Safeguards for informal patients

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Who is an informal patient?

In light of the plethora of new provisions safeguarding patients who might previously have been cared for and treated informally, it may be instructive to consider who may now be considered a truly informal patient, i.e. one for whom neither process nor formality is needed.[2] When applied to an incapacitated patient requiring treatment for mental disorder, the word "informal" may now seem oxymoronic and possibly redundant. Can such a patient ever be truly informal? Part IV of the model statute suggests that an informal patient is one who lacks capacity and does not object to proposed treatment which is in their best interests, or a patient who may be treated without the use of compulsory powers; but even such a patient must now be subject to some formality if their care or treatment is to be long term or they are to be deprived of their liberty in order to ensure proper safeguards are in place.

Currently the boundary between the *Mental Capacity Act 2005* ("MCA") and *Mental Health Act 1983* ("MHA")[3] is essentially one determined by whether the patient objects to treatment and is defined with formidable complexity in schedule 1A to the MCA. A patient eligible for MCA deprivation of liberty ("DOL") safeguards, who could be an elderly person in long term residential care, is now subject to formal processes. There is little true informality for a patient lacking treatment capacity. It is questionable whether even a capacitated patient with mental disorder, who is by definition vulnerable, may be treated informally under the MHA[4] if they feel suborned into consenting by the possibility of coercion. The terminology offers a slightly deceptive impression of a benign approach with concomitant levels of autonomy, but while it is appropriate to highlight a difference from compulsory process and keep formality to a minimum for the sake of informality, it is also important not to overplay formality in the name of safeguards. The latter appears to be the vice in which the MCA and MHA is now arguably gripped.

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2 *Shorter Oxford English Dictionary definition is "not done or made according to a recognized form; irregular, unofficial, unconventional or without formality or ceremony..."*

3 *Both as amended by the Mental Health Act 2007*

4 *Section 131*

HL v UK (2004)[5]

The unpicking of informal status was achieved in *HL v UK* which set the benchmark for safeguards for informal patients and the trigger for legislative reform culminating in the introduction of the MCA DOL safeguards by the MHA 2007. It is worth recalling the facts of that case:

HL was diagnosed with learning disability and mood disorder. He was admitted for treatment under the provision of the *Mental Health Act 1983* for informal patients[6] having self harmed and was taken initially under sedation to A&E where he continued to be agitated and very anxious. However, he was compliant with medication and not attempting to leave and so was not detained under the MHA, nor placed on a locked ward, but he would have been detained had he tried to leave. This presumption in favour of informal admission and treatment was promoted by the Percy Commission whose recommendations founded the MHA 1959, although Percy did not envisage a deprivation of liberty in the case of informal patients.[7] HL was regularly sedated in hospital and healthcare professionals exercised effective power over him. The House of Lords[8] decided by a majority that HL was not in fact detained, but that in any event, and whether he was or not, he could be lawfully treated under the common law doctrine of necessity as an informal patient.

The violation of article 5(1) found in *HL v UK* was not so much about the lack of substantive criteria for informal patients in relation to the common law doctrine of necessity developed over the centuries (from as early as 1772)[9], than about an insufficiency of procedural rules which cast doubt as to whether the requirement of lawfulness aimed at avoiding arbitrariness was satisfied[10]. Particularly striking was the "lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted." A specific contrast with the MHA 1983 was made. In particular what is needed was identified as:

- A formalised admission procedure which identifies who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions
- The exact purpose of admission e.g. for assessment or treatment
- Limits in terms of time, treatment or care
- A continuing clinical assessment of the persistence of the disorder warranting detention
- The appointment of a representative of the patient who can make objections and application on the patient's behalf.[11]
- A regular review of the legality of any deprivation of liberty.[12]

Interestingly, the ECtHR also specifically acknowledged the government's concern to avoid the "full, formal and inflexible impact of the 1983 Act", and curiously it endorsed, in that spirit, the provisions contained in the MCA Bill as providing for "detailed procedural regulation of the detention of

5 *[2005]40 EHRR 32.*

6 *Section 131.*

7 *Royal Commission on the Law relating to Mental Illness and Mental Deficiency 1954–1957, Cmnd 169 discussed in R.Robinson, 'Amending the Mental Capacity Act 2005 to provide for deprivation of liberty', Journal of Mental Health Law May 2007 pp 25–40.*

8 *R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] AC 458.*

9 *Ibid at 118*

10 *Ibid at 119*

11 *Ibid at 120*

12 *Ibid at 123*

incapacitated individuals"[13]. Of course the Bill[14] as introduced in fact only permitted restrictions on liberty[15] and later expressly excluded restraint amounting to a deprivation of liberty under article 5(1) ECHR.[16] Nevertheless this is a clear indication that formality as in the MHA is not what is required. The government's response has been convoluted and the subject of much criticism for its intricacy and prolixity, particularly of the provisions of MCA schedules A1 and 1A.[17] The decision in *HL* suggests that this level of formality was most probably unnecessary. The model statute offers a more elegantly minimalistic set of provisions for incapacitated patients in long term care (over 28 days) and those deprived of their liberty in their best interests (see Part IV).

