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Deprivation of liberty in hospital: the MHA versus DoLS dilemma

ARTICLE

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SUMMARY

When admitting patients to hospital and treating them, psychiatrists and other health professionals may need to deprive them of their liberty. Where this occurs, professionals will need to work within a statutory framework to practice legally and protect their patients' right to liberty under Article 5 of the European Convention on Human Rights. Within England and Wales, some clinical scenarios will require a choice to be made between the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA) and its Deprivation of Liberty Safeguards (DoLS). This choice can be complex, is often overlooked and frequently misunderstood in clinical practice. Deciding between the two frameworks must be done on a case-specific basis. With the use of code of practice guidelines, case law and an unfolding clinical scenario we aim in this article to support clinicians in taking a clear-sighted approach to the dilemma and the factors to consider when deciding between the two regimes.

LEARNING OBJECTIVES

After reading this article you will be able to:

- recognise when mental health patients sit at the interface of the Mental Health Act and the Mental Capacity Act and Deprivation of Liberty Safeguards and are eligible to be admitted and treated under either legal framework
- know the criteria that determine when to use one legal framework rather than the other and how the codes of practice and case law recommend that clinicians approach a dilemma between them
- make a clear-sighted decision between either legal framework, citing relevant factors to support your decision.

KEYWORDS

Psychiatry and law; ethics; human rights; consent and capacity; education and training.

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In this article we explore the legal interface between the Mental Health Act 1983 (MHA) and the Deprivation of Liberty Safeguards (DoLS) of the Mental Capacity Act 2005 (MCA) in England and Wales. We will look specifically at circumstances where clinicians are required by law to choose a framework in order to legally deprive a patient of their liberty and admit them to hospital for treatment of their mental disorder.

Situations where a patient could be subject to either the MHA or the MCA DoLS – the 'MHA versus DoLS dilemma' – are common (Gilburt 2021) and clinicians must justify their use of either framework (Department of Health 2015: para. 13.60), whether they are seeking a DoLS authorisation or making a recommendation for admission under the MHA.

This is a complex area of law, often overlooked in clinical practice, and frequently misunderstood by those involved (Clare 2013; Gilburt 2021). In this article we will explain how to establish that there is a genuine dilemma and how case law and the codes of practice advise it is approached, and list factors that would point to using one framework over the other. Throughout, we will apply these to a fictitious clinical scenario to demonstrate the uncertainty of the law. At the end of the article, we will touch on the future of the interface and make recommendations for when clinicians feel stuck.

'A pressing need for clarity'

The complexity of the MHA and MCA DoLS interface is such that clinicians are required at times not only to apply both frameworks separately to a case, but to then appraise one against the other. This is an exceptional demand on professionals without legal or jurisprudential training. As we will see, it can also require clinicians to make Cartesian distinctions between 'mental health patients' and 'physical health patients', something at odds with our understanding of disease. Our fictitious scenario is designed to demonstrate that even after case law and code of practice guidance is closely followed many cases will still be legally equipoised.

Given this, it is not possible for any paper on the interface to give a single principled answer that resolves all cases, and this is recognised by lawyers and the courts. Nevertheless, clinicians will need to make legally defensible decisions and this article aims to support them to do so with a clearer understanding of where they stand. We also hope to reassure clinicians that the uncertainty goes 'all the way up' and does not rest at their feet to solve. As Mr Justice Hayden remarked in *Northamptonshire Healthcare NHS Foundation Trust v ML* [2014],

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there is 'a pressing need for clarity and predictability at the interface of these two complex regimes'.

Article 5 right to liberty and security and DoLS

At its core, the MHA versus DoLS dilemma is about the need to work within a legal framework when depriving patients of their liberty to treat their mental disorder. It is important to briefly review what it means to deprive a patient of their liberty, why doing so requires a legal framework and why the DoLS exists alongside the MHA.

Article 5 of the European Convention on Human Rights (ECHR) establishes that we all have a right to liberty and security, and for a clinician to confine us to hospital when we are unable or unwilling to agree would, on the face of it, violate this human right (*HL v The United Kingdom* [2004]). However, our right to liberty and security is not absolute and where we are of 'unsound mind' (i.e. have a mental disorder) it can be lawful to be deprived of our liberty, but this must be done in accordance with a procedure prescribed by law.

