

## IS THERE AN ALTERNATIVE TO COMPULSORY DETENTION FOR ADULTS WHO LACK CAPACITY?

### Introduction

*Providing services for people with learning disabilities requires a delicate balance between managing risk and promoting opportunity and choice. Within this process it is at times evident that aspects of the Law and care provision are not always mutually agreeable. The Mental Health Act (1983) is widely used for people with learning disabilities in health service care and is a prime example of the dissonance caused when the law and care philosophies disagree.*

*Professionals wish to act in both the least restrictive way and in the best interest of their patients, but are concerned that they may be acting outside of the law. The recent ruling in the European Court of Human Rights regarding R v Bournewood has brought this dilemma into sharp focus. By considering statutory and common law, the Human Rights Act, the pending Mental Incapacity Bill (DCS 2004) and clinical decision making processes, it is clear that these differences are sometimes difficult to resolve.*

*In reviewing the legal position and the clinical dilemmas faced by professionals, this paper asks whether the development of assertive advocacy may provide a less restrictive alternative than the Mental Health Act whilst still protecting the interests of both the patient and of services.*

*unless there are distinct and widely agreed grounds justifying such an infringement. Article five of the Human Rights Act (1998) represents the right to liberty and security stating that no one can be deprived of their liberty unless under specified circumstances and in accordance with prescribed law. It refers to the lawful detention of persons of unsound mind, which would generally be considered to signify procedures prescribed by the Mental health Act (1983). Thus the presently acknowledged impact of article five is that services for people with a learning disability must ensure that individuals are housed in the least restrictive setting achievable. Furthermore those who are detained must not be subject to a greater level of security, including custodial and behavioural regimes, than is warranted by their condition.*

*In this context proponents of the Mental Health Act (1983) argue that the Act offers both support and protection for those to whom it applies. However it can also be argued that the Act may be an unnecessary barrier for care providers and lead to inappropriate stigmatisation and restriction of choice for the individual. To avoid the negative impact of formal detention, one argument is that in many instances, care can be provided under the Common Law doctrine of necessity and best interest.*

### Human Rights

*It is a given fact that every person has fundamental rights that may not be infringed*

### Common Law

*On review it is clear that one of the most confusing areas in law, is the extent to which*

the Common Law can be used to detain or restrain informal persons who lack mental capacity. According to Hoggett (1996) informal patients have two basic rights - to refuse some or all of their treatment and to leave hospital if they so wish. These rights are not set in statute, but have become rooted in the Common Law stemming from each individual's principle right to personal autonomy and self determination. Despite this, it has been established (Poutney v Griffiths, 1975) that staff in psychiatric hospitals have a general 'right of control' over all patients, but that the extent of this remains uncertain.

In *Black v Forsey* (1987) common law confers upon a private individual power to detain, in a situation of necessity, a person of unsound mind who is a danger to himself or others. However considering the Law analysis of Fennel (1984) and Hoggett (1996) these powers only allow for an informal person to be detained or secluded for a limited period. Many people with a learning disability and challenging behaviour require long term care and this presents clinicians with a dilemma in determining what constitutes a "limited period".

The extent to which Common Law powers may be used to control individuals is not entirely clear especially regarding the meaning of "reasonable force". Hoggett (1996) suggests that using restraint is reasonable as long as "the force used is no more than is in fact necessary to accomplish the objective for which it is allowed" and the reaction is "in proportion to the harm threatened". Once again the Law appears to leave the clinician to determine necessity and proportionality.

Where clients lack the capacity to express an informed desire to leave, and are cared for in 'locked' environments to prevent them from wandering off, they are not detained in law but detained *de facto*. According to Tingle and Cribb (1995), restricting a person's freedom is false imprisonment, yet certain restrictions are permissible, i.e. when the client is unthinkingly

trying to leave. Under such circumstances the nurse and the doctor have a duty of care and no false imprisonment could be claimed. Problems arise where a purposeful desire to leave is evident and under these circumstances prevention without statutory authority may not be legal.

The controversial case of *R v Bournewood* (1998) offered no further clarity. Following the case it was generally accepted that informal mentally incapacitated clients can receive treatment as long as they are not dissenting from being there and are accepting treatment without duress. The House of Lords overruled the Court of Appeal ruling stating that the client's admission and retention was justified under common law on the grounds of necessity. The Court of Appeal had erred in finding that the client was detained as he had made no attempt to leave and had been accommodated on an unlocked ward.