Model statute and liberty

Given the importance of personal liberty, article 5 requires that national law should be "sufficiently precise to allow the citizen – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail."[18] The model statute has a straightforward registration procedure which relies upon agreement between a doctor and approved practitioner that four conditions for the deprivation of liberty are met. This leads to the P being registered with an appropriate authority, triggering a care plan to be written by the responsible clinician. There is consultation with others, including a substitute decision maker, and access to a tribunal. There seems to be little to criticise in the simplicity this offers.

Registration: timing and responsibility

What is less clear from the model statute is when the registration procedure must commence and it is not clearly stated that it must be completed in advance of any deprivation of liberty actually occurring. It is a pre-requisite of the model that treatment is either already taking place in a hospital or care home, or that such treatment is necessary, and can be lawfully provided without compulsion and it is reasonably believed that P needs to be deprived of liberty in her best interests. The importance of prior authorisation was high-lighted by the Joint Committee on Human Rights[19] and by the court in *Sunderland City Council v PS and CA*[20] as a requirement under article 5(1).

Additionally, it is not clear by whom or how the registration procedure is to be triggered, or who carries the obligation to trigger it. Someone is required to have addressed their minds to three pre requisites before an approved clinician must examine P and be satisfied that the conditions for registration are met: a) a reasonable belief as to lack of capacity, b) a need for long term residence or deprivation of liberty and c) no need for any compulsion. Without more clarity in this procedure as to who bears this responsibility there must be room for 'professional lapses' of the kind from which *HL v UK* intended to offer protection.[21]

The reality may well be that the approved clinician or care home manager will be the person to keep this under review, but the obligation must surely be that of the managing authority who would otherwise be

13 *Ibid at 122*

14 *The MCA Bill was introduced into the House of Commons on 17 June 2004 and is discussed in HL at paras 77–78.*

15 *Clause 6(4)*

16 *Section 6(5) MCA which was repealed by the MHA 2007, ss 50(1), (4)(a) and 55, Sch 11 pt 10.*

17 *The Parliamentary Joint Committee on Human Rights report on the Mental Health Bill, fourth report of session 2006–7, February 2007 at para 90, and fifteenth report of session 2006–7, May 2007 at para 1.26; see also the preface to R.Jones 'Mental Health Act Manual' 2008 11th ed.*

18 *HL at 114.*

19 *Fifteenth report of session 2006–7 para 1.28 and fourth report para 83.*

20 *[2007] EWHC 623 at 23.*

21 *HL at 121, citing Lord Steyn from Bournewood above.*

responsible for an unlawful detention. It is possible to envisage a situation where a patient could fall through the procedural net because there is no consensus between members of a care or clinical team as to these pre conditions, or where a P who has been in long term care which commenced at a point in time when she was not incapacitated and had some restrictions voluntarily impose upon her because she was confined to her bed for a period of treatment, but which crossed the boundary into a deprivation of liberty with the worsening of a dementia or other similar illness. In such situations it would be left to a concerned family member or friend to intervene.

At this early stage the threshold for examination by an approved clinician must presumably be low. Even so the concepts under consideration are complex, inevitably raising the spectre of error with the consequence of patients remaining unlawfully detained for a period of time.

P objects

Assessing whether or not an incapacitated P objects, or is likely to object to treatment or care if she could, is not likely always to be straightforward. Active resistance by a constant demand or attempt to leave a place may be easy enough to evaluate. Less easy will be passive or inconsistently expressed resistance. The default setting may well be to treat this patient as complying, but any treatment administered under the general authority in clause 6 may not be lawful. The requirement to evaluate P's objections, and the difficulties that causes, arises under the MCA also when a decision is being made between treatment under the MCA or the MHA. The test of ineligibility for the MCA under schedule 1A is notoriously difficult to encapsulate briefly but it does necessitate an evaluation of whether the patient is objecting to being a mental health patient or treatment. So if the patient is refusing to comply with treatment for mental disorder then they may be detained and subject to compulsory treatment under the MHA if necessary. More difficult might be a situation where there is a reason to believe that the person would object if able to do so. The Addendum to the MCA Code of Practice says they must be treated as objecting (paragraph 4.46). The Addendum highlights the difficulties under that Act when treatment is for mental disorder, and particularly where a person is unable to communicate, or has limited communication ability (chapter 4).