The MHA 1983 provides a legal procedure but before the introduction of DoLS in 2009 there was no equivalent procedure for patients who were admitted to hospital without capacity to consent to their admission in circumstances that did not 'fit' the MHA – for instance, for treatment of a physical disorder or when they were complying. The inadequacy of this situation was identified in *R v Bournewood Community and Mental Health NHS Trust* [1998] and later ruled on in the European Court of Human Rights case of *HL v UK* [2004]. The lack of a legal framework became known as the 'Bournewood gap' (Box 1).

Following *HL v UK* the DoLS were introduced to amend the MCA and provide a legal procedure for lawfully confining incapacitated patients to both hospitals and care homes. The MCA remained the legal framework for providing their treatment.

In *Cheshire West and Chester Council v P* [2014] Lady Hale explained that patients are deprived of their liberty when three conditions are met: they are subject to continuous control and supervision and are not free to leave (the so-called 'acid test'); they are unwilling or unable to consent to their confinement; and the confinement is 'imputable to the State' (i.e. a public body is responsible for the deprivation, such as the National Health Service or a local authority).

Importantly, a deprivation of liberty needs to be considered when it is judged 'likely' that a patient will be deprived of their liberty. Here, 'likely' means not that it is more likely than not that the person could be deprived of their liberty but that there is a 'real risk', i.e. one that cannot 'sensibly be ignored' (*AM v SLAM NHS Foundation Trust & The Secretary of State for Health* [2013]).

BOX 1 The Bournewood gap

R v Bournewood Community and Mental Health NHS Trust [1998]

HL was a 48-year-old man with autism and severe intellectual disability, unable to speak and living with his paid carers, Mr and Mrs E, who saw him as family. On a visit to a day centre he became distressed and as his carers could not be contacted he was sedated and admitted to the behavioural unit in Bournewood Hospital. As HL was compliant with admission procedures and did not object or make to leave, the Mental Health Act was not used and he was admitted informally. Lacking capacity, he was treated under the common law doctrine of necessity.

Mr and Mrs E appealed his confinement. The House of Lords ruled that, as an incapacitated patient who was not objecting, HL could be detained in hospital under common law doctrine. However, in his review Lord Steyn described with concern 'the Bournewood gap' for compliant incapacitated patients:

'The common law principle of necessity […] contains none of the safeguards of the [Mental Health] Act of 1983. It places effective and unqualified control in the hands of the hospital psychiatrist […].'

HL v United Kingdom [2004]

HL's case went to the European Court of Human Rights. There the court ruled that the common law doctrine of necessity did not meet the Article 5(1)(e) European Convention on Human Rights requirement that a patient's confinement is done in accordance with a procedure prescribed by law.

Together, these definitions greatly expand the circumstances under which patients are or may be deprived of their liberty in hospital. So much so that for patients without capacity being admitted to hospital for a mental disorder, their admission will almost always be a deprivation of liberty (Wessely 2018).

In summary, to legally admit a patient to hospital in circumstances that would deprive them of their liberty, clinicians have three available options (*Northamptonshire Healthcare NHS Foundation Trust v ML* [2014]):

(a) to confirm that the patient has capacity and is giving their informed consent to being confined to hospital
(b) to apply a legal framework such as the MHA or the DoLS
(c) to seek a court order.

(Further nuances to this are explored in Ruck Keene et al, 2019.)

Identifying the dilemma

The way that the MHA and DoLS have been drafted means that there are situations where both can apply

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BOX 2 *AM v SLAM NHS Foundation Trust & The Secretary of State for Health* [2013]

AM was a 78-year-old woman with a 30-year history of depression and a previous informal admission to hospital. She lived with her daughter CM, who had been denying mental health professionals entry to the family home. AM was transferred to hospital under section 135 of the Mental Health Act and admitted under section 2 of the Act. On review of her section the First-tier Tribunal judged that, if discharged, AM would be taken home by her daughter and would not receive the treatment she needed. The family appealed to the Upper Tribunal, arguing that as AM lacked capacity but was compliant with hospital admission her section was unnecessary and she should stay in hospital voluntarily, or under the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) if this were required.

As a compliant patient without capacity, AM sat at the MHA and DoLS interface.

in principle, although they cannot be used together. In *AM v SLAM* [2013] (Box 2) Mr Justice Charles set out the circumstances where this occurs and by extension when and why it does not occur. A visual summary of this is shown in Fig. 1.

