

# ***Compulsory Admission in England & Wales – use of the Mental Health Act 1983 as Amended 2007***

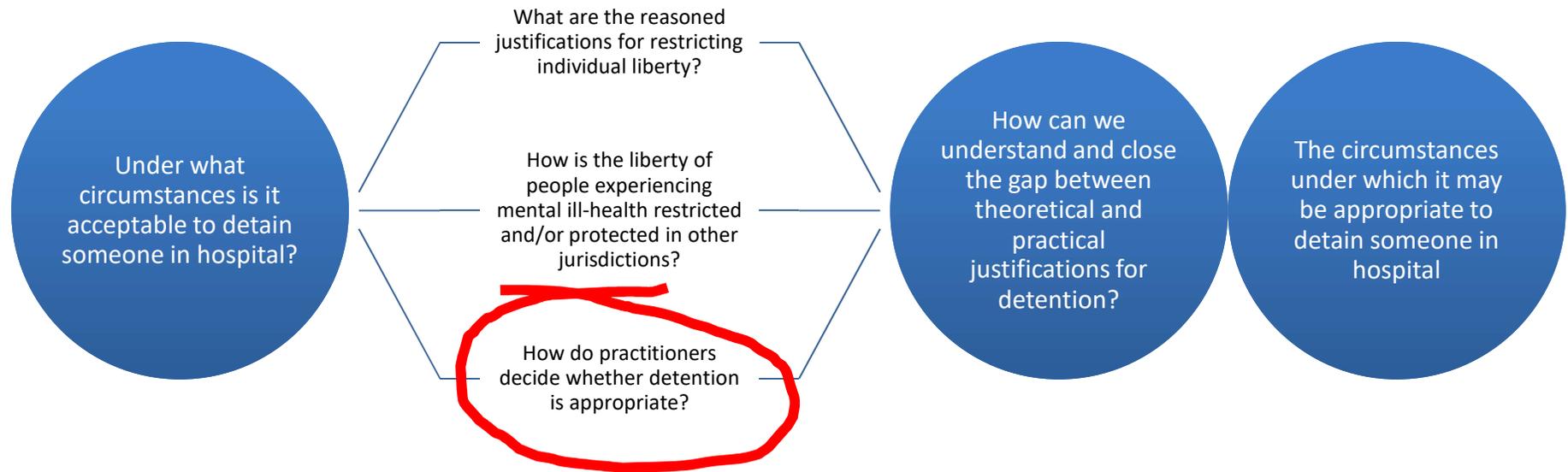
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Acknowledgements:

The Wellcome Trust,  
Cambridgeshire & Peterborough NHS Foundation Trust,  
Anthony Holland, Isabel Clare, Marcus Redley (CIDDRG)  
John McMillan, Michael Gunn, Adrian Grounds

# An alternative approach: integrated empirical ethics



# The empirical study

- ‘Theoretically informed ethnography’ – practice as a source of moral knowledge (Pols)

# What did clinicians make relevant?

- Diagnosis: serious MI > other mental disorder, (bad behaviour)
- Decision-making capacity: functional ability, insight
- Alternatives to detention under MHA: home treatment, persuasion, MCA
- Benefits of treatment: do they outweigh the burdens for this patient?
- Risks of not detaining: harm to others, harm by others, harm to self, 'best interests'

# 'Straightforward cases'

- Clear-cut Soft Paternalism = easy decision to detain
- Clear-cut Hard Paternalism = easy decision to release

*Psy: She had taken an impulsive overdose. She was not suicidal in mood, she was well supported, she wasn't really depressed, it had all been in response to social stress and she was waiting for her parents to pick her up.*

*Psy: he just became very, very psychotic... he thought that he'd cracked some very powerful sort of code and only he knew it. And then he felt that there were these women who were interfering... he actually attacked a girl because of that belief. Not because of anything else, it was because she was interfering with that process that only he was engaged in. And, all of his, like, processes, if you like... to me, he did not have the capacity to make, I think, even small decisions, let alone for his treatment or anything... This was a very unwell man, requires treatment, doesn't have the capacity, and you step in on those grounds.*

# Hard cases

- identifying appropriate cases for Soft Paternalism
- enacting the Harm Principle

*Psy: I think I'm being slightly controversial here, but I think the GP's concern here was more about covering our arses for any potential risk, rather than what was in the best interests of the patient. And I was more concerned about the long-term strategy of managing this person, the therapeutic relationship with the team and so on. So I think we all had slightly different takes on what would be the best thing to do in this case. I think eventually, again I'm being a little bit controversial, I think the GP's fears about a potential nasty incident communicated itself sufficiently to both the social worker and me, and we decided the safest option would be for him to be in hospital.*

# Diagnosis

Practical criterion	Practical Test	'Practical wisdom'
Presence of a serious, treatable condition	Evidence of psychosis or severe affective disorder is elicited, based on previous assessment, collateral information or mental state examination.	(1) Detention for compulsory treatment should not be used simply as a means of enforcing of social norms. (2) Detention is justified by an improvement in an underlying condition.

