FACULTY FOR THE PSYCHIATRY OLD AGE

Guidance for old age psychiatrists on appropriate restriction of liberty of inpatients outside of the mental health act following the European Court’s decision on HL v UK (the “Bournewood” case).

Background summary:

The “Bournewood” case involved a man with autism, lacking the capacity to consent or object to medical treatment, who was admitted informally and treated under the common law doctrine of necessity. The professional team disagreed with HL’s paid carers’ wishes to visit and to discharge HL home, and these carers (with whom he had been resident for 3 years) commenced legal action to secure his discharge from hospital. Actions in the High Court, Court of Appeal, and the House of Lords followed, with the European Court of Human Rights ultimately finding that in the absence of the use of the Mental Health Act, HL’s right to liberty and security had been violated. This has implications for old age psychiatry in the care of people who lack the capacity to consent to treatment in hospital. Further details of the ruling can be found on the internet1. The critical issues for old age psychiatrists appear to be in the definition of deprivation as opposed to restriction of liberty, and with regard to good practice in involving carers and next of kin in care planning.

European Courts findings on breaches of the right to liberty

The European Court was particularly concerned that professionals were exercising “complete and effective control” over HL’s care and movements; “over his assessment, treatment, contacts and notably, movement and residence”, with little influence of the paid carers over these issues. Unlike detention under the mental health act, there were no procedural rules by which people were admitted or detained, no safeguards to prevent unnecessary restrictions of liberty, and no speedy process by which a person might have their deprivation of liberty reviewed with the power to discharge them if appropriate.

The European Court did not consider that HL should have been detained under the mental health act, and recognised the governments concern to avoid the “full, formal and inflexible impact of the Mental Health Act. The ruling does not necessarily apply to all patients who staff might prevent from leaving unescorted for their own safety. The relationship between appropriate restriction and the complete deprivation of liberty is one of degree or intensity of the restriction. Involving appropriate others as patient representatives in formulating a care plan would ensure that professionals were not exerting complete control.

Suggested procedures
The government is currently consulting on new procedural safeguards which it accepts are required. In the meantime the following guidance is recommended, to fit within existing models of care but providing safeguards to minimise the risk of complete professional control over an incapacitated individual, involve patient representatives in care planning and ensure an easily accessible review mechanism. The Mental Health Act should continue to be considered where appropriate.

1. Assess capacity:
When admission is planned, consider whether the patient has capacity to agree to admission and the likely management that will be required there. If the patient is a danger to themselves or others, and is declining necessary admission or treatment, then this may require the use of the Mental Health Legislation (MHA) rather than an informal admission.

2. If capacity in doubt, involve relevant advocate
Where there is doubt about capacity to consent to admission or likely initial management, the responsible consultant, or nominated deputy, should document on what basis this decision has been made, and should document that the closest relevant advocates are in agreement with this admission and initial management.

3. Early review
Within one working week of admission, the responsible consultant, or nominated deputy, should document:
   a) The relevant advocate has been involved in consideration of the care plan which will include necessary restrictions of liberty.
   b) The relevant advocate has been informed of how to raise concerns about the persons well-being and care.

4. Ongoing review
If the admission extends to 1 month, capacity should be re-assessed, and if lacking, the responsible consultant, or nominated deputy, should document:
   a) The relevant advocate has been involved in consideration of the care plan which will include necessary restrictions of liberty.
   b) A review date has been set for the next care plan review (not exceeding 6 months)

5. Access to Independent review
The Trust should have a procedure that will provide a timely review where there are concerns by any party that an individual’s liberty is being unnecessarily restricted. This procedure should be explained in writing to the relevant advocate and freely available to visitors to the ward, or on request. The independent review might be carried out according to the Trust policy for handling complaints, an independent patient advocate, or other dedicated procedure. If there is disagreement between the staff and family, and it is the professionals view that for reasons of safety or well being to the person or other individuals that the person remain in hospital, then assessment for detention under the mental health act should be considered, to allow for formal review of the requirement for admission under the normal procedures for a Mental Health Review Tribunal or Manager’s Panel.
Faculty for the Psychiatry of Old Age
INTERIM GUIDANCE NOTE ON
IN-PATIENT MANAGEMENT
FOLLOWING THE BOURNEWOOD CASE

Please refer to Page 2 of the guidance note for an explanation

1. Is there capacity to consent to admission and likely management?
   - Yes: No action needed
   - No: Consult and document discussion with relevant advocate about care plan and how to raise concerns

2. REVIEW CAPACITY

3. CARE PLAN
   - Has a month passed since admission?

4. INDEPENDENT REVIEW