Following this Case Law it remained open to interpretation and clinical judgement to determine what constituted "passive compliance". On the 5th October 2004 the European Court of Human Rights ruled against the Trust and in essence overturned the House of Lords judgement, insisting that the incapacitated adult has the right to the legal framework of the Mental Health Act (1983).

The difficulty with any legal precedent is that it does not take into consideration that every case is different. It provides a blanket ruling, which is frequently in conflict with clinical practice and common law doctrines of necessity and best interests. Until such time as an individual case challenges the current legal precedence, the case law as it stands remains unhelpful.

### **The process of making clinical decisions**

Undoubtedly in Learning Disability services for the incapacitated adult, acting

under the Common Law doctrine of best interest pervades all practice. It is impossible to justify any actions other than those that will most benefit the individual. Recourse to the Mental Health Act (1983) clearly requires a clinical judgement about either purposefulness to leave, or dissent to care and treatment, in situations where the individual poses a significant risk to himself or others.

This in itself requires an interpretation of behavioural presentations. Changes in the person's environment and other contextual issues mean that implicit assumptions cannot be made. Yet in managing services, providers invariably find themselves in emergency situations where they have to balance the individual's right to exercise choice, with the risk such choices may present to the client and to the service.

Detention under the Mental Health Act (1983) does not offer reason in itself to restrict environments or the physical freedom of individuals. Equally there should be no inherent supposition that environments cannot be limited when clients are informal. In either situation there is a need to constantly review services to ensure that care is provided in the least restrictive settings possible.

Within this process it is important to acknowledge that you cannot have freedom without having rights, however it is possible to accept that people have certain rights without allowing them total freedom. Thus decisions must be made based upon reason to find the correct balance of rights, duty and responsibility. Invariably decisions that restrict liberty and freedom constitute the principle of double effect, where to act or not to act may each result in undesirable consequences. Therefore any such decisions should ensure that the act is morally good or at least neutral. The purpose must be to achieve a positive goal with any negative consequence being only a side effect. The positive goal must not be achieved by way of the negative, and finally, the negative consequence must not outweigh the positive result.

## To Act or not to Act?

There is a view that organisations orientate to the use of the Mental Health Act (1983) under the auspices of 'protecting' and 'safeguarding' both patients and frontline staff, and to satisfy a preoccupation with risk management. Invariably this relates to having legislative processes and clear systems available to underpin their framework of care. Mental Health Act Tribunals, Managers' Hearings and obtaining a Second Opinion on pharmacological intervention are all perceived as a safeguard and a form of client advocacy.

There is also a feeling that the Mental Health Act Commission offers an independent supervisory body to regulate service delivery and care. However there is equally a view that in reality neither the Commission nor the Legislative process offers a genuine challenge to the decisions and actions of clinicians. Indeed it might be argued that for this population at least, they represent a time consuming distraction that may even negatively impact upon client care. The "safeguards" in essence are concerned purely with the "legality" of detention and offer no independent challenge to professionals about the nature, validity or effectiveness of the care they provide.

Given that people with learning disabilities are often conceptualised by their needs or problems, formal detention may stigmatise individuals both in the context of current services and future opportunities. Conversely it can be argued that being detained does not heighten the innate stigma attached to having a learning disability or comorbid issues such as mental illness and challenging behaviour.

It is clear that organisations will orientate to the use of a legislative framework such as the Mental Health Act as the alternatives are more abstract and offer less structure to augment established systems. Even if it is assumed that the Mental Health Act Commission is relatively ineffectual, they are the foremost supervisory body overseeing the care of this exceptionally

vulnerable group of people. Nonetheless, there is the added risk that in order to maintain people with a learning disability in an inappropriate environment that may not meet their needs, the Mental Health Act could be used as a justification and excuse for ignoring an expression of choice and to disguise service deficiencies.

### **The proposed Mental Capacity Bill**

The revised Mental Incapacity Bill (DCA 2004), to be renamed the Mental Capacity Bill, is intended to provide a statutory framework to protect incapacitated persons, their carers and professionals. It affords a checklist to ensure that decision makers ascribe to making decisions that are in the person's best interests.

As a consequence carers and professionals will be protected from liability if they conform to the key principles of the Bill. As such, each individual must be assumed to have capacity unless it is demonstrated otherwise and any assessment of capacity must be contextually specific to the decision being taken. Everyone should be enabled to make their own decisions or participate as fully as possible. They must also retain the right to make what may be perceived as unwise or eccentric decisions. Finally any decision made on behalf of others must be one that is the least restrictive of basic rights and freedoms.

