DEPRIVATION OF LIBERTY IN THE ACUTE HOSPITAL

What will be the impact of Liberty Protection Safeguards?

CURRENT LANDSCAPE UK

Mental Health Act Review (E+W)

- White paper 2021

Mental Capacity Act Amendment Act 2019 (E+W)

- Code of practice a work in progress

Mental Health Act Review (S)

- Ongoing

Mental Capacity Act (Northern Ireland) 2016

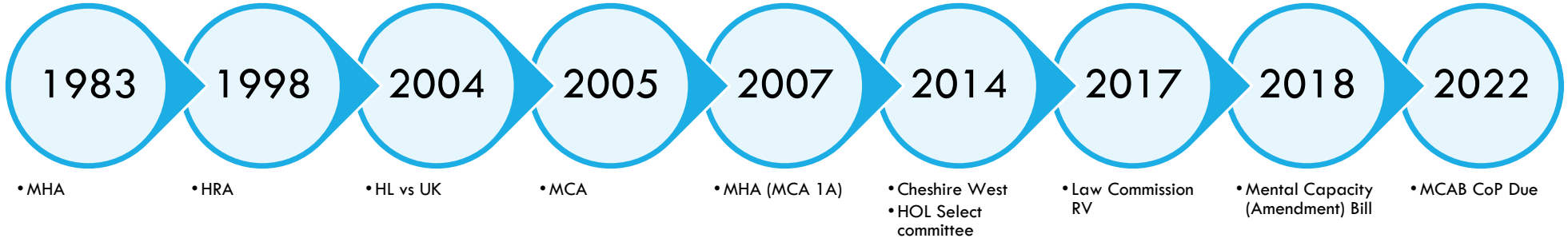
- Fusion law to replace MHA
- Not yet fully enacted

ARTICLE 5 OF THE HUMAN RIGHTS ACT 1998:

'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'

WHAT IS A DEPRIVATION OF LIBERTY?

TIMELINE OF LEGISLATION



DOLS: SCHEDULE 1A TO THE MCA 2005

AGE:	• Must be at least 18
MENTAL HEALTH:	• Must be suffering from a mental disorder within the meaning of the MHA
MENTAL CAPACITY:	• must lack capacity
BEST INTERESTS:	• in the best interests of the person to be deprived of their liberty and is necessary and proportionate
ELIGIBILITY:	• Not detained under the MHA
REFUSALS:	• no valid advance refusal of the treatment for which the DOL authorisation is being sought
It is the DOL that is being authorised: no statutory definition of DOL	

WHAT'S WRONG WITH DOLS?

In General:

- long and complicated!
- Draconian, off-putting and potentially upsetting language
- Impractical as relevant to huge numbers of people (esp since Cheshire West)
- BUT many compliant incapacitated people aren't in hospital or care home-what about people in their own homes or supported living?
- Weaker protections than MHA and no aftercare
- Potential COI for local authorities
- There may be worse things than not being free to leave….
- Doesn't eradicate de facto detention

General Hospitals:

- Not designed with General hospital in mind
  - General Hospital 'carve out' only through case law
- You can't convey someone using DOLS authorisation
- DOLS doesn't travel with the patient-separate authorisations needed
- Overlap between remit of MHA and MCA
- Many people have more than one problem requiring DOL

MENTAL CAPACITY (AMENDMENT) ACT 2019

Still no statutory definition of DOL (for CoP)

Provision for interim/emergency DOL (Section 4B MCA)

- To provide life sustaining treatment (doesn't cover giving the treatment)
- To prevent serious deterioration

Schedule AA1 (LPS)

- Scheme for authorising arrangements enabling care and treatment (if person lacks capacity and arrangements give rise to DOL)
- 16+
- Responsible body can authorise arrangements in ANY setting

Intention to authorise prospectively

TO BE ELIGIBLE FOR LPS AUTHORISATION

Person lacks capacity to consent to arrangements

Person has a mental disorder

Arrangements **necessary** to prevent harm and **proportionate** to the likelihood and seriousness of the harm (note no BI)

ROLES AND RESPONSIBILITIES

RB must consult with person and others

New role of Approved Mental Capacity Professional

Authorisations are portable

Review 1yr 1yr 3yr

Safeguards:

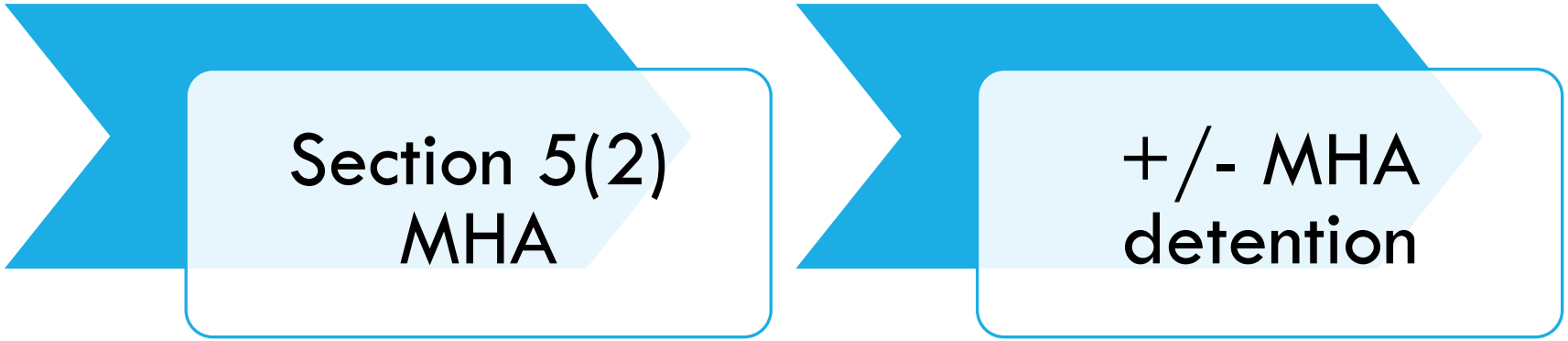
- Right to information
- Regular review by RB
- Right to challenge (CoP)
- Support of an appropriate person e.g IMCA

DEPRIVATION OF LIBERTY IN THE EMERGENCY DEPARTMENT

MHA consultation 2021

- Section 4b MCA or extend section 5(2) to the ED?


Section 4b MCA
Request MHA assessment
+/- MHA Detention


Section 5(2) MHA
+/- MHA detention

SHOULD SECTION 5(2) BE EXTENDED TO THE ED?

Arguments against the proposal:

• The use of a specific holding power in ED for people with mental disorder (or presumed mental disorder) may be discriminatory in restriction of a right to leave

• Extending a legal power to be more restrictive is not in line with the overall ethos of MHA reform

• Extension of holding powers does not address the reasons why people may want to leave the emergency department. Reforms should focus on quality of care and creating an environment which is supportive of those presenting in mental health crisis

• Section 4B of the MCA is worded to be broad enough for clinicians to act where they believe they need to hold someone in order to prevent serious harm (or further serious harm)

• If section 5 is extended to apply in the ED there will then be confusion as to whether to use section 4B of MCA or section 5 of MHA

• Neither of these powers gives authority to treat, which will remain, as now, a common law authority, with the MCA as protection against litigation for battery where the treatment is provided on the basis of best interests

• The extension carries a risk of the new holding power being used inappropriately to detain those who wouldn't otherwise fall under the remit of the MHA, including intoxicated people

Arguments for the proposal:

• The MCA is confusing to apply to patients in the ED who make clear that they have suicidal intent and who are being held to await a formal MHA assessment. Extending the powers of Section 5 would be a much clearer framework for 'holding' such patients in the ED.

• The MCA does not apply to children under16, and while Common Law can be used, the MHA would still be much clearer for children and adolescents than Common law.

INSIDE THE ACUTE HOSPITAL…

What about disorders at the interface?

- Dementia
- Delirium
- Brain injury

What about people with both mental health and physical health problems requiring DOL?

Care Quality Commission

Assessment of mental health services in acute trusts programme

How are people's mental health needs met in acute hospitals, and how can this be improved?

Acute trusts need to improve staff education and governance of the Mental Health Act

Staff in acute hospitals were often not clear about the legal process for detaining someone in hospital. When they were detaining a person under the Mental Health Act 1983 (MHA), staff were often unclear about roles and responsibilities between acute and mental health trusts. More generally, staff in acute hospitals lacked knowledge about the MHA and how it worked. We also found that there was confusion around the MHA and Mental Capacity Act 2005 (MCA) and when to use which piece of legislation and associated guidance.

IMPACT ON THE ACUTE HOSPITAL SETTING?

Fundamental problem with distinguishing ‘mental’ from ‘physical’ and lack of acknowledgement of problems at the borderline or problems in more than one domain

Expectation that NHS management and staff will have sufficient understanding of MCA to manage the process

Potential change in practice in the ED

Still very bureaucratic

Relationship between MCA and MHA is unresolved

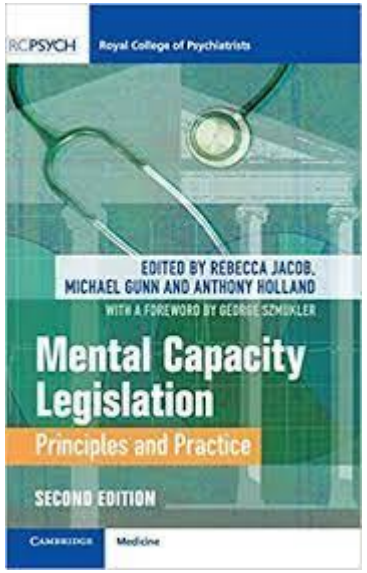
QUESTIONS TO PONDER…

How will the new LPS affect your practice?

How well prepared is your service for LPS?

If you don't practice in E+W what are your DOL arrangement and how do they compare with LPS?

RESOURCES TO KNOW ABOUT:



https://www.mentalcapacitylawandpolicy.org.uk/

https://www.39essex.com/

https://mentalhealthcop.wordpress.com/

https://thesmallplaces.wordpress.com/

https://autonomy.essex.ac.uk/