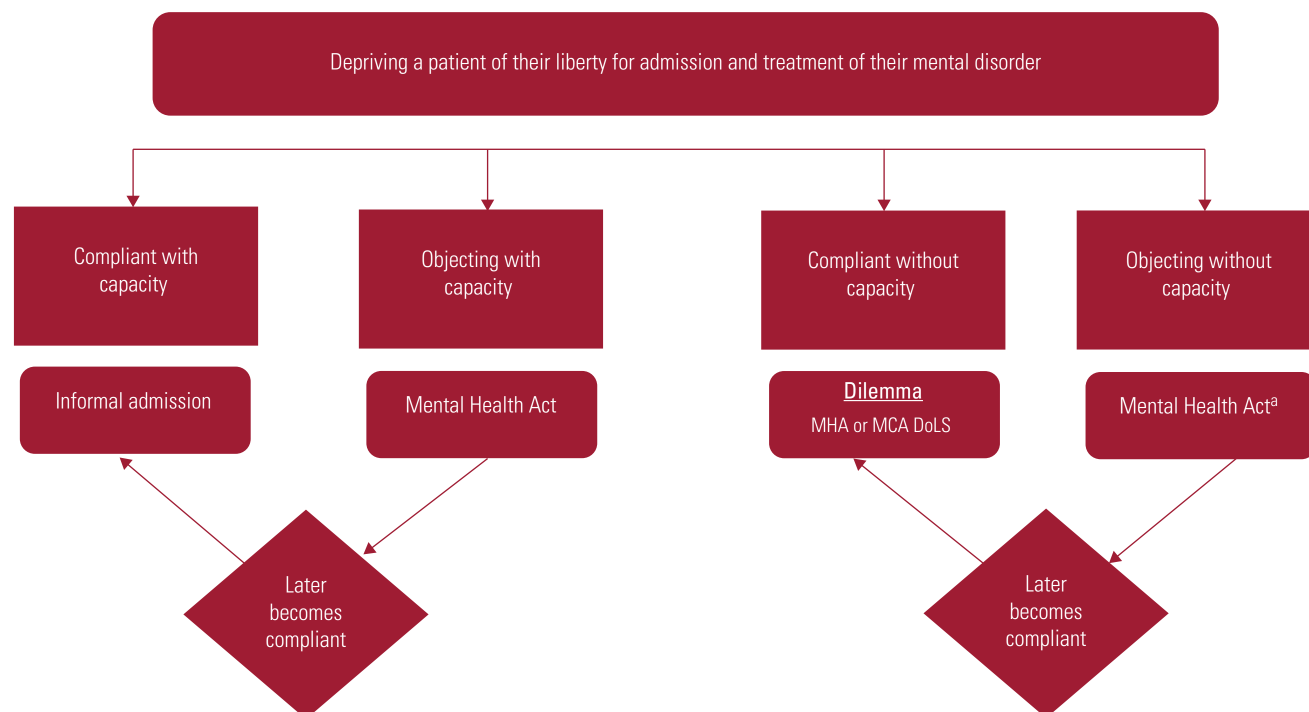
Mr Justice Charles set out three steps clinicians can take to identify the dilemma. They have been put into three medico-legal questions by Ruck Keene et al (2019) and amended only slightly below (they were revisited by Mrs Justice Theis in *Manchester University Hospitals NHS Foundation Trust v JS & Others* [2023], but their substance not changed). They are:

(a) Is the person suffering from a mental disorder for which they require assessment or treatment in a hospital?
(b) Does the person have capacity to consent to the proposed admission to hospital and to the treatment they will receive there for a mental disorder?
(c) Is the person ineligible to be deprived of their liberty under the MCA? Are they objecting?

We will apply these to a fictitious scenario to demonstrate how this decision-making can work and what else clinicians may need to consider.

Clinical scenario: part A

Mr J is a 43-year-old male referred to general hospital by his general practitioner (GP) after concerns were raised by his family that he was low in mood, interacting less and not eating well after being made redundant from work. Mr J is known to suffer from a recurrent depressive disorder and when he is unwell becomes catatonic, requiring electroconvulsive therapy



a. An exception to this is where a patient has a health and welfare lasting power of attorney who is consenting to the treatment to which the patient is objecting. In these instances they may be eligible for admission and treatment under MCA and DoLS.

FIG 1 Deciding between use of the Mental Health Act 1983 (MHA) or the Deprivation of Liberty Safeguards (DoLS) of the Mental Capacity Act 2005 (MCA) when depriving a patient of their liberty for hospital admission to treat mental disorder. Adapted from Sorinmade et al (2015), with permission.

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(ECT). Mr J is mute when approached and on examination he has increased tone, posturing and there is evidence of uneaten lunch at his bedside. The medical team have done bedside observations, blood testing and a computed tomography (CT) head scan and are asking about the next steps for his care.

