

Number 83

Bournewood – Guidance on Implementation

The European Court of Human Rights has recently overruled the decision of the House of Lords in the case of R v Bournewood Community and Mental Health Trust (in ReL) [1998] which ruled that a voluntary incapacitated patient had not been unlawfully detained, having been admitted and remaining in the hospital under the common law doctrine of “necessity”.

The essence of the European Court’s decision was that although the patient had not been confined to the Bournewood Hospital, the evidence was that had the patient attempted to leave the hospital premises he would have been detained. The court said that the healthcare professionals responsible for the patient had “exercised complete and effective control over his care and movements”; it was not credible to say that he was free to leave. He was de facto detained.

The treating doctors had defended the treatment of the patient on the basis that it was in the patient’s “best interests” and thus justified under the common law doctrine of “necessity”, to accommodate the patient in the hospital. The European Court held that detention under the common law was in breach of Article 5 of the European Convention on Human Rights (that has been incorporated into English law under the Human Rights Act 1998 since the Judgment of the House of Lords). Article 5 protects the individual’s right to liberty and provides that where individuals are detained, e.g. the lawful detention of persons of unsound mind, that detention must accord with a procedure prescribed by law. The European Court pointed to the “arbitrary nature of the detention of Mr L” and specifically emphasised the lack of any “fixed procedural rules by which the admission and detention of compliant incapacitated patients was conducted”. This lack of procedural safeguards was noted to be in marked contrast to the safeguards provided to detained patients under the Mental Health Act 1983 (“MHA”).

The European Court hold that the Common Law lacked the following qualities essential for a law permitting detention if it is to comply with Article 5:

- Formalised admission procedures indicating who could propose admission, for what reasons and the basis of what kind of medical and other assessment and conclusions;
- The requirement to fix the exact purpose of admission (for example, for assessment or for treatment);
- Limits in terms of time, treatment or care attached to the admission;
- Specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention;
- The nomination of a representative of a patient who could make objections and applications on his or her behalf and, by this, provide added procedural protection for the patient.

The lack of such protective safeguards resulted in the situation where, in the Court’s view, the healthcare professionals assumed full control of the liberty and treatment of a vulnerable incapacitated patient solely on the basis of their own clinical assessments. Whilst the Court did not cast any doubt over the good faith of the healthcare professionals and their conduct in relation to the patient, the lack

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of any checks over their clinical judgments and against any professional lapses was considered to amount to a breach of Article 5(1).

The Dilemmas following the European Court's Judgment

The European Court's decision has raised a number of questions without providing a straightforward solution. The clearest way of avoiding "Bournewood" type claims would be to ensure that incapacitated patients are formally detained and consequently reviewed under the Mental Health Act 1983, although the prospect of such claims may be fairly low.

An added complexity is that there may be situations in which those treating the patients consider detention under the MHA might be against a patient's interests, particularly in the case of elderly patients. There are also likely to be concerns about the stigma associated with detention.

The European Court also found that the patient's rights under Article 5(4) had been breached. That Article provides that anyone who is deprived of his liberty by detention should be entitled to take proceedings by which the lawfulness of his detention "shall be decided speedily by a Court and his release ordered if the detention is not lawful". The Court expressed the view that at the time of Mr L's detention, neither judicial review nor any other legal remedy was sufficient to guarantee a review in accordance with Article 5(4).

The Government's Response

The Department of Health has recently published a guidance note on the implications of the European Court's judgment¹.

The Government has emphasised in its guidance that the European Court did not find that Mr L should have been formally detained under the MHA. The Government has taken the view that the European Court's judgment is not to be interpreted as meaning that procedural safeguards for people in Mr L's position must be identical to those for patients detained under the MHA. The guidance note refers to the Court's comments that "the Government's understandable concern.....[is] to avoid the full, formal and inflexible impact of the 1983 Act" on patients in the situation of Mr L. Nevertheless, the Government acknowledges that in order to avoid further violations of Article 5(1) new procedural safeguards must be introduced for patients who are not formally detained but who are, in effect, deprived of their liberty on grounds of necessity and best interests under the common law.²

With regard to the breach of Article 5(4), the Government has expressed the view that no further action is required to be taken in this respect given the enactment of the Human Rights Act 1998 in October 2000.³

The Government has stated that, in accordance with intentions to provide additional procedural safeguards to incapacitated patients who are not formally detained, it intends to bring forward proposals for a new system of safeguards. As part of this process, it will consult with interested parties with the hope that it can achieve procedural safeguards which are effective, proportionate and deliverable in practice.

