The Bournewood proposals were issued by the Department of Health to clarify issues surrounding the compliant incapacitant patient where they are being, or risk being, deprived of their liberty. Drs Nusrat Khan, Shirish Bhatkal and Ajit Shah discuss why successful implementation of these proposals will require further clarification regarding some of the practical issues that arise.

The Bournewood proposals will have a significant impact on the day-to-day practice of clinicians dealing with people in hospitals and care homes who lack capacity and are deemed at risk of deprivation of liberty. The Bournewood case concluded in October 2005 at the European Court of Human Rights where the court ruled that the informal admission of a compliant incapacitous patient constituted detention resulting in a breach of Article 5(1) and Article 5(4) of the European Convention on Human Rights. Following this ruling the Government has committed itself to provide a legal framework that will afford greater protection for such individuals. ‘At the first available legislative opportunity’ the amendments will be made to the Mental Capacity Act 2005 through the Mental Health Bill. To this effect the government has issued via the Department of Health — the Bournewood proposal.

The Bournewood provisions will cover patients in hospitals and people in care homes under the Care Standards Act 2000. This Act provides for the administration of a variety of care institutions, including children’s homes, independent hospitals, nursing and residential care homes, whether placed under public or private arrangements. Hospitals or care home managers will have to apply to the relevant supervisory body for authorisation of deprivation of liberty. Without this authorisation, it will be unlawful to deprive someone of their liberty under the Mental Capacity Act 2005. This Act clarifies the legal uncertainties arising from existing common law regarding consent to medical treatment. It deals with decisions relating to people who lack mental capacity and are unable to act autonomously. It will be up to the supervisory body (the relevant local authority in the case of care homes and the relevant primary care trust in the case of hospitals) to obtain the prescribed assessments and also appoint an Independent Mental Capacity Advocate (IMCA) for ‘unbefriended’ patients. These include age, mental health, mental capacity, best interest, eligibility and objections assessments. If authorisation is given, the duration will be determined on a case-by-case basis — with the maximum period being 12 months before reauthorisation is required if necessary. If granted, the supervisory body must appoint someone to act as the person’s representative, based on the recommendations of the best interests assessor. The proposals also make provisions for review of authorisation if deemed necessary by interested parties (eg, the person appointed as their representative, or an attorney or deputy).

The Government estimates that as many as 50,000 of those permanently admitted to care homes and 22,000 hospital inpatients may be affected. It is anticipated that in the main, this will affect elderly people suffering with dementia as well as those with significant learning difficulties. Implementing the proposals for this group of people will inevitably lead to an increased burden on services catering for this population.
The proposals, alongside creating new rights, will also impose unfamiliar duties on local authorities, NHS hospitals and the independent sector. The proposals raise many practical questions; among these is what would amount to deprivation of liberty as opposed to restriction of liberty. The proposals state the distinction between the deprivation of and the restriction upon liberty is merely one of degree or intensity, and not one of nature or substance. Without further clarification of such ambiguous terms, the care home managers and the hospital authorities may find it difficult to identify those at risk of deprivation. Despite the publication of the Draft Illustrative Code of Practice, definition of this term continues to be an issue. There is a possibility that in order to prevent unlawful detention of people and subsequent legal action, there may be an over inclusion of people identified for authorisation resulting in a larger than anticipated burden on the services.

Further clarification will be required regarding the training and expertise of assessors to undertake the necessary assessment as detailed in the proposals. Considering the complexity of the range of assessments required, there would be a need for more than one assessor, which in itself raises questions of resources and whether the supervising local authorities and primary care trusts have the staff capacity. This is particularly pertinent given the current situation regarding the shortage of social workers currently responsible for the majority of such assessments. A substantial number of such assessments will take place in the elderly population with dementia requiring long-term care. Geriatric wards may be faced with additional responsibilities of identifying and seeking authorisation while managing delirious patient; this may impair their ability to dispense more routine day-to-day care. There is a potential for authorisation to be refused, placing clinicians in a difficult situation regarding the patients' future management. The provision of appeal to the Court of Protection in such scenarios will obviously delay decisions resulting in longer hospital admissions. With these additional responsibilities and potential liabilities placed on care homes, there may be reluctance for them to admit complex cases possibly resulting in an increased number of delayed discharges from hospitals adding extra burden to the already struggling NHS.

Conclusion

Through issuing the Bournewood proposals the Government intends to close the ‘Bournewood gap’, where people who lack capacity to consent are treated informally in circumstances that amount to a deprivation of liberty. These proposals go some way towards strengthening the rights of hospital patients and those in care homes, as well as ensuring compliance with the European Convention on Human Rights. However, in order for its successful implementation there are a number of practical issues as highlighted above that need further clarification. There is a need for clinicians to be aware of the new proposals and the likely impact on their practice.

Conflict of interest: none declared.

References

1. HL v. United Kingdom
4. Hewitt D. Closing the Bournewood Gap? 156 NLJ 1234, August 2006

Key points

- The ‘Bournewood gap’ describes a situation when people who lack capacity to consent are treated informally in circumstances that amount to a deprivation of liberty.
- Authorisation for deprivation of liberty needs to be granted following appropriate assessments by the supervisory body.
- Many practical considerations arise from the proposals including financial implications, training and expertise of assessors, and potential conflicts of interest.

Concerns have been raised about the status of the local authority as the ‘supervisory body’ where the patients in the care home are funded by the same local authority. This could result in a conflict of interest as the local authority would have a financial interest in whether to authorise or refuse a deprivation of liberty. There are obvious financial implications in implementing the proposals, including the cost of assessments and reassessments, which will need to be conducted after the period authorised for detention. This is particularly important in the elderly population with dementia requiring long-term care. Geriatric wards may be faced with additional responsibilities of identifying and seeking authorisation while managing delirious patient; this may impair their ability to dispense more routine day-to-day care. There is a potential for authorisation to be refused, placing clinicians in a difficult situation regarding the patients’ future management. The provision of appeal to the Court of Protection in such scenarios will obviously delay decisions resulting in longer hospital admissions. With these additional responsibilities and potential liabilities placed on care homes, there may be reluctance for them to admit complex cases possibly resulting in an increased number of delayed discharges from hospitals adding extra burden to the already struggling NHS.