articles 5(1) and 5(4) of the Convention: the individual's right to be detained only via a procedure prescribed by law and the right to a speedy review of the legality of the detention. This means that if a patient lacks capacity and a deprivation of liberty is felt necessary to provide the care required, common law can no longer be used and a choice must be made between deprivation of liberty safeguards and the Mental Health Act.

The new legislation has been criticised for its complexity and its unclear interface with existing mental health law.<sup>7–10</sup> One concern is the failure of the Code of Practice to define deprivation of liberty, stating: 'this is ultimately a legal question and only the courts can determine the law'.<sup>1</sup> Unfortunately, existing case law, the best guide available, is not definitive and is open to different interpretation.

## Deprivation v. restriction of liberty

In the judgment of *HL v. UK*, the European Court of Human Rights made it clear that the question of whether someone has been deprived of liberty depends on the particular circumstances of the case and stated: 'The distinction

between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance'.<sup>5</sup> However, the Joint Committee on Human Rights<sup>11</sup> criticised the government's draft illustrative guidance,<sup>12</sup> based on existing case law and listing factors that may amount to deprivation of liberty, as not reflecting Munby J's analysis of deprivation of liberty in *DE and JE v. Surrey County Council*.<sup>13</sup> The Joint Committee on Human Rights favoured Munby's view that the key factor in determining whether there is a deprivation of liberty is not whether the person's freedom within the institutional setting is curtailed but whether or not the person is free to leave.<sup>13</sup> So, as things stand, the boundaries between lawful restrictions of liberty and deprivation of liberty remain blurred. If Munby's analysis of the European Convention of Human Rights is upheld by courts in the future, the numbers of patients in hospitals and care homes whose care amounts to deprivation of liberty may have been massively underestimated, with huge resource and cost implications.

## Interface with the Mental Health Act

Many of the criticisms of the deprivation of liberty safeguards stem from uncertainty about their intended parallel use with existing mental health law. Although the Mental Capacity Act and Mental Health Act are grounded in very different principles – patient autonomy and best interests v. paternalism and risk reduction – there is significant overlap in coverage of the two statutes. This undoubtedly leads to confusion about which regime to use in which situations.

Where a patient meets criteria for admission under Mental Health Act Sections 2 or 3 and objects to either admission or treatment, the Mental Capacity Act Schedule 1A states that the Mental Health Act should be used. The presence, or not, of objection therefore becomes an important factor in determining which statute to use. Unfortunately, the deprivation of liberty safeguards Code of Practice does not go so far as to define 'objection' in this context. To complicate matters further, any decision has to

<sup>†</sup>See editorial pp. 217–220, original paper pp. 221–225 and special article pp. 243–245, this issue.

be balanced with Mental Health Act guidance that advises, where possible, that the Mental Capacity Act should be used as a safe and effective (least restrictive) alternative to the Mental Health Act. This means that clinicians are offered little practical guidance to aid their judgements about whether individuals who lack capacity and need treatment for mental disorder are 'objecting'. Furthermore, the decision about which piece of legislation to use will be based on clinical judgement rather than clear legal definitions. There is concern that this will result in arbitrary decisions being made to treat individuals with the same condition under different detention regimes, leading to potential discrimination: precisely the situation that the judgment in *HL v. UK* (paragraph 79) wanted to avoid.<sup>5</sup>

### Deprivation of liberty as a positive intervention

Importantly, the Mental Capacity Act safeguards are also intended for use in general hospitals and, most widely, in care homes. It is in the latter environment that they may have their most positive effects. The deprivation of liberty safeguards process places emphasis on careful care planning, patients' best interests and the use of least restrictive options for delivering care or treatment. High staffing costs and a risk-averse culture have been obstacles to preventing such care in the past. However, it is to be hoped that the new legislation will trigger a shift in practice by encouraging well-considered care and treatment regimes.

Despite the uncertainties, the fact remains that it is now unlawful to deprive incapacitated patients of their liberty without using either the Mental Health Act or Mental Capacity Act detention regime. Clinical teams and care organisations now have no option but to address their use of risk-averse practices and become explicit about any need for restrictive measures that may amount to deprivation of liberty. It seems probable, given the cumbersome paperwork required to apply for a deprivation of liberty safeguards assessment, that the new legislation will result in increased Mental Health Act use in psychiatric hospitals. Recent case law has also suggested that where admission is for treatment of mental disorder and the patient is objecting, primacy should be given to the Mental Health Act – the patient's reasons for objection are not relevant for this purpose.<sup>14</sup> Therefore the interface between the two detention regimes is perhaps more clear-cut than previously thought. However, outside the psychiatric hospital setting, without the 'fallback' option of the

Mental Health Act, it will be difficult to delay changes that ensure restrictive practices are kept to a minimum. Where deprivation of liberty is necessary to provide care in the patients' best interests, it should now be seen as a positive intervention, with correct safeguards for the patient provided by the Court of Protection.

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