



UNIVERSITY OF  
CAMBRIDGE

## CEL7 Mental Ill-health: Legal & Ethical Issues

### Overview

Last year, in the unit on Consent, Capacity & Best Interests, we considered the balance between the principles of *beneficence* and *respect for autonomy*. This unit covers the application of those general legal and ethical principles to the special situations that arise around the medical care of people who may have a mental disorder. Mental ill-health may impair decision-making capacity, although many people experiencing a mental disorder will have no such impairment. When patients have impaired decision-making ability, relatively greater weight is given to the principle of beneficence, although this does not mean that the wishes and feelings of the patient can be disregarded altogether. Paternalism, interfering with a person, against their wishes, on the grounds that the interference is for the person's own good, may be part of psychiatric practice. This takes place within two legal frameworks: the Mental Capacity Act 2005 and the Mental Health Act 1983, as amended 2007.

### Objectives

Students should be able to:

- Describe the ethical, legal and professional implications of the care of patients with mental illness (2, 2l, 4, 5a, 6a, 6d, 6f, 7, 7e, 14b, 14c, 14g, 16, 17b, 18, 22e, 23, 24)
- Assess the ethical implications of a diagnosis of mental illness for the patient and those close to them, and the social and cultural influences on mental health diagnosis (24)
- Identify the key components of mental health law and discuss the justifications used for compulsory detention, restraint and treatment (4, 7g)
- Distinguish between the appropriate use of mental capacity law and mental health law in medical practice (4, 7e, 7g, 7i)

The objectives for this unit are taken from the mental health section of the 2019 Consensus Statement on Learning Outcomes for UK medical students, published by the Institute of Medical Ethics in conjunction with all UK medical schools and the GMC. The numbers in brackets indicate the sections of Outcomes for Graduates (GMC, 2018) covered by that objective.

## 1. Ethics of psychiatric diagnosis

The strength of our justification for compelling someone to receive psychiatric treatment depends upon the degree to which we can be sure that they have an illness **and** the degree to which we can be sure that we should interfere with the liberty of another person when they are ill. One of the ethical challenges of psychiatry is dealing with the issue of subjectivity in diagnosis. How can we justify intervening in the lives of our patients, in order to make them better, if we can't say for certain that they are ill?

### Psychiatry and the fact/value distinction

In general medicine, most conditions can be classified on the basis of aetiology (e.g. meningococcal meningitis) or structural pathology (e.g. Berry aneurysm). The diagnosis is based on verifiable, reproducible data, so disagreement is not rational. Only a few conditions are not classifiable in this way and must be classified on the basis of symptoms. These conditions are called syndromes (e.g. migraine).

In psychiatry, whilst a few conditions do have a clear physical pathology (e.g. Alzheimer's Disease) most conditions must still be classified on the basis of symptoms and behavioural signs, many of which are located on a spectrum that includes normal experiences and behaviour (e.g. manic – happy – sad - depressed). The diagnosis is based upon opinions, evaluations and beliefs, and there is scope for legitimate disagreement. Two opposing models attempt to explain the apparent shortage of facts in psychiatry, compared with the rest of medicine: the medical model and the anti-psychiatry model.

**Medical Model:** The underlying assumption of biological psychiatry is that psychiatric disorders are caused by dysfunction in the brain. The reason that we cannot yet classify most psychiatric conditions according to aetiology or pathophysiology is simply that neuroscience has not yet progressed far enough for us to identify all of the underlying pathology of mental disorder. For example, now that we have identified the underlying pathology in Alzheimer's Disease, we can say for sure whether or not someone had the condition. When we understand the pathology of depression and schizophrenia, we will be able to develop tests to say for sure whether people have those conditions

**Anti-psychiatry:** The underlying assumption of the anti-psychiatry movement is that psychiatry is fundamentally different to physical medicine because diagnosis has no factual basis - it is an evaluative process. Holding irrational beliefs is something that human beings do (think about the last time one of your friends fell in love – they probably believed that the object of their affections was a near-perfect specimen of humanity, that they were destined to meet, that this person was 'the one' etc. and yet you may have had your doubts about them...) Can people who hold irrational beliefs be validly and reliably labelled as ill?

## **A compromise position: Values Based Medicine**

Bill Fulford argues that, in comparison to physical medicine, psychiatry is more *obviously* value laden because:

- The values in physical medicine are widely shared e.g. pain, nausea and paralysis are undesirable, hence the evaluations that we make often appear to be objective facts
- The values in psychiatry are more diverse, concerned with motivation, desire, affect and belief – so there is more room for disagreement.