### **Service development through assertive advocacy**

While professional opinion may differ, the welfare of the client is central to all and remains the focal point for all service and practice development. We would argue that existing Legislative frameworks do not adequately protect the client, and may potentially lull

service providers into a false sense of satisfaction by managing the risks, when in reality they are not meeting the needs of the individual. Chapter 5 of the Mental Health Act Commission Tenth Biennial Report (2004) concentrates on values within services. It encourages professionals to not merely respond to pending developments of Convention rights, but to try and influence such developments positively in the interests of the services they provide. Therefore professionals should be responsible for encompassing Human Rights values into their own local policies to develop better care by promoting best practice rather than risk avoidance.

We believe there is a need for further exploration of how assertive advocacy can be efficiently provided for this vulnerable group of people. This is not in the context of the proposed Mental Health Act reforms, which do nothing more than reflect what is already widely available. Advocacy in this manner provides information and if appropriate helps individuals represent their views. The problem at the present time is that the advocacy remit is to engage with clients and reflect views, thoughts and feelings. This offers nothing for the incapacitated client who either refuses or is unable to actively engage with advocacy services and advocates have argued that they are understandably unable to represent this most vulnerable group of individuals.

Clearly advocacy should not form a process of proxy decision-making or substituted judgement. However it does need to be available in a more assertive and literal sense by demonstrating and pleading the cause of those who are being represented. It should be a mechanism for requesting explanations, questioning responses and challenging inconsistencies both in relation to service provision and commissioning. We would argue that advocates should be asking the sort of reasonable questions of service providers as any capacitated adult would ask even if they cannot engage actively with the client.

We would further argue that hospital managers have a responsibility to those vulnerable and incapacitated adults cared for within their organisation. Rather than regularly reviewing the legality of detained patients, we would argue that they have a role in reviewing all vulnerable incapacitated adults especially where these persons have no relatives to advocate on their behalf.

Advocacy should be constantly insisting that carers and professionals alike are able to justify that their practice and service delivery meets the best interests of each individual client. It should challenge processes and insist that they evolve with the individual. It should demand evidence that care is provided in the least restrictive settings possible and that basic rights and freedoms are upheld to the highest degree feasible. It should also challenge services to substantiate that they are person centred and signed up to the principles of rights, independence, choice and inclusion (DOH, 2001).

## Conclusion

Ultimately professionals and care organisations for people with learning disabilities must be challenged to prove that the services they deliver accord to their espoused philosophies. Experience suggests that services often inadvertently deceive themselves and rarely deliver on their rhetoric. In this regard the Mental Health Act does not appear to be a safeguard for either the patient or the professional. More assertive advocacy would assist in ensuring that practice always serves best interests and is delivered in the least restrictive setting. It may also assist in achieving the fine balance between risk management and promoting choice and opportunity, something that the Mental Health Act is unable to achieve.

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## References

- Black v Forsey** 1987). S.L.T. 681. The Times 31, 1988, HL.
- Department for Constitutional Affairs** (2004). *Mental Incapacity Bill*. [www.dca.gov.uk/menincap/mcbfactsheet](http://www.dca.gov.uk/menincap/mcbfactsheet).
- Department of Health** (2000). *Reforming the Mental Health Act*. [www.doh.gov.uk/mentalhealth](http://www.doh.gov.uk/mentalhealth).
- Department of Health** (2001). *Valuing People: A new Strategy for Learning Disability for the 21st Century*. London, HMSO.
- Fennell, P.** (1984). *Detention and control of informal mentally disordered patients*. *Journal of Social Welfare*, 354-359.
- Hoggett, B.** (1996). *Mental Health Law*, 4th Edition. London: Sweet & Maxwell.
- Human Rights Act.** (1998). European Convention of Human Rights. [www.echr](http://www.echr).
- Mental Health Act** (1983). London: HMSO.
- Mental Health Act Commission** (2004). *Tenth*

*Biennial Report 2001-2003: placed amongst strangers.* London: HMSO.

**Poutney v Griffiths** (1975). 3 W.L.R. 140.

**R. v Bournewood Community Mental Health NHS Trust ex parte** (1998). 1 All ER 634CA./  
3 All ER 289 HL.

**Tingle, J. and Cribb, A.** (1995). *Nursing Law and Ethics.* London: Blackwell Science.