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The Mental Capacity Act 2005 and its potential impact on the use of restraint

The staged implementation of the Mental Capacity Act 2005 (further referred to as the Act) began in April 2007 and was completed in October 2007. The Act provides a comprehensive statutory framework for making decisions for people in England and Wales, aged 16 years and over, who lack capacity to make a particular decision at a particular time. Section 5 of the Act codifies the common law doctrine of necessity and provides a defence to anyone who performs an act in connection with the care and treatment of another person – in that person's best interest – reasonably believed to lack capacity in that matter. There are, however, three conditions which must be met here:

1. The person who acts takes reasonable steps to establish whether the individual lacks capacity in relation to the matter in question.
2. The person who acts reasonably believes that the individual lacks capacity in relation to the matter.
3. The person who acts reasonably believes that it will be in the best interest of the individual who lacks capacity for the act to be done.

The defence does not apply if the act carried out constitutes a criminal offence or if the act is carried out negligently. Furthermore, if there exists a valid advanced decision to refuse the proposed care or treatment, the relevant interventions may not be carried out. Thus section 28 of the Act provides that:

1. 'Nothing in this Act authorises anyone –
 - (a) to give a patient medical treatment for a mental disorder, or
 - (b) to consent to a patient's being given medical treatment for a mental disorder,if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act.
2. 'Medical treatment', 'mental disorder' and 'patient' have the same meaning as in that Act.'

It is important to note that the Mental Health Act 1983 (and the Mental Health Act 2007) is concerned with the treatment of mental disorder, whereas the Mental Capacity Act 2005 is concerned with both physical and mental disorder of those lacking capacity, a much larger group

than those defined by the Mental Health Act categories of mental disorder.

The Mental Capacity Act 2005 and restraint

Section 6 of the Act sets out two limitations on the scope of section 5 acts, namely restraint and a valid decision of a donee of a lasting power of attorney granted by the person lacking capacity or a deputy appointed for the person lacking capacity by the Court.

This section is concerned with the prevention of harm to the person lacking capacity rather than preventing that person from causing harm to others; unless 'best interest' is to be expanded to incorporate that outcome.

Restraint is defined in the Act as the use of, or a threat to use, force where a person is resisting and any restriction of liberty of movement whether or not that person resists.

However, two conditions must be satisfied in order to justify the use of restraint. First, the person taking action must reasonably believe that it is necessary to use restraint in order to prevent harm to the person lacking capacity (section 6.2). Second, the act of restraint has to be a proportionate response, in terms of both degree and duration, to the likelihood of the person who lacks capacity suffering harm and the seriousness of that harm (section 6.3).

Thus, restraint can only be justified if it is used to prevent harm to the person lacking capacity, involves the minimum force necessary and is used for the shortest duration possible. Moreover sections 6.4b and 6.5 provide that although restriction of liberty is permitted by the Act, any act resulting in deprivation of liberty of the incapacitated person will amount to a breach of Article 5 of the European Convention on Human Rights. Section 6 will therefore not provide protection for any action that amounts to 'deprivation of liberty' as defined by Article 5 of the European Convention.

The Article protects the 'right to liberty and security' of a person, with the underlying aim to ensure that no one is deprived of this liberty arbitrarily. However, paragraphs 1a to 1f provide an exhaustive list of circumstances



in which a person can be lawfully deprived of their liberty. Furthermore, paragraphs 2 to 5 set out a number of procedural safeguards for those deprived of their liberty.

The two areas of potential difficulty with the use of restraint are the requirements that such a response is proportionate and that restraint does not amount to a deprivation of liberty.

Proportionate response

The Act requires that for an act of restraint to be justified, such a response has to be proportionate to the possibility and seriousness of harm to the person lacking capacity. 'Harm' is not defined in the Act but it can be considered here as not restricted to physical harm. Thus restraint may be appropriate where there is a risk of financial harm (e.g. ripping of bank notes) or psychological harm (e.g. actions which may result in verbal abuse from others) (Jones, 2007).

Part of the consideration is to anticipate the immediacy and severity of harm based on the subjective appraisal of the circumstances. In the event that the lawfulness of an act with respect to a person lacking capacity is challenged, consideration of its appropriateness will ultimately be determined, for a professional carer, in a legal forum with reference to the Bolam test (*Bolam v. Friern Hospital Management Committee* [1957]). However, of greater significance is how this safeguard will operate when the restraint has been exercised by (lay) carers and who will be in a position to report a potential misuse if the (restraining) actions take place outside hospital or nursing home.