Proponents of VBM argue that we should recognise this. The ‘medical’ model overemphasises the factual element of psychiatric diagnosis and the ‘anti-psychiatry’ model overemphasises the evaluative element. Good practice depends on an awareness of both perspectives, and the payment of attention to the values of patients as well as the values of professionals. The 10 features of VBM are outlined below:

**AWARENESS:** being aware of the values in a given situation

**REASONING:** thinking about values when making decisions

**KNOWLEDGE:** knowing about values and facts that are relevant to a situation **COMMUNICATION:** using communication to resolve conflicts/complexity

**USER CENTRED:** considering the service user’s values as the first priority **MULTIDISCIPLINARY:** using a balance of perspectives to resolve conflicts

**THE ‘TWO FEET’ PRINCIPLE:** all decisions are based on facts and values; evidence-based practice and values-based practice therefore work together

**THE ‘SQUEAKY WHEEL’ PRINCIPLE:** values shouldn’t just be noticed if there’s a problem

**SCIENCE AND VALUES:** increasing scientific knowledge creates choices in health care; this can lead to wider differences in values

**PARTNERSHIP:** in values-based practice, decisions are taken by service users working in partnership with providers of care

For patients, receiving a diagnostic label can be: a relief, an explanation of events, a route into treatment and, in some cases, a defence against being held responsible for behaviour that may not be under the patient’s control. On the other hand, it may also result in: stigmatization and loss of autonomy rights, and discourage the use of ‘non-medical’ coping strategies. Given the risks and benefits of diagnosis, and the fact the patient cannot give or withhold consent to being labelled that (unlike the requirement for consent for investigation and treatment), the process should be treated with due care and respect. The process of diagnosis in psychiatry has a powerful moral component.

## 2. Detention & restraint: Legal issues

'No adult citizen of the United Kingdom is liable to be confined in any institution against his will, save by authority of law. That is a fundamental constitutional principle, traceable back to Ch. 29 of Magna Carta 1297... [Mental health patients] present a special problem since they may be liable, as a result of mental illness, to cause injury either to themselves or others. But the very illness which is the source of the danger may deprive the sufferer of the insight necessary to ensure access to proper medical care... Powers therefore exist to ensure that those who suffer from mental illness may, *in appropriate circumstances*, be involuntarily admitted to mental hospitals and detained'

Sir Thomas Bingham MR in *Re S-C* [1996] 1 All ER 532 CA

It is not just Magna Carta that grants adults in the UK the right to freedom from unjustified detention. The UK, and its institutions (including the NHS and Social Services) must respect the rights held by citizens under the European Convention on Human Rights (ECHR), and UK law (including mental health and mental capacity legislation) must be consistent with those rights, and the rulings of the European Court of Human Rights (ECtHR). In this context, we must be aware of the rights granted by Article 5 of the ECHR – the right to liberty and security.

*Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:*

*a. ....*

*e. the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;*

*f. ....*

The right to liberty is not absolute. People may be deprived of their liberty on one of the grounds laid out in clauses a-f. Clause e means that UK citizens may be detained on the basis of 'unsoundness of mind', provided that the detention is consistent with the UK's legal framework. The wide power to detain people on grounds of unsoundness of mind is subject to limits specified in the case of *Winterwerp v the Netherlands* (1979):

1. There must be objective medical evidence of a true mental disorder presented
2. The mental disorder must be of a nature or degree warranting confinement
3. There must be periodic review of the continued need for detention

To these must be added a fourth principle, that detention must be a proportionate response to the circumstances (*Litwa v Poland*).

In summary, people may only be deprived of their liberty provided that this is a necessary and proportionate response to a mental disorder, authorised and regulated by a statutory framework. In the UK, we have several statutory frameworks covering this area of medical practice, including laws which have been enacted but are yet to be implemented at the time of writing (September 2019). In England & Wales, there are two frameworks: the Mental Health Act 1983 (as amended by the Mental Health Act 2007) and the Mental Capacity Act 2005, as amended by the 2007 Deprivation of Liberty Safeguards (MCA-DoLS). The MCA-DoLS are set to be replaced by new Liberty Protection Safeguards in Spring 2020.

Scotland also has two frameworks: the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) Scotland Act 2003, (as amended by the Mental Health (Scotland) Act 2015, which came into effect in June 2017), under which 'significantly impaired decision-making as a result of the mental disorder' (SIDMA) is a criterion for compulsion.

In Northern Ireland, the Mental Capacity Act (Northern Ireland) 2016 is set to be implemented in 2020, although this may be delayed by the current absence of a devolved government in NI. This is an innovative piece of legislation that will 'fuse' mental health and mental capacity legislation. Currently, mental health practice in NI is regulated by the Mental Health (Northern Ireland) Order 1986.

This unit will focus on the law of England and Wales, where you will undertake your clinical placements in psychiatry and where most of you will begin your medical careers. If you practice in other jurisdictions, you must familiarise yourself with your legal responsibilities and the rights of your patients where you are working.