Step 1 – MHA: mental disorder and the necessity test

For the MHA to apply, clinicians will be aware that patients must be suffering from a mental disorder and, just as importantly, that this is of a nature or degree to necessitate admission for either assessment or treatment. This is known as the 'necessity test'.

When patients are already in hospital receiving treatment for a physical condition, working out whether they need to be in hospital for a mental disorder can be difficult. Clinicians will need to clarify the relationship between the patient's reason for admission and their mental disorder to be sure they can be detained under the MHA. An approach to this was set out in *GJ v The Foundation Trust* [2009], where Mr Justice Charles defined the 'but for' test (Box 3).

In Mr J's case he is relapsing in his depression and is catatonic. At significant risk of self-neglect and a further deterioration in his health, effectively treating him is likely to include medication and ECT but possibly intravenous fluids and supported enteral nutrition too. Irrespective of where he is admitted, treating his mental disorder is likely to meet the necessity test of the MHA. Readers may also decide that the 'total package of care' his mental disorder requires includes physical treatment and that this should be provided under section 145 of the MHA too (Box 3).

On the face of it, therefore, Mr J would be within scope of the MHA.

Step 2 – DoLS: lacking capacity and the 'best interests plus' test

A patient can consent to being confined and admitted to hospital 'informally' for treatment of a mental disorder if they have capacity to do so and have been provided with the information relevant to that confinement. The relevant information was set out in *A PCT v LDV* [2013] and summarised in a useful table by Sorinmade et al (2015) (Supplementary Appendix 1, available at https://doi.org/10.1192/bja.2024.35).

Mr J's inability to communicate means that he is unlikely to be able to consent to his confinement (although a comprehensive capacity assessment is crucial (Beale 2024)) and as he lacks capacity, he falls within the scope of the DoLS. As it is very unlikely that if Mr J tried to leave he would simply be allowed to do so, he is likely, on objective assessment, to be judged as confined to hospital.

Given this, clinicians would need to apply the 'best interests plus' test (Ruck Keene 2019) to work out whether his confinement is legal. They would need to show that it is in his best interests *plus* that it is necessary to prevent harm coming to him and that this is a proportionate response to the likelihood and seriousness of those risks (MCA: Schedule A1 Hospital and care home residents: deprivation of liberty).

If Mr J meets the 'best interests plus' test he would fall within the scope of both the MHA and DoLS, the former as a mental health patient for whom admission is necessary, and the latter as a patient who lacks capacity and needs confining to hospital in his best interests. All else being equal, either regime could be used. There may, however, be reasons the DoLS cannot apply.

BOX 3 'But for' test

GJ was a 65-year-old man admitted to hospital under the Deprivation of Liberty Safeguards (DoLS). He had diagnoses of vascular dementia, Korsakoff's syndrome, alcoholic amnesia and poorly controlled diabetes. The treatment for his mental disorder was supportive and he was not objecting to the medication it required. His admission was prolonged and an application was made to the Court of Protection arguing he should be detained under the Mental Health Act (MHA). In deciding between the DoLS and MHA, Mr Justice Charles concluded that, but for his ongoing diabetes management, GJ would not have needed further hospital admission and so was ineligible for detention under the MHA.

When deciding between the MHA and DoLS the 'but for' test is helpful. It focuses clinicians on working out whether a patient would be treated in the community for their mental disorder if they did not need treatment in hospital for an unrelated physical condition. It can be thought of as the 'real reason test': is the real reason the patient is in hospital for treatment of a physical disorder or a mental disorder?

Answering this involves deciding what the 'total package of care and treatment' is for their mental disorder. For this, section 145(4) of the MHA is relevant.

Section 145(4)

There may be circumstances where hospital treatment is being given for a physical condition and the condition is best understood as a 'symptom or manifestation' of the patient's mental disorder rather than something separate from it. If so, it may be more appropriate to consider the treatment as part of the 'total package of care' needed for the patient's mental disorder when deciding whether they need to be in hospital. Part of a psychiatrist's role is supporting other specialties to work this out.

Awaiting placement?

The 'but for' test can support with other challenging scenarios, such as patients with dementia awaiting a care placement. *But for* somewhere to be discharged to, does the patient require further confinement in hospital for their mental disorder? Here it is worth reiterating that 'case E' objecting patients are only ineligible for DoLS when they are eligible for admission under the MHA (Mental Capacity Act: Schedule 1A, para. 5(4)). For interested readers, Clare et al (2013) explore four variations to this scenario in their paper.