S3: 'suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital'

[s1(2)Mental disorder means any disorder or disability of the mind, additional conditions for ID, alcohol and drug dependence excluded]

*Psy: we even wondered if this was personality disorder....*

*GP: Mm, I was going to say could it be PD [personality disorder], not depression.*

*PD with alcohol.*

*Psy: Well this is what we got, you know...But the history didn't support that and*

*{psychotherapist} agreed. You know, the history is admission, ECT, sections,*

*hypomanic spell, you know. It just doesn't fit with a personality disorder. But, you*

*know, in between, reasonable function, but not so much recently.*

*Sectioning people with dementia, on the whole, is a bad thing, because it's not fair. It's a different deal, getting sectioned if you've got dementia than if you've got functional illness because if you've got functional illness it's likely that with some treatment you will recover and go back to where you were*

# Decision-making capacity

Practical criterion	Practical Test	Intuitions inferred
Decision-making capacity is impaired	<p>(1) Patient has impaired cognitive capacities, usually as a result of intellectual disabilities, dementia, slowed thinking in depression or disordered form of thought in psychosis.</p> <p>(2) Patient has impaired insight into the nature of the problem or need for treatment, possibly inferred from disagreement with practitioners.</p>	Detention is justified when mental disorder appears to be interfering with the patient's decision-making processes (with concerns expressed over how to judge this objectively).

*Psy: I think basically he seemed to be willing to come into hospital informally and it seemed that he understood the reasons for the admission. He seemed to be having capacity to make that decision.*

*Psy[making the case for detention under the MHA]: And you know, there's something almost cognitively lacking in her, in that she'll have, we'll have a long discussion and at the end of it, the ward round, she'll say 'Can I go home then?'*

# Necessity of detention

Practical criterion	Practical Test	Intuitions inferred
Alternatives to detention ruled out	<p>(1) Community treatment is not viable (will not contain risk, patient is not engaging or carers are exhausted).</p> <p>(2) Informal admission is not possible (patient cannot be persuaded to accept admission, or patient deemed to lack capacity and is not agreeing to admission).</p>	<p>(1) The use of force or overt coercion is a form of moral harm</p> <p>(2) A perception of coercion by the patient may be another form of moral harm. Both of these harms undermine justifications for detention.</p>

S3: such treatment cannot be provided unless he is detained under this section and appropriate medical treatment is available for him

*AMHP: Can she be treated at home? This is what I'd like to know.*

*Psy1: That is, I think, the big question. There is undoubtedly an element of risk. Can that risk be sufficiently ameliorated in home treatment or not? What do you think?*

*Psy2: I'd say no. I think, from the little we know, the picture changes a bit too much.*

*An' I'm not quite sure that home treatment will contain that.*

*Psy [to GP]: We'll recommend a section 2 and the AMHP will complete if she doesn't agree to come in when the ambulance arrives*

*AMHP: We are guided by the principle of the least restrictive alternative. We want to give her some choice but we also need to keep her safe...*

*Psy[to AMHP]: So you said you may decide not to make a recommendation? Depending on whether she comes downstairs or not?*

*AMHP: Yes, I think that just depends on whether or not...*

# Risk

Practical Criterion	Practical Test	'Practical Wisdom'
Failure to detain increases risk to the patient's interests	Failure to treat will result in harm to patient's overall best interests.	Practitioners are obliged to protect the best interests of their patients.

S3: it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment

*GP : So the choices are really do you take the risk of her running off, absconding one more time, possibly killing herself, taking an overdose, doing something risky, or do you say well look, enough's enough.*

*Psy : She's sleeping very poorly, she's up in the night, she was up at three o'clock in the morning and in with her children. Ah, we just don't know what is... what form her behaviour's going to take.*

*Psy : It was in her best interests according to the legal criteria for her to come in, but was also in her best long-term interests for any deterioration or flare-up not to reach the stage where the option to return [to the family home] would have been precluded.*

# Availability of effective treatment

Practical criterion	Practical Test	Intuitions inferred
Benefits of treatment for potential patient outweigh burdens	Proposed treatment is likely to bring about remission or improvement in symptoms in the short-term.	Detention is justified by an improvement in an underlying condition.

S3: appropriate medical treatment is available for him

[s145(4): medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations]

*AMHP : He [man detained for treatment for schizophrenia] went down to a place [hospital] in London and actually did really well.*

*Psy: It was more and more clear for me that if we detain her [a teenager with conduct disorder], it's a very big label on her and it's not at all needed. She does have long-standing issues, but those are all issues that are not something that can be changed, actually, by bringing her into the hospital.*

# Suggestions for practice

- Keep considering capacity and treatability...
- ...but don't impose your values on others
- Approach with caution:
  - Letting awareness of risks outweigh other criteria
  - Using MHA for protection of vulnerable adults
  - Using MHA to promote 'best interests'
  - (Assuming MCA is the 'least restrictive option')

# Suggestions for future legislation

- Base on reason for interfering with liberty (not on what you intend to do)
- A framework for enacting Soft Paternalism
  - Capacity-based (cognitive & evaluative)
  - Promote best interests
  - Procedural safeguards increase with degree/duration of interference
  - Decisions made by clinicians
- A framework for enacting the Harm Principle
  - Only when Soft Paternalism does not apply & CJS is inappropriate (lack of criminal responsibility)
  - Predictability and treatability will affect utilitarian calculus
  - Decisions made by Court

Thanks for listening