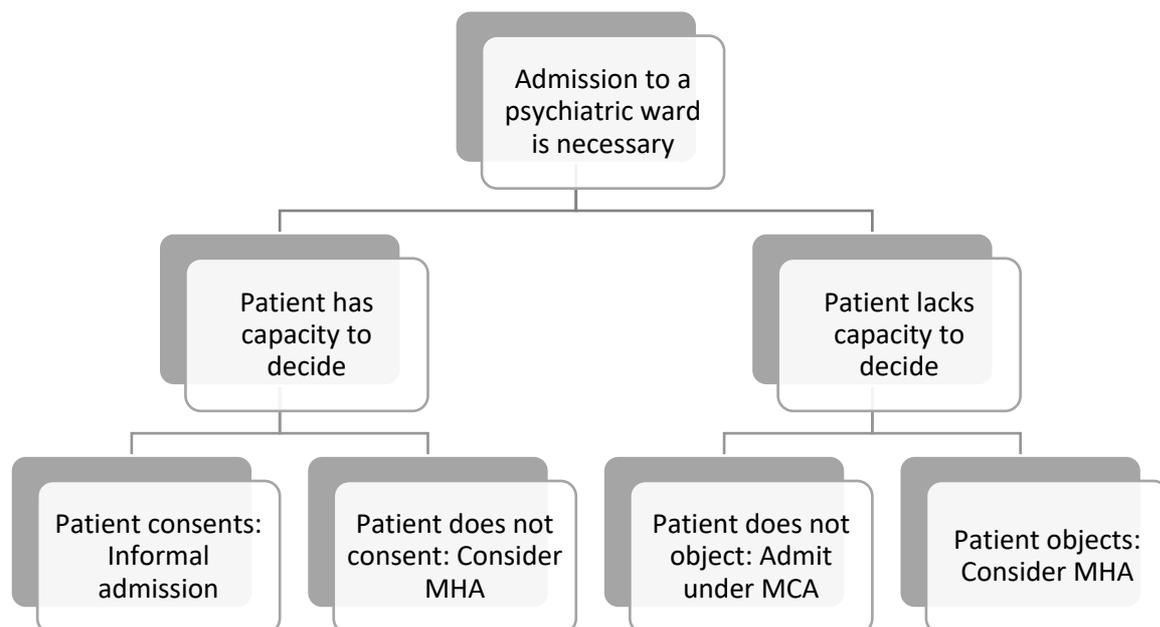
## Detention under the MHA – Civil Detention

The MHA gives various groups of people powers to detain people for the purposes of assessing and/or treating mental disorders. Here are some of the powers to detain that you might see in use:

- S2 Admission for assessment (or assessment followed by treatment)
- S3 Admission for treatment
- S4 Admission for assessment in cases of emergency
- S5(2) and 5(4) Application in respect of a patient already in hospital
- S136 Mentally disordered persons found in public places
  
- S35 Remand to hospital for report on accused's mental condition
- S36 Remand of accused person to hospital for treatment
- S37 Power of courts to order hospital admission or guardianship

You need to understand how they apply in practice – who can use the power to detain, and under what circumstances.

**Informal admission** is less restrictive of the patient's liberty than detention under the Mental Health Act and should be used where possible. There is a presumption of capacity, and lack of capacity is established using the test laid out in the Mental Capacity Act. If a patient with-holds consent (or lacks the capacity to give consent and objects to admission and/or treatment), consider whether the criteria for detention under the Mental Health Act apply



**Section 2** is used to detain patients for up to 28 days for the purpose of assessment. This can include assessment of response to treatment. An application can be made prior to admission to hospital, or during a voluntary admission (if a patient withdraws consent).

Criteria for detention under s2 are that the patient

- 1) *is suffering from a mental disorder* (it is enough that he or she is exhibiting symptoms or signs of mental disorder, firm diagnosis is not needed as the purpose of admission at this stage is for assessment),
- 2) *of a nature or degree which warrants detention for assessment* (degree refers to the current symptoms and their severity, nature refers to course of the patient's illness and factors such as the likelihood of relapse in the absence of treatment),
- 3) *in the interests of the patient's health* (e.g. by working out what is causing the symptoms and starting effective treatment) *or safety* (e.g. by preventing serious self-harm or neglect whilst assessment is completed and treatment instigated) *or to protect others* (e.g. preventing aggressive behaviour whilst assessment is completed and treatment instigated).

Detention under s2 admission cannot be extended beyond 28 days – once that period has expired the patient must either be discharged from hospital, remain as a voluntary patient, or be detained under s3.

**Section 3** is used to detain patients for the purpose of treatment. An application can be made prior to admission to hospital, during a voluntary admission (if a patient withdraws consent), or following a period of assessment under s2.

Criteria for detention under s3 are that the patient

- 1) *is suffering from mental disorder* (this includes any mental or behavioural disorder, with two important exceptions: detention cannot be authorised on the basis of a sole diagnosis of dependence of alcohol or drugs, or on the basis of a sole diagnosis of learning disability unless it is accompanied by 'abnormally aggressive or seriously irresponsible conduct')
- 2) *of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital* (so a patient with a well-established relapse pattern could be detained on the grounds of nature alone when early warning signs appear, even if the episode is not yet severe, or a patient who has just entered remission as a result of a period of compulsory treatment could remain detained if this is necessary to maintain treatment needed to prevent relapse);
- 3) *it is necessary for the health or safety of the patient or for the protection of other persons that they should receive such treatment* (to treat symptoms, prevent further deterioration, or prevent harm to self or others)
- 4) *and the necessary treatment cannot be provided unless they are detained* under this section (if community-based treatment would manage the risks, or if informal admission is possible, these options should be taken);
- 5) *and appropriate medical treatment is available* (this is defined as treatment aimed at alleviating symptoms or preventing deterioration, there is no requirement to establish that it is likely to be effective, or that the patient is engaging with the treatment. Treatment is defined broadly and includes all aspects of multi-disciplinary care.)