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Step 3 – objection

In Schedule 1A (Persons ineligible to be deprive of liberty by this Act), the MCA lists the circumstances where a patient cannot be deprived of their liberty under the DoLS. These are described in the MCA as ‘cases A to E’.

The case most pertinent to the MHA versus DoLS dilemma in hospital is case E – an objecting patient. Where a patient is objecting either to being a mental health patient or to being given some or all their mental health treatment, and they are eligible for treatment under the MHA, then they cannot be treated for their mental disorder under the MCA (Schedule 1A, para. 5(4)). An exception to this is if they have a health and welfare attorney consenting to the treatment to which they are objecting (Ministry of Justice 2008: para. 4.45). The case E exemption also does not apply to those in a community setting, such as a care home.

In practice, this means that objecting often plays a pivotal role in deciding between the two regimes. As explained in *DN v Northumberland Tyne & Wear NHS Foundation Trust* [2011] the intention here is that those who lack capacity to consent to being admitted to hospital, but are clearly objecting to it, should be treated like those who are objecting with capacity.

Judging whether a patient is objecting is complicated, as is the concept itself (explored by McKillop et al, 2011). Clinicians will need to consider both what the patient is and is not saying, is and is not doing, and their broader beliefs and values. This includes considering circumstances from their past ‘so far as it is still appropriate to have regard to them’ (MCA: Schedule 1A, para. 5(7)).

The codes of practice provide further guidance. The MHA Code of Practice explains that objection from a patient does not need to be reasonable (Department of Health 2015: para. 13.51) and the bar for finding a patient to be objecting is low, recommending that clinicians err on the side of caution if establishing an objection is difficult, or they doubt whether the patient is objecting or if they think that the patient would object if they could (para. 14.20). The MCA stresses that a patient is objecting even if they are only objecting to some of the required mental health treatment, including admission to hospital.

An important dynamic for clinicians not to overlook is whether a patient’s objection is directed towards their admission and treatment or something or someone else (Ministry of Justice 2008: para 4.46).

Clinical scenario: part B

During his admission, Mr J has received intravenous fluids and nutrition via a nasogastric tube. He has not attempted to remove his nasogastric tube or cannula and has not resisted his nursing care, but he has not engaged with staff or family either. He has been admitted to psychiatric hospital under the MHA twice before, receiving ECT each time. The clinical trajectories were similar: he responded well, regained his capacity and then agreed to remain in hospital to complete ECT.

Mr J’s historical relationship to admission and ECT is reasonably well-known. Readers can ask themselves whether it is ‘still appropriate to have regard to’ this known history and whether, given his inability to communicate any preference, they are free of any doubts that he would object to some aspect of his treatment.

As a compliant patient without capacity, if Mr J is judged not to be objecting there would be a genuine dilemma between the legal frameworks (Box 4).

The dilemma: compliant without capacity

For the compliant patient without capacity there is a genuine choice between the DoLS and MHA. In this next section we will review how the codes of practice and case law can support clinicians to decide between them.

Primacy of the MHA?

It is still commonplace for assessors to talk of the MHA taking precedence in instances where either regime can be applied (Gilburt 2021). Until *AM v SLAM*, this appeared to be supported in case law. In *GJ v The Foundation Trust* Mr Justice Charles had previously written that the MHA had ‘primacy’ and this had been generalised beyond the case to mean that any apparent dilemma should be resolved by defaulting to the statutory framework of the MHA.

Priority of the MCA?

In *AM v SLAM* it was argued that AM’s circumstances (and by extension Mr J’s) were precisely those defined in the Bournewood gap. As the

BOX 4 The MHA versus DoLS dilemma: capacity and compliance

The case of *AM v SLAM* clarified the appropriate legal framework (the Mental Capacity Act’s Deprivation of Liberty Safeguards or the Mental Health Act) depending on the patient’s situation:

- compliant with capacity – ineligible for the DoLS under the MCA. Informal admission.
- compliant without capacity – MCA DoLS or MHA
- objecting with capacity – MHA
- objecting without capacity – MHA.

(Adapted from *AM v SLAM NHS Foundation Trust & The Secretary of State for Health* [2013])

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DoLS were introduced for patients falling into this gap they argued that the MCA DoLS should have 'priority'.

'Least restrictive way of best achieving the proposed treatment'

In *AM v SLAM* Mr Justice Charles addressed both these positions and provided us with the clearest summary of the law's current position on the dilemma.