Deprivation of liberty

Unlike the MCA the model statute defines "deprivation of liberty". The MCA provides guidance in the addendum Code of Practice. The model statute uses a simplified formulation: P is to be considered deprived of his or her liberty if a) s/he would not be permitted to leave the hospital or care home upon expressing a wish to do so or attempting to do so, **or** b) effective control is exercised over P's care and his or her freedom of movement is so confined as to amount to a deprivation of liberty (clause 18(2)).

This form of words is by now familiar from the cases of *HL* and *JE v DE*[22]. The classic definition of an article 5 deprivation of liberty in Strasbourg case law requires consideration of a range of factors which are variable depending on the individual circumstances. This is the well known *Guzzardi/Ashingdane*[23] formulation which considers the concrete situation of the individual, taking account of the type, duration, effects and manner of implementation of the measure in question.

22 *HL above at 91 and JE v DE and Surrey County Council [2007] 1 MHLR 39 at para. 117*

23 *HL at 89.*

The inclusion of a definition accepts criticisms made of the MCA amendments by the Parliamentary Joint Committee on Human Rights ('JCHR') and others (particularly JUSTICE)[24] on the grounds that deprivation of liberty is a less flexible and elusive concept than the government insisted. They argued that reliance on the Code of Practice was inadequate because it may be departed from for good reason. Further, a lack of certainty is a double edged sword promoting the twin dangers of over inclusion and over exclusion. Certainty protects fundamental rights and there is a costs and time saving benefit if protracted argument is avoided over what the case law means. The JCHR specifically endorsed the approach taken by Munby J in *JE* (above) where he held that the crucial issue is whether or not the person is "free to leave".

This is a simple concept to apply and likely to identify a true deprivation of liberty with little exception. It is not clear what the second limb at clause 18 (2) (b) in the model statue adds to this save for offering an alternative test which does not depend upon whether a person is free to leave or not. This addition may be tautologous and even circular, leading to confusion especially because this limb is also defined by reference to a deprivation of liberty.

Although the facts of *JE* and *HL* are quite different, neither was free to leave. HL was compliant and not asking to leave, yet he would have been prevented from leaving and detained under MHA criteria. But for his compliance he was potentially sectionable. Under schedule 1A MCA criteria, HL would be within the scope of the MHA (he was eventually sectioned), but he would have been still capable of being subject to MCA DOL safeguards because of his lack of objection (compliance).[25] He would remain in the same situation under the model statute, and so subject to DOL registration while in hospital. If his compliance with treatment had been in doubt, or his history of compliance poor or he had been asking or trying to go home, the clinician in charge would have no choice but to apply the MHA . Under the model statute the choice to be made is based on a unified set of criteria extended to take account of the issues of compliance and proportionality.

In *JE*, DE was repeatedly asking to go home but was not permitted to do so. If he had been compliant as HL was, then if he would have been prevented from leaving, or from being removed by family, then he would not be free to leave and need DOL safeguards. He was in a care home and so not detainable under the MHA. The model statute applies to both treatment and care in a hospital or a care home and so does not suffer this distinction which under current legislation has the potential to produce arbitrary and discriminatory results with regard to charges applied for after care.[26]

An attractive feature of a fused model would be that if DE was DOL registered in the care home but needed compulsory treatment for mental disorder, then that should be achievable without a change in registration and by the extension of existing procedures. Again the unified set of criteria would assist in streamlining this transition. A less attractive and new feature, however, would be that compulsory treatment could be employed for conditions other than mental disorder. For example, an incapacitated diabetic patient may well refuse insulin, necessitating frequent restraint for its administration. Under the Szmukler scheme a question arises as to whether this is achievable under the general authority or if it should be authorised as compulsory treatment?

24 *Fourth report of session 2006–7, para 84*

25 *See schedule 1A case scenario E.*

26 *Lucy Scott Moncrieff, 'Two Steps Forward, One Step Back' Journal of Mental Health Law May 2007 pp 107–114; and JCHR fourth report at 91.*

HM v Switzerland[27] is the case the government is fond of utilising in favour of an argument not found in other Strasbourg cases namely that an apparent deprivation of liberty in a person's best interests may in fact be no more than a restriction of liberty.[28] In that case HM was found not to be deprived of her liberty. This argument was firmly dealt with by Munby J in *JE* when he said it "would seem to lead to the absurd conclusion that a lunatic locked up indefinitely for his own good is not being deprived of his liberty. And if beneficent purpose cannot deprive what is manifestly a deprivation of liberty of its character as such, why should beneficent purpose be of assistance in determining whether some more marginal state of affairs does or does not amount to a deprivation of liberty?"[29] The House of Lords recently revisited this argument, this time in the context of crowd control at a May Day rally in central London *(Austin v Commissioner of Police of the Metropolis)*[30]. Their Lordships decided that article 5 was not engaged at all because the detention (now known as 'kettling') of the crowd was in their collective best interests and the police were acting in good faith. The logical inconsistency highlighted by Munby J (above) is abundant in this approach which arouses questions regarding the need for any mental health legislation or DOL safeguards whatsoever.[31] A petition in *Austin* has been lodged with the ECtHR[32] and one can only hope that the court will re-establish some clarity around this definition.