A s3 admission can be renewed if, after six months, the patient still meets criteria for detention.

No one can be detained under s2 or s3 unless they have been examined by two doctors who both complete the necessary forms giving their reasons for believing that the patient meets the relevant criteria for detention. One of the doctors must have received prior approval under s12 MHA, certifying that he or she has particular knowledge and expertise in the assessment or treatment of

mental disorder. The second doctor need not have s12 approval – and does not need to be a psychiatrist. Ideally, at least one of the two doctors should have previous knowledge of the patient e.g. as their GP.

An Approved Mental Health Practitioner (AMHP) who is not a doctor must also meet the patient and discuss the case with the Nearest Relative. If the AMHP accepts the two medical recommendations for admission, they can then apply for the patient to be admitted and convey them to hospital.

In cases of 'urgent necessity' an AMHP may make an emergency application for admission under **section 4** founded on only one medical recommendation, which must be made by a s12 approved doctor. This authorises detention for 72 hours, enabling the patient to be admitted to a mental health unit and cared for whilst arrangements for assessment for detention under s2 or s3 are made.

**Section 5** is used if a patient has already been admitted to hospital informally but then withdraws consent or, if they lack capacity, shows signs of objection. It provides emergency holding powers which justify restraining the patient from leaving, enabling time for a full assessment for detention under s2 or s3.

S5(2) 'doctor's holding powers' authorise the hospital to detain the patient for up to 72 hours if it appears to the approved clinician in charge of the treatment (the patient's consultant or, if they are off-duty, his or her 'named deputy' – usually the resident on-call psychiatrist) that *an application ought to be made under this Part of this Act for the admission of the patient to hospital, usually on the grounds that the patient is likely to leave if they are not detained.*

S5(4) 'nurse's holding powers' authorise the hospital to detain the patient for up to six hours if it appears to a suitably qualified nurse that that the patient is *suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital* and that it is not practical for the patient's consultant (or his or her nominated deputy) to attend immediately to make an application under s5(2).

A patient being assessed or treated in the Emergency Department (A&E) *cannot* be detained under s5, because they have not officially been admitted to hospital. If they cannot be prevented from leaving, and you have concerns about their health or safety, or the safety of others, then you *must* make arrangements with community MH services, their GP or the police to ensure that they are followed up urgently.

**Section 136** grants the police the power to detain people who appear to be suffering from a mental disorder and to be in need of immediate care and control, in a place of safety, for up to 24 hours (extendable to 36 hours, by a doctor, for medical reasons only).

A Police Constable must, **if it is practicable to do so**, consult a doctor, nurse or AMHP before exercising this power. The power can be exercised anywhere other than:

- Any house, flat or room where that person, or any other person, is living, or
- Any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.

For the purpose of exercising this power, the Police Constable can enter any place where the power may be exercised **by force**.

The MHA defines a Place of Safety as:

- Residential accommodation provided by social services
- Hospital (emergency department or a purpose-built s136 suite)
- Police Station

Police stations must **never** be used for under 18's.

Police stations can only be used for adults **in exceptional circumstances**.

- Can use a person's home as a Place of Safety if the occupier(s) agree.

Outcomes may be that the person is released from custody and either goes home or goes to hospital voluntarily, that they are transferred to a general hospital (if, for example, they have a medical condition such as hypoglycaemia, head injury or acute alcohol withdrawal that has manifested as behavioural disturbance), or that a Mental Health Act assessment is arranged.

### **Detention under the MHA – Criminal Justice System**

In addition to the powers to detain granted under the civil section of the MHA, there are some equivalent powers available to the courts, for people charged with or convicted of a criminal offence for which the punishment could include imprisonment.

**S35** applies to people awaiting trial or sentencing before the Crown Court, or awaiting sentencing before a magistrates' court, (or if the magistrates' court is satisfied that the person did the criminal act he or she is accused of or the person consents to the magistrates' court exercising its powers under s35). The Court may remand the person to hospital for periods of up to 28 days at a time, for up to 12 weeks in total, to enable a psychiatrist to prepare a report on that person's mental condition. *S35 is similar to s2 for remand prisoners.*

**s36** applies to people awaiting trial or sentencing before the Crown Court. Instead of remanding the person to custody, the Court may remand that person to hospital for treatment., for periods of up to 28 days at a time, for up to 12 weeks in total. The Court can make this order on the evidence of two doctors that the person 'is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him.' *s36 is similar to s3 for remand prisoners.*

**S37** applies to people who have already been convicted. The court may authorise detention in hospital, provided it 'is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder and that... the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; ... and the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section'. *S37 is similar to s3 for convicted prisoners.*

If further restrictions are necessary, in order to protect the public from serious harm, **s41** grants the Crown Court the powers to make a 'restriction order' in addition to a s37 'hospital order'. The effect of a restriction order is to restrict discharge from hospital, and gives the Secretary of State powers concerning the granting of leave and discharge from hospital.

## **MCA Deprivation of Liberty Safeguards & Liberty Protection Safeguards**

As you learned in the workshop on Consent, Capacity & Best Interests, the Mental Capacity Act states that if a patient, as a result of a disorder or dysfunction of the mind or brain, lacks the capacity to make a decision about hospital admission or medical treatment for themselves, then the decision should be made on their behalf, acting in their best interests.