Mr Justice Charles clarified that when referring to the 'primacy' of the MHA he was referring specifically to its primacy in the case of *GJ v The Foundation Trust*, where the patient was objecting. More importantly, he stressed that taking a general position on either framework is dangerous and that deciding which regime to use should be fact sensitive and case specific. He emphasised that there may be cases where a patient is admitted under the MHA where they could otherwise have been admitted under DoLS. In short, neither takes precedence.

Instead, as stated in the MHA Code of Practice, clinicians are advised to use the regime that provides 'the least restrictive way of best achieving the proposed assessment or treatment' (Department of Health 2015: para. 14.13).

Parity between the Acts?

The requirement to identify the least restrictive way of best achieving the proposed treatment may nonetheless be interpreted as, in effect, biasing one Act over another.

It could be interpreted as favouring the DoLS on the grounds that they are an inherently less restrictive framework than the MHA, a view widely held among clinicians (Clare 2013; Gilburt 2021).

Conversely, the requirement 'to best achieve the proposed treatment' may be interpreted as favouring the MHA. This would reflect a similarly widely held view that although the MHA is more restrictive, its safeguards provide a higher level of independent scrutiny better suited to protecting the interests of mental health patients (Gilburt 2021). This view is defended by Jones (2007) and McKillop et al (2011).

Mr Justice Hayden in *Northamptonshire Healthcare NHS Foundation Trust v ML* [2014] was explicit in emphasising the parity of the regimes: 'both regimes afford equally rigorous structures and either one might potentially be suitable on the facts'. This is repeated in the MHA Code of Practice: 'Decision-makers should not proceed on the basis that one regime is generally less restrictive than the other … [nor] proceed on the basis that one regime generally provides greater safeguards than the other' (Department of Health 2015: 13.58–13.59).

The codes of practice and case law acknowledge the qualitative difference between the regimes – that they are not the same – but stress their parity and encourage clinicians to appraise each according to the facts of the case. In doing so, they explain, it may then become apparent that for a particular case one or other regime is less restrictive and better suited to meeting the needs of the patient (Department of Health 2015: para. 13.58).

The dilemma in practice

We are sympathetic to readers who find this advice both a challenge to their conventional understanding of the Acts and, given its deliberately non-specific nature, less than helpful in practice.

Factors to consider

Pulling together guidance from the codes of practice and case law, we set out in Box 5 the factors that need to be considered when making a choice.

There are also commonly cited factors that should be avoided. These were identified in a survey by Gilburt (2021) to explore how clinicians resolved the MHA versus DoLS dilemma in practice. Across a survey of best interest assessors, section 12 doctors, approved clinicians and allied mental health practitioners, the research asked participants how they justified choosing one regime over the other. This provided a list of common reasons that we think should be avoided in clinical practice. We summarise these in Box 6.

There are various reasons to avoid these factors. As mentioned above, the MHA Code of Practice states that clinicians should not base their decision between Acts on their (or by extension their care team's) familiarity with either Act, as they are required to be familiar with both. Choosing between Acts according to personal preference, or a blanket rule or organisational policy is, as Gilburt (2021) puts it, not a choice at all. As the MHA Code of Practice warns, it risks legally arbitrary practice, with the regime chosen according to who is admitting the patient or where in the country they are, rather than the particularities of their case.

Concerns about the availability of assessors for one Act or the other, or the ease with which one regime can be applied, are understandable but not legally relevant when answering which framework is the least restrictive for the patient. It is worth noting too that in the survey responses this concern went both ways, with clinicians in aggregate answering that both the DoLS and MHA were more burdensome. We suspect concerns about burdensomeness partly reflect a familiarity and preference for one Act over the other.

There are real difficulties created by the resource-constrained environments clinicians operate in. However, choosing a regime to overcome resource constraints or to facilitate one aspect of a patient's

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BOX 5 The MHA versus DoLS dilemma: factors to consider (suggesting the Mental Health Act)

Fluctuating capacity (MHA Code of Practice, para. 4.22)

Where a patient's capacity fluctuates frequently and on regaining capacity it is unlikely they will consent to their confinement or treatment, then the MCA will be less suitable.

Likely non-compliance (*AM v SLAM NHS Foundation Trust & The Secretary of State for Health* [2013])

As with questions of capacity, if the patient is unlikely to remain agreeable to confinement and treatment then the MHA will be more suitable.

Harm to others (MHA Code of Practice, para. 4.22)

Where restraint is required to maintain the safety of others – and would not be authorised by the MCA as a proportionate response to prevent the patient harming themselves – then the MHA will be required.