Treatment safeguards

Although not required by the ECHR, a continuing disappointment with the MCA is that there are no treatment safeguards by way of supervision and review of treatment of serious one-off or ongoing treatments, for those incapacitated patients complying with treatment. The MCA relies on the protective effect of consultation with family and friends, or in their absence an IMCA to cover this deficit. There are no checks on serious medical treatment such as ECT also, or the long term use of psychotropic medication for mental illness which may be authorised under section 5 MCA.

The model statute provides specific safeguards for serious medical treatment (including ECT, medication for mental disorder beyond a three month period and other treatments to be defined by regulation) (part III) which broadly accord with those developed under part IV of the MHA. The provisions apply to every person receiving care or treatment under the Act or receiving treatment authorised by a substitute decision maker or tribunal. The safeguards therefore apply not only to those who are DOL registered or subject to compulsion, but also to patients in long term care or being treated under the general authority. They consist of consultation with P where practicable, the primary carer, the substitute decision maker or, where there is none, a suitable person appointed by the tribunal. In the event of disagreement, an approved doctor is to provide a second opinion, and may be instructed in any event where serious treatment is proposed by the primary carer, the substitute decision maker or an advocate. Persistent disagreement will be referred to the tribunal for a determination (clause 10(3)). MHA safeguards appear to go further for those lacking capacity to consent if medication is to be administered beyond three months: the second opinion doctor must consult with two people who have been concerned with the patient's medical treatment before issuing a certificate (section 58(4) MHA).

27 *(2002) 38 EHRR 314*

28 *HM (above) at para 48.*

29 *JE (above) at para 47, adopting somewhat unfortunate terminology.*

30 *Austin v Commissiner of Police of the Metropolis [2009] UKHL 5, per Lord Hope at paras 34 and 37, reigned in by the 'footnote' opinion of Lord Walker (43–4).*

31 *D.Hewitt, 'Whose liberty?' Solicitors Journal, 17/2/09.*

32 *This has been confirmed by junior counsel acting for Austin.*

The test to be applied by the second opinion doctor or tribunal is not set out in the model statute but must by default be the best interests of the person as a general requirement of the statute. This is probably sufficient within article 8 ECHR and the requirement for a "procedure prescribed by law". Under the proposals for informal patients compulsion will not be an issue, but proper understanding of the P's level of understanding when offering compliance would be, so that P is not mistakenly treated against her will. This brings one back to the issue of assessing what passivity amounts to in the context of an objection (see above). A beneficial extra precaution would be for the second opinion to re assess the patient's capacity to consent to the proposed treatment. But a difficulty with the provisions as currently drafted is that there will only be a second opinion in the event of a disagreement with a carer or similar person. In this regard the MHA safeguards in section 58 appear much stronger for a compliant incapacitated patient.[33]

The decision in *Storck v Germany*[34] emphasising the State's positive obligation to protect physical integrity under article 8 requires remedies that are prospective and not just retrospective. The model statute's provision of access to a tribunal probably takes account of that requirement.

Discussion

Subject to aspects of detail, the overall scheme in the model statute has an appealing simplicity which demonstrates that concepts of capacity and best interests as we know them are capable of founding the care and treatment of compliant incapacitated patients so that differences between mental and physical disorder are kept to a necessary minimum. The ECHR does tolerate differences of treatment if justified.[35] Some fine tuning is required, for example, there is no provision for taking and conveying a compliant patient. This point exercised the JCHR in relation to a similar absence in the MCA. This need acknowledged the situation where it was known that a person was being taken from their home into a deprivation of liberty which therefore was a continuation of the detention begun at home.[36]

Further, the potential for compulsory treatment other than for mental disorder, e.g. the insulin dependent diabetic patient referred to above, may need a degree of cultural adjustment in clinical practice.

33 *The need for strong protections of compliant incapacitated patients deprived of liberty under article 5 on the basis of the decision in HL and by parity of reasoning under article 8 for interferences with physical integrity, was highlighted by the JCHR, Fourth Report of session 2006–7 (above), para 96.*

34 *Appl no. 61603/00, 16 June 2005, at 150.*

35 *In Price v UK (2002) 34 EHRR 1, a four limb deficient thalidomide woman was held in a prison cell with no special facilities. She should have been treated differently to normal prisoners. Her treatment violated article 3.*

36 *Above, Fourth Report at 88–89.*