Under the MCA, restrictions and restraint, including restraint that restricts the person's freedom of movement, are lawful (under s. 6), provided that it is believed to be both 'necessary', and that it is proportionate to (i) the risk of the person coming to harm; and (ii) the severity of that harm. However, some informal patients treated under the MCA may be subject to more onerous restrictions or restraint, which amount to a 'deprivation of liberty'. According to case law, a deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave (regardless of whether or not they ever express a wish to leave – *P v Cheshire West*), and the person lacks capacity to consent to these arrangements'. This group of men and women are very vulnerable because they lack the capacity to give consent to their admission to hospital and/or their treatment there and may be unlikely to challenge the limitations placed on their freedom. However, unless they are detained under the MHA, they do not have access to the MHA's well-established system of safeguards, including Second Opinions (see next section), appeals and, if they do not appeal, automatic referral to Managers Hearings and Tribunals.

There are three groups of adults who lack capacity and who may be subject to a deprivation of liberty but who do not meet criteria for detention under the MHA:

- 1) People affected by a mental disorder that is impairing capacity (such as dementia or a learning disability accompanied by 'seriously irresponsible behaviour') receiving care that involves continuous supervision and control in a setting other than a hospital (such as a nursing home or 24hr supported accommodation). The MHA can only be used to authorise detention in hospital.
- 2) People receiving hospital-based care or treatment involving continuous supervision and control, for a condition which is not a mental disorder within the meaning of the MHA, but who also have a mental health condition which impairs their capacity to consent to the care arrangement and which necessitates continuous care and control (e.g. a person with dementia being treated for a physical health condition in a general hospital, who is disorientated in this environment and would wander off if unsupervised). The MHA only authorises detention for the assessment or treatment of a mental disorder, as defined within the Act.
- 3) People receiving hospital-based care or treatment involving continuous supervision and control, for a mental disorder that is impairing capacity, for whom detention under the MHA is not necessary because they do not object to the admission or to any aspect of the treatment. The MHA Code of Practice recommends that this group of patients should not be detained under the MHA.

In a landmark case, the European Court of Human Rights in *HL v UK* (the Bournwood case) ruled that the absence of procedural safeguards and access to appropriate review under this framework violated article 5 of the European Convention on Human Rights (the right to liberty).

The case concerned L, a man with severe autism and learning disability, who was unable to communicate verbally. He lived with carers in an 'adult foster placement' and attended a Day Centre. Whilst at the Day Centre, he was admitted to psychiatric hospital, due to behavioural difficulties. He did not have capacity to make his own decision about admission, but he did not object or try to leave, so the treating team made the decision on his behalf. As these events occurred before the MCA 2005 was enacted, L was admitted under the common-law justification of

‘necessity’; if the same set of circumstances arose today, admission would be on the grounds of best interests, as defined in the MCA. L’s foster family wanted him to return to their care, but the hospital restricted their access to him and the consultant responsible for L’s care did not agree to discharge. L was effectively detained in hospital for a long period without any external review of the appropriateness & proportionality of this arrangement. L’s foster father had to challenge the detention through the courts, all the way to the ECtHR in Strasbourg.

The ECtHR ruled that the situation faced by people who lacked capacity to take their own discharge, but who were not detained under (and therefore protected by the safeguards associated with) the MHA amounted to an infringement of the right to liberty.

The MCA Deprivation of Liberty Safeguards were enacted in 2007 in order to safeguard the personal autonomy (including the right to liberty and security of person) of people in this situation, to ensure that they were subject to the minimum restriction necessary. However, this framework has proved complex and difficult to apply. Under the Mental Capacity (Amendment) Act 2019, a new framework has been agreed.

At the time of writing (September 2019), the MCA Deprivation of Liberty Safeguards (DoLS) remain in law. However, they are due to be replaced with the impending implementations of the new Liberty Protection Safeguards (LPS), scheduled for implementation in 2020. This unit will focus on the new safeguards, on the grounds that they are likely to be implemented by the time you qualify.

According to the Social Care Institute for Excellence (SCIE), key features of the Liberty Protection Safeguards (LPS) include:

1. They apply to people aged 16 years old and over.
2. There is no statutory definition of a deprivation of liberty beyond that in the Cheshire West and Surrey Supreme Court judgement of March 2014: *Is the person subject to continuous supervision and control?* and *Is the person free to leave?* – with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave
3. Deprivations of liberty have to be authorised in advance by the ‘responsible body’. For NHS hospitals, the responsible body will be the ‘hospital manager’. For arrangements under Continuing Health Care outside of a hospital, the ‘responsible body’ will be their local CCG (or Health Board in Wales). In all other cases – such as in care homes, supported living schemes etc. (including for self-funders), and private hospitals, the responsible body will be the local authority.
4. For the responsible body to authorise any deprivation of liberty, it needs to be clear that: a) The person lacks the capacity to consent to the care arrangements; b) The person has a mental disorder; c) The arrangements are necessary to prevent harm to the cared-for person, and proportionate to the likelihood and seriousness of that harm.