Recall powers (DoLS Code of Practice, para. 4.48)

Where it is important for hospital managers to have a formal power to return a patient to hospital who is away without leave then this will require the MHA.

Advance decision-making (MCA Code of Practice, para. 9.37)

An advanced decision to refuse confinement or treatment for a mental disorder can be overruled by the MHA but not the MCA.

Section 117 aftercare

In *Manchester University Hospitals NHS Foundation Trust v JS & Others* [2023], Mrs Justice Theis stressed that MHA section 117 aftercare is designed to facilitate discharge for mental health patients. The MHA may be more suitable where discharge is likely to be complex or protracted.

(Mental Health Act (MHA) Code of Practice: Department of Health 2015; Deprivation of Liberty Safeguards (DoLS) Code of Practice: Ministry of Justice 2008; Mental Capacity Act (MCA) Code of Practice: Department for Constitutional Affairs 2007)

treatment (e.g. expediting their admission to a mental health bed) misuses the Acts, which are designed to provide the most appropriate legal framework for all the care and treatment a patient requires (Gilburt 2021).

How the dilemma is resolved in practice

Despite a range of factors to consider and avoid, choosing between the MHA and DoLS can remain unclear. In the face of this uncertainty, clinicians are likely to be resorting to more general, heuristic, approaches (Clare 2013; Gilburt 2021).

Gilburt (2021) suggests that professionals are unlikely to be approaching their decision from a position that the Acts are considered equal. She noted that participants' choices were broadly influenced by their professional role, their patient's clinical condition and the treatment or care the patient required. When asked, allied mental health professionals, approved clinicians and section 12 approved doctors skewed towards using the MHA, whereas best interest assessors skewed towards using the MCA. Patients with delirium, dementia, intellectual disability or permanent brain injuries were considered more suitable for the MCA DoLS than those with psychotic or mood disorders. Patients requiring psychotropics, ECT or behavioural interventions were considered better suited for the MHA than those requiring treatment of physical health problems, social care placement or hospital admission because of social concerns or placement breakdown.

Research into decision-making at the interface suggests it is likely that clinicians' perspectives are at odds with the ethos of parity and least restriction set out in case law and the codes of practice. As Gilburt (2021) implies, asking clinicians to weigh which of the MHA or DoLS is least restrictive in any given circumstance may be countercultural to

BOX 6 The MHA versus DoLS dilemma: factors to avoid

Familiarity or burdensomeness

Clinicians may choose a framework because they, or their team, are more familiar with it or they think it is simpler or less burdensome to apply.

Preference or blanket rules

Clinicians may have a personal preference for one framework or operate within an organisation that prohibits the use of a framework in certain circumstances, for example limiting use of the Mental Health Act (MHA) in general hospitals or Deprivation of Liberty Safeguards (DoLS) in psychiatric hospitals.

Availability of assessors

Clinicians may choose a framework on the grounds that they are struggling to find the relevant assessors, or there will be delays in reviews or responses to applications.

Bed availability

Clinicians may choose a framework because without it they will struggle to find the patient a bed (e.g. struggling to admit a patient unless they are detained under the MHA).

(After Gilburt 2021)

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a conventional view that never considers the MHA as less restrictive. Gilburt's (2021) concern about a lack of understanding of the MHA and DoLS interface was shared by Clare et al (2013), suggesting little change over time.

Clinical scenario: returning to Mr J

This friction between practice and guidance is perhaps best illustrated by returning to our clinical scenario.

The factors to consider and avoid above do not appear to take us further in determining which regime to use for Mr J. One relevant consideration is the use of ECT. As ECT has its own statutory requirements under the MHA (section 58A criteria) we imagine most clinicians would argue that the MHA is the most appropriate legal framework as the very presence of these safeguards implies their need. Conversely, the MCA explicitly identifies ECT as a 'serious medical treatment' (Department for Constitutional Affairs 2007: para. 10.45) and in doing so identifies the legal procedure to administer it under the MCA. This includes applying for the safeguard of an independent mental capacity advocate (in the absence of someone other than paid staff to support the patient in determining their best interests) (para. 10.1), considering applying for a second opinion (para. 10.31) and, if required, referring to the Court of Protection (para. 10.37).

We suspect that for many clinicians Mr Justice Hayden's remarks that these safeguards are 'equally rigorous' and that the least restrictive option (*Northamptonshire Healthcare NHS Foundation Trust v ML* [2014]) should be considered will be at odds with the perspective they take when deciding on this case.