However, the Act does not seem to preclude the repeated short-term use of restraint for a recurring situation. Such a measure, when required frequently over a prolonged period of time (e.g. several times daily for several days), is unlikely to comply with the requirement that restraint should only be used for the 'shortest possible time' (Mental Capacity Act 2005 Code of Practice, paragraph 6.47) and, therefore, may amount to a disproportionate response. In such circumstances, the use of the Mental Health Act 1983 should be considered.

Restriction v. deprivation of liberty

Any act of restraint amounting to deprivation of liberty within the meaning of the European Convention on Human Rights is not permitted under the Mental Capacity Act 2005 as it would constitute a violation of Article 5 of the Convention, and will not come under the protection of section 6 of the Act.

However, the distinction between what amounts to a restriction of liberty and a deprivation of liberty can be difficult to draw. The European Court of Human Rights' principle of distinguishing between the two was outlined in *Guzzardi v. Italy* [1980] where the European Court held, at paragraph 92, that:

'The Court recalls that in proclaiming the "right to liberty" paragraph 1 of Article 5 is contemplating the physical liberty of the person; its aim is to ensure that no one should be

dispossessed of this liberty in an arbitrary fashion . . . In order to determine whether someone has been 'deprived of his liberty' within the meaning of Article 5, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.'

This approach was taken in *Ashingdane v. UK* [1985], and repeated in *H.L. v. UK* [2004] (the Bournemouth case) where the European Court held that H.L. was deprived of his liberty because the professionals, under whose care he was, exercised 'complete and effective control' over his 'assessment, treatment, contacts and notably, movement and residence.' Following *H.L. v. UK* [2005], the Department of Health issued guidance on the matter of deprivation of liberty (Department of Health, 2006).

Restraint and medication

The use of sedative medication during restraint can potentially result in unintended and unforeseen complications (the principle of double effect). It is not uncommon that medication which is used to calm down a person results in sending them to sleep, sometimes for significant periods of time. It can be argued in such circumstances that the medication, used for restraint, resulted in the deprivation of liberty and thus contravenes Article 5 rights. Professionals will have to be aware of these potential difficulties to ensure they do not act illegally. Even though the use of medication to restrain a person may not be regarded as unlawful *per se*, it may be considered to be so if it results in depriving them of their liberty. Ultimately, the use of medication can be considered lawful, irrespective of the complications, if it could be shown to be clinically necessary, appropriate and proportionate.

The Act was not designed to authorise deprivation of liberty of persons lacking capacity. However, the Mental Health Act 2007, which received Royal Assent on 19 July 2007, provides amendments to this Act concerning this matter (the Bournemouth safeguards). The amendments authorise deprivation of liberty following a request from hospital or care home managers to the relevant 'supervisory body'. The supervisory body for requests from hospitals will be the relevant commissioning primary care trust or, if in Wales, the Welsh Assembly. The local authority will be the supervisory body for requests from care homes. For those in settings other than hospitals or care homes (e.g. adult foster placements, supported accommodation, day centres, etc.) authorisation will have to be granted by the Court of Protection.

Once an authorisation has been received, the supervisory body will commission assessment into the person's age (must be 18 years and above), mental health and mental capacity. The assessment will also address whether the deprivation of liberty is in the person's best interest, whether it is necessary to prevent harm to them and whether it is a proportionate response. Where it is medical treatment that amounts to a deprivation of liberty, any authorisation will not concern the treatment itself, but the deprivation of liberty it represents. In case



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of an emergency whereby prior authority cannot be obtained from the supervisory body, the managers of the relevant hospital or care home may authorise deprivation of liberty. However, a request for authorisation to the supervisory body will have to be sought within 7 days of the person first being deprived of their liberty. It remains to be seen whether authorisation will still be required where a liberty-depriving emergency treatment has come to an end within the grace period of 7 days.

It will be important that professionals strike the right balance in resorting to restraint so as not to result in the deprivation of a person's liberty. One area of further concern is the restriction of movement of individuals, for instance in a nursing home for the mentally ill. Measures which purpose is to limit the liberty of movement should be exercised with caution, as they could easily encroach onto the deprivation of liberty.

Conclusion

The Mental Capacity Act 2005 codifies the common law doctrine of necessity in relation to acts done on behalf of incapacitated individuals over the age of 16 years. In general, it is unlikely to lead to significant changes in current practice since it does not introduce new powers or duties. Still, the Act, with its amendments, improves the criteria and safeguards for depriving people who lack capacity of their liberty, even though the latter are based on comparatively abstract notions, such as 'best interest', 'proportionality', 'necessity' and 'likelihood of harm'

(Hewitt, 2006). Its effectiveness and success in guarding the interest of those who lack capacity will depend not only on the ability of professionals in hospitals, care homes and other settings to respect the provisions and act lawfully, but also on the ability of individuals and their representatives to access the justice system.

Declaration of interest

None.

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