5. In order to determine this, the responsible body must consult with the person and others, to understand what the person's wishes and feelings about the arrangements are.
6. An individual from the responsible body, but not someone directly involved in the care and support of the person subject to the care arrangements, must conclude if the arrangements meet the three criteria above (lack of capacity; mental disorder; necessity and proportionality).
7. Where it is clear, or reasonably suspected, that the person objects to the care arrangements, then a more thorough review of the case must be carried out by an Approved Mental Capacity Professional.
8. Where there is a potential deprivation of liberty in a care home, the Act allows care home managers – if the local authority felt it was appropriate - lead on the assessments of capacity, and the judgment of necessity and proportionality, and pass their findings to the local authority as the responsible body
9. Safeguards once a deprivation is authorised include regular reviews by the responsible body and the right to an appropriate person or an Independent Mental Capacity Advocate to represent a person and protect their interests.
10. As under DoLS, a deprivation can be for a maximum of one year initially. Under LPS, this can be renewed initially for one year, but subsequent to that for up to three years.
11. Again, as under DoLS, the Court of Protection will oversee any disputes or appeals.
12. The new Act also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation.

### 3. Compulsory psychiatric treatment: ethical & legal issues

#### Mental Capacity Act

If a patient has not been detained under the Mental Health Act, the framework that you learned about in CEL 3 (Consent, capacity and best interests) applies, even if the proposed treatment is for a mental disorder.

As a quick reminder, this means that the framework for psychiatric treatment in the community, in A&E, or during informal admission to hospital is:

- If the patient has capacity to make their own decision, this must be respected. Treat on the basis of consent, and do not treat if consent is not given.
- If the patient lacks the capacity to make this decision, follow the framework laid out in the MCA. If treatment is in the patient's best interests, it should be provided unless there is a valid and applicable Advance Decision to Refuse Treatment.

If restraint is necessary to administer the treatment (e.g. if IM medication for rapid tranquilization is required) consider whether the treatment and restraint combined are in the patient's best interests, whether they are necessary, and whether this is proportionate to (i) the risk of the person coming to harm; and (ii) the severity of that harm.

Bear in mind also that, even for patients detained under the MHA, the authorisation for some aspects of their treatment may come from the MCA. Medical treatment for conditions unconnected to the medical disorder (e.g. amputation of a gangrenous limb, caesarean section in a complicated pregnancy, to take two examples from case law) cannot be authorised by the MHA. Either the patient must consent or, if they lack capacity to consent, the framework laid out in the Mental Capacity Act must be followed.

## **Mental Health Act**

As a general rule, once a patient is detained under ss2, 3, 35, 36 or 37 of the MHA, consent is not required for the administration of psychiatric treatment. The justification for treatment is provided by s63 MHA which states:

The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering... if the treatment is given by or under the direction of the approved clinician in charge of the treatment.

NB: s63 does NOT apply to patients subject to emergency holding powers (ss 5(2), 5(4), 4, 136). Consent or the MCA provide the only justifications for treating those patients.

What kinds of treatment are covered by s63?

Some forms of psychiatric treatment are excluded under ss 57, 58 & 58A (see below). Apart from those, all forms of medical treatment for mental disorder are covered. 'Medical treatment' is defined in s145:

In this Act, unless the context otherwise requires—  
"medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.

The meaning of medical treatment for mental disorder has been developed in relevant case law. Besides obvious examples (e.g. anti-psychotic medication for schizophrenia), it includes a) treatment for underlying conditions that are causing a mental disorder (e.g. treating hypothyroidism that is causing depression or cognitive impairment) and b) treatment for the physical consequences of mental disorder (e.g. NG feeding to treat malnourishment caused by anorexia nervosa, administration of an antidote after an episode of self-poisoning). Treatment also includes nursing interventions such as 'safe holds' and physical control and restraint, when these are necessary.

**Seclusion** is defined in the MHA Code of Practice as: ‘The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others’.

Seclusion should not be used solely to manage self-harm. If seclusion is necessary, a dedicated room must be used. It should only be used for detained patients – if it becomes necessary for an informal patient, a MHA assessment must be convened as soon as possible. A member of staff should be in sight at all times. A doctor must review the patient within one hour of seclusion commencing, and every four hours while it continues. Nursing observations should be attempted every 15 minutes, and a nursing review by at least two nurses conducted every two hours. Seclusion must end when it is no longer warranted.

**Long-term segregation**, where a patient is not confined to one room, but is kept apart from other patients, is sometimes necessary to prevent harm to others. If segregation is used, the safeguarding team must be informed, the patient must be reviewed daily, and an external hospital must review the case if segregation is used for longer than three months.

**Second Opinion Approved Doctors (SOADs)** are experienced consultant psychiatrists who visit hospitals where they do not normally work in order to review treatment plans for patients whose treating teams wish to treat under the provision of ss 57 & 58 of the MHA (medication administered for longer than three months, ECT and more invasive treatments). A SOAD will speak to the patient, review the notes, consult with the patient’s consultant, a nurse and an allied health professional involved in the patient’s treatment. If the SOAD is satisfied that the proposed treatment is appropriate, then he or she will complete a form to authorise the treatment.