When in doubt

Clinicians may still feel stuck. Here, reflecting on the institutional, personal and interpersonal pressures involved and recognising that there may be no 'good' outcome is important (Adshead 2021). Indeed, the law does not demand perfection. What it demands, in effect, is a coherent explanation of why one regime has been chosen over the other. Making a choice with a clear rationale will remain best practice.

In some cases, most obviously those where there is a debate about whether the patient is objecting, there can be a 'stand-off' between those concerned with the MHA and those concerned with DoLS. Mrs Justice Theis emphasised in *Manchester v JS* [2023] the need in such cases for a discussion to take place between the relevant bodies in a 'spirit of cooperation and appropriate urgency'. Ultimately, the Court of Protection can be approached for a determination as to whether a patient is an 'MHA patient' or a 'DoLS patient', although this should always be seen as a last resort.

Future resolutions to the dilemma

As argued by Ruck Keene (2013), the level of complexity and uncertainty in this area of the law may mean it fails to meet the test of 'lawfulness' set out in the Europe Court of Human Rights: namely, that the law needs to be precise enough for citizens to reasonably foresee what the legal consequences of a given action might be (*HL v UK* [2004]).

In its proposed revisions, the Independent Review of the Mental Health Act 1983 (Wessely 2018: p. 27) aimed to provide greater certainty at the interface, recommending that the MHA should only be available where a mental health patient without capacity is obviously objecting to their admission; otherwise they should be admitted and treated under the MCA DoLS. If so, we suspect Mr J would be admitted and treated with ECT under the MCA and DoLS.

Unfortunately, at the time of writing it is unlikely that further clarity will be achieved by statutory reform. Proposals by the Independent Review of the Mental Health Act were not accepted by the previous government in its draft Mental Health Bill 2022, and the Liberty Protection Safeguards, intended to replace DoLS, maintain the same policy line as in DoLS. If or when the Liberty Protection Safeguards are introduced, they would recast the dilemma in slightly different language but not fundamentally alter it.

Summary

When considering a legal framework to confine a patient to hospital for treatment of their mental disorder, choosing between the Mental Capacity Act's Deprivation of Liberty Safeguards and the Mental Health Act can be complex. The guidance provided in the codes of practice and in case law helps frame how to identify and approach this dilemma. They emphasise parity between the regimes, taking a case-based approach and focusing on the least restrictive option. This is likely to be at odds with how clinicians conventionally understand both Acts and determine which one to use.

Supplementary material

Supplementary material is available online at https://doi.org/10.1192/bja.2024.35.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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J.C. drafted the article, with written contributions from A.R.K. and M.L. All authors agreed the final content.

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Declaration of interest

None.

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MCQ answers
1 b 2 c 3 d 4 e 5 e

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MCQs

Select the single best option for each question stem

1 **Deprivation of Liberty Safeguards were devised as a procedure in UK law to safeguard which ECHR Article for patients lacking capacity?**
a Article 6 Right to a fair trial
b Article 5 Right to liberty and security
c Article 9 Right to freedom of thought, conscience and religion
d Article 2 Right to life
e Article 8 Right to respect for private and family life

2 **When is a patient eligible to be treated under either the MHA or DoLS?**
a When the patient has capacity and is objecting
b When the patient lacks capacity and is objecting
c When the patient lacks capacity and is complying
d When the patient has capacity and is complying
e None of the above

3 **When considering whether a patient is objecting to their mental health treatment, which of the following statements is *false*?**
a A health and welfare attorney can consent to treatment on behalf of an objecting patient
b The objection exemption of the MCA does not apply to those in the community, for example patients in a nursing home
c A patient's past relationship to mental health treatment should be considered so far as it is still appropriate to do so
d The objection exemption of the MCA applies only if the patient is objecting to all the proposed mental health treatment, including admission
e Clinicians should err on the side of caution and assume an objection if they have doubts

4 **Which of the following is *not* a factor to avoid when considering which legal regime to use?**
a Familiarity or burdensomeness
b Preference or blanket rules
c Availability of assessors
d Bed availability
e The patient's fluctuating capacity

5 **When deciding between the MHA and DoLS, which approach is recommended?**
a The MHA has primacy
b The MCA DoLS take priority
c The MHA should be picked as it is inherently better suited to mental health patients
d The MCA DoLS should be picked as they are procedurally lighter and more respectful of patient autonomy
e Clinicians should choose the least restrictive way of best achieving the proposed treatment

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