¹ Advice on the decision of the European Court of Human Rights in the case of H –v- UK [gateway reference 4269] published on 10 December 2004.

² See paragraph 25 of the Department of Health's Guidance Note, *ibid* 1.

³ The Government is considering whether any further action is needed in the light of the recent judgment by the Court of Appeal in the case of R(MH) –v- Secretary of State for Health which concerned a patient detained under Section 2 of the MHA who was incapable of making an application to the MHRT.

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Until those safeguards have been legally enacted, any hospital or care home which arranges the treatment or care for an incapacitated patient, such as Mr L, in a manner that could be construed as amounting to deprivation of that patient's liberty, is likely to be acting unlawfully unless the patient has been detained under the MHA.

Accordingly, the Government has suggested that certain steps can be taken in the interim by healthcare professionals to seek to avoid a claim that hospitals and care homes have acted in a manner in relation to an incapacitated patient that violates Article 5. Systems should be put in place so that when making arrangements to provide care to such an individual which involves a restriction on their liberty, consideration should be given to whether any proposed treatment might constitute a deprivation of the patient's liberty. If so, consideration should be given to alternatives to enable the patient to obtain adequate care which falls short of deprivation of liberty.

The Government's guidance points to various "elements of good practise" which it is anticipated might avoid the risk of legal challenge. These include the following:

- Ensuring that decisions are taken (and reviewed) in a structured way, which includes safeguards against arbitrary deprivation of liberty. Any system introduced with the intention of providing safeguards should include a procedure whereby a proper assessment of the patient is undertaken to check that he lacks capacity and that decision should be taken on the basis of appropriate medical advice by a person qualified to make that judgment.
- Effective, documented care planning (including the Care Programme Approach where relevant) for such patients, including appropriate and documented involvement of family, friends, carers and others interested in the patient's welfare.
- Ensuring that alternatives to admission to hospital or residential care are considered and that any restrictions placed on the patient while in hospital or residential care should be kept to the minimum necessary in all the circumstances of their case.
- Ensuring that appropriate information is given to patients themselves and to family, friends and carers. This should include information about the purpose and reasons for the patient's admission, proposals to review the care plan and the outcome of such reviews and the way in which a challenge can be made to decisions of healthcare staff. It is suggested that local advocacy services could be made use of to assist patients and their families etc.
- Taking proper steps to help patients retain contact with family, friends, carers, with proper consideration given to the views of these people. In the exceptional case where there exists good clinical reason(s) why contact with family etc. is not in the patient's best interests, those reasons should be clearly documented and explained to the people they affect.
- Ensuring both the assessment of capacity in the care plan are kept under review. The Government have suggested that it would be helpful to include an independent element in the review, which might include involvement of a social worker or a member of the community health staff or by seeking a second medical (or other appropriate clinical) opinion either from within the hospital/care home or elsewhere. Such a second opinion is particularly important where family members, carers or friends do not agree with the proposed decision regarding the patient's treatment and care.

In the event that there is no way of providing appropriate care which does not amount to deprivation of liberty, then the Government recognises that consideration has to be given to the use of formal powers of detention under the MHA. However, it points out that there are dangers in using the MHA simply to be "on the safe side". Although it provides procedural safeguards, the use of the MHA will not necessarily be welcomed by patients themselves; the guidance notes the "stigma" that often attaches to the MHA, as we have pointed out above.

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It has been suggested that those responsible for the care of incompetent voluntary patients should only consider detention at a stage when a patient tries to leave. We question whether this is justified clinical practice that could be supported if subject to legal challenge. It seems to us to be an artificial approach to the issue in that most healthcare professionals are likely to have an immediate view as to whether they seek to stop a patient leaving the premises. Another approach that has been suggested is to have some form of exit system which the unit considers, whilst theoretically open for patients, is unlikely to be utilised by them. This might include a system that requires the use of an electronic keypad which may be very difficult for patients to use. Again, we consider that this is likely to be viewed as a technical way of attempting to avoid the consequences of the European Court ruling and will only be seen as a de facto detention. We therefore consider that it is extremely difficult to set out specific criteria to determine when consideration should be given to the use of detention under the MHA and that inevitably the situation has to be judged on the facts of each case.

Care providers should consider introducing a protocol dealing with the treatment of incompetent voluntary patients, reflecting the Government's recent guidance.

Should you require any further advice on the issues raised by this briefing, including assistance with drafting relevant policies, please contact Andrew Parsons at andrew.parsons@rlb-law.com.

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