**Psychosurgery** is a rarely used form of treatment, provided in highly specialised centres for conditions such as severe, intractable depression or severe, intractable OCD. If such surgery is performed on an informal patient, consent is obviously required. If it is performed on a patient who is detained under the MHA, s57 states that consent is still required *and* the treating team must obtain SOAD authorisation. In summary, *consent and the authorisation of a SOAD are required for psychosurgery.*

**Electro-convulsive therapy** also has additional safeguards, laid out in s58A. Before prescribing ECT for adult detained patients, the consultant responsible must assess capacity.

Refusals of patients with capacity must be respected.

If the patient has capacity and consents to ECT, the consultant must complete a certificate to record this.

If the patient lacks capacity, the consultant must refer the patient to a SOAD. The SOAD will follow the same procedures as described above (review patient and treatment plan, discuss the case with a nurse and an allied health professional) and will authorise treatment if he or she agrees that a) the patient lacks capacity, and b) ECT is appropriate in this case, and c) there is no valid Advance Decision to refuse ECT, and d) no valid decision made by the donee of a LPA, a deputy appointed under the provisions of the Mental Capacity Act, or the Court of Protection (all of whom have the power to rule that ECT should not proceed if they hold the opinion that it would not be in the best interests of the patient).

Note that normally, the authorisations for treatment provided by the MHA trump the powers to refuse treatment provided by the MCA. ECT is a special case where the relative powers of the MHA

and MCA are reversed and the MCA trumps the MHA.

ECT cannot be administered to detained patients under the age of 18, unless they consent and a SOAD authorises the treatment by certifying that the patient has capacity and that the treatment is appropriate.

*In summary, for adult detained patients, ECT requires consent or the authorisation of a SOAD. Authorisation may be granted only if the patient lacks capacity, and treatment is appropriate, and there is no valid AD or proxy decision to refuse ECT. For detained patients under 18, ECT requires consent and the authorisation of a SOAD. Authorisation may be granted only if the patient has capacity, and treatment is appropriate.*

**Treatment with psychotropic medication**, including IM administration, for a period of up to three months is authorised by s63. For longer periods of treatment, there are extra safeguards for detained patients, outlined in s58.

If the patient has capacity, and consents to continuing with the treatment, the consultant completes a T2 certificate recording this fact and treatment can continue. NB if treatment changes after this point (even the addition of prn medication or night sedation) a new certificate is required before the treatment can lawfully be administered, if those classes of treatment were not included on the original certificate. You might wonder why the patient would remain under a section if he or she was consenting to treatment. The reason is that a patient may agree to treatment but not to remaining in hospital, or may agree to treatment in this context, but have a history of non-concordance in the community.

If the patient a) lacks capacity or b) does not consent to the treatment, the consultant must follow the procedures outlined above and contact an SOAD. The SOAD will follow the same procedures undertaken before authorising psychosurgery, but in this case can authorise treatment if the patient is unable to give consent due to impaired capacity, or if the patient has capacity, but refuses the treatment, but the SOAD agrees with the treating consultant that the treatment is appropriate. SOADs will discuss the treatment plan with the team, and will not authorise plans including doses above BNF maximum or polypharmacy unless there is a clear rationale for these measures.

*In summary, to administer medication for more than three months, consent or the authorisation of a SOAD is required. The SOAD can authorise treatment if the patient lacks capacity or if the treatment is deemed appropriate.*

Sometimes, there may be an urgent need for ECT or psychotropic medication before a SOAD authorisation can be obtained. Under those circumstances, s62 provides limited authorisation for treatment in the absence of consent or a SOAD authorisation. Two sessions of ECT can be administered if it is immediately necessary to save the patient's life (eg if they have stopped drinking) or to prevent a serious deterioration of his condition. Psychotropic medication, can be administered for the same reasons and also, provided it is 'non-hazardous', if it is immediately necessary to alleviate serious suffering or represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

**Supervised community treatment** may be used to facilitate the discharge of a patient detained under s3, using a Community Treatment Order (CTO). This does not provide authorisation for treatment in the community- if a patient subject to a CTO refuses to accept depot anti-psychotic medication outside hospital, this refusal must be respected. However, it does authorise the

consultant responsible for the patient's treatment to exercise the 'power of recall' if the patient requires treatment in hospital (e.g. because they refuse treatment in the community) and there would be a risk of harm to the health or safety of the patient, or to other persons if the patient were not recalled to hospital for treatment.

## **4. Safeguarding of Vulnerable Adults**

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. The following information is taken from guidance published by the Social Care Institute for Excellence and the General Medical Council.

### **Definition of adult safeguarding**

It is important to be clear about who the formal adult safeguarding process applies to. The Care Act statutory guidance defines adult safeguarding as:

*'Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.'*

This definition hints at the challenges of safeguarding, but it is important to be clear about which adults we are discussing. A local authority must act when it has 'reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.' (Care Act 2014, section 42)

*Safeguarding is for people who, because of issues such as dementia, learning disability, mental ill-health or substance abuse, have care and support needs that may make them more vulnerable to abuse or neglect.*

If you have a safeguarding concern, you must report it to the adult safeguarding lead in your organisation (hospital or GP practice)

## What is abuse and neglect?

There are many forms of abuse that doctors and health care professionals need to be aware of. These include:

- Physical abuse
- Domestic violence/abuse
- Sexual abuse
- Psychological or emotional abuse
- Financial or material abuse
- Modern Slavery
- Organisational/ institutional abuse
- Neglect/acts of omission
- Self neglect

If you are familiar with the types of abuse and the clinical indications of abuse it will help you to identify which patients are at risk of harm. Many forms of abuse are criminal offences.

## Differentiating between poor care and potential safeguarding issues

### Poor care

- A one-off medication error (although this could, of course, have very serious consequences).
- An incident of understaffing, resulting in a person's incontinence pad being unchanged all day.
- Poor-quality, unappetising food.
- One missed visit by a care worker from a home care agency

### Potential causes for concern

- A series of medication errors.
- An increase in the number of visits to A&E, especially if the same injuries happen more than once.
- Changes in the behaviour and demeanour of an adult with care and support needs.
- Nutritionally inadequate food.
- Signs of neglect such as clothes being dirty.
- Repeated missed visits by a home care agency.
- An increase in the number of complaints received about the service.
- An increase in the use of agency or bank staff.
- A pattern of missed GP or dental appointments.
- An unusually high or unusually low number of safeguarding concerns

## **Six key principles**

You have the responsibility to follow the 6 safeguarding principles enshrined within the Care Act 2014:

1. Empowerment – Personalisation and the presumption of person-led decisions and informed consent. “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”
2. Prevention – It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”
3. Proportionality – Proportionate and least intrusive response appropriate to the risk presented. “I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as I require.”
4. Protection – Support and representation for those in greatest need. “I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able.”
5. Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me.”
6. Accountability – Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life.”

**Safeguarding law and practice differs across the four countries of the UK. You must be familiar with the procedures where you work.**

## **Disclosing information about adults at risk of harm**

In England, certain persons or bodies must give information to a Safeguarding Adults Board, at its request, to enable or assist the board to perform its functions. The explanatory notes to the Care Act 2014 make clear that individual doctors can be asked for information under this provision.

There are legal requirements in Wales for certain persons and bodies (including Health Boards and NHS Trusts) to provide information in response to requests from Safeguarding Boards and local authorities

Similar requirements exist in Scotland for public bodies (including Health Boards) to provide information to councils, where they know/believe an adult is at risk of harm action is required to protect them, and to Adult Protection Committees.

In Northern Ireland, arrangements exist for information to be shared in respect of vulnerable adults with the Northern Ireland Adult Safeguarding Partnership (NIASP)

It will usually be appropriate to tell patients about any disclosures you make, even if they are required by law.

### **What should I do if an adult who appears to be at risk of harm refuses help?**

All adult safeguarding processes and laws in the UK say that safeguarding procedures must be person-centred and must take account of the views and wishes of the adult concerned. Safeguarding is not something that is 'done to' a person and the steps you take will usually be agreed with your patient, in line with local safeguarding processes.

Challenging situations can however arise when confidentiality rights must be balanced against duties to protect and promote the health and welfare of patients who may be unable to protect themselves, and who refuse offers of help.

If you are faced with this situation, and there are no legal requirements to disclose information, ask yourself:

#### **Does the adult have capacity to decide whether to accept help?**

- Start from the presumption that the adult has capacity to make the decision, and maximise their ability to do so.
- Communicate with them in a way that best meets their needs. If necessary check with those close to the adult, or others in the healthcare team, about how to best to communicate with them
- Discuss their options at a time and place that helps them understand and remember what you say
- Ask whether having a friend or relative with them would help them to remember information or help them make the decision
- Offer written or audio information if it will help

If the adult doesn't have capacity to decide, it will usually be appropriate to tell a responsible person or authority (such as a local safeguarding lead, or the local authority) if you believe that the person is experiencing, or at risk of, abuse or neglect. You should follow local safeguarding processes.

#### **What if a patient refuses help?**

Adults who initially refuses help may change their decision over time. To help them you can:

- Explore their reasons for refusing help
- Encourage them to consider how they could benefit from it
- Prompt them to consider the potential consequences of not taking action
- Provide information about sources of support – or offer to see them again

#### **Is anyone else at risk of serious harm?**

It is important to respect the adult's wishes and confidentiality. But if their circumstances could put someone else at risk of serious harm, it may be in the public interest to disclose information to the appropriate person or agency.

## **Could disclosure be justified even if no one else is at risk of harm?**

An important principle in our guidance is that doctors must respect patients' rights to self-determination as long as they have capacity to make decisions for themselves, and their decisions do not expose others to a risk of death or serious harm. We therefore emphasise the importance of seeking consent to disclose confidential information, and abiding by patients' wishes.

But in very exceptional circumstances, you may be able to justify disclosing information without consent, where:

- it is necessary to prevent a serious crime such as murder, manslaughter or serious assault
- there is clear evidence of an imminent risk of serious harm to the individual and no alternative (and less intrusive) methods of preventing that harm.

This is an uncertain area of law and, if you can, you should seek independent legal advice before making such a disclosure without consent.

Written by Dr Elizabeth Fistein, University of Cambridge  
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