Autonomy, liberty, and risk: The ethical and legal challenges of suspending leave of absence for patients detained under the Mental Health Act 1983 during the COVID-19 (coronavirus) pandemic

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Abstract

During the COVID-19 pandemic, many governments around the world have imposed significant restrictions on freedom of movement to tackle the virus. Mental health units have mirrored this approach, implementing restrictive measures to safeguard the health of patients, staff, and the wider community. This paper explores the relevant legal provisions and ethical principles that guide medical decisions regarding restriction of liberty, before considering the suspension of leave from hospital that occurred in several mental health services in response to the pandemic. It reviews how existing ethical principles within the field of public health may support a better-informed decision-making process, should similar widespread restrictions be imposed again.

Keywords

COVID-19, coronavirus, mental health law

Introduction

Professionals within mental health services are regularly confronted with complex decisions about their patients; decisions that are often shaped by ethical principles, and both international and domestic law.¹ One of the most common dilemmas faced by clinicians involves balancing patient autonomy and liberty against the risks associated with mental disorder.

Negotiating these dilemmas is made more challenging by an evolving landscape in which there are changing attitudes towards autonomy and developments in the relevant law.² The COVID-19 pandemic has subsequently added fresh complexity to the decision-making around preventative detention and leaves from hospital.

This paper will first outline the ethical principles that guide detention in hospital, before applying these principles and the relevant case law to the suspension of leave from mental health units that occurred during the COVID-19 pandemic in England and Wales.³ Finally, it will consider how available guidance on the ethics of public health emergencies may support future decision-making.

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Changing attitudes towards patient autonomy is reflected in the proposed changes to the Mental Health Act (MHA 1983) in England & Wales, with the independent review of the MHA 1983 focusing its recommendations on reducing compulsion and increasing patient choice.6 These recommendations are set alongside international treaties that challenge existing domestic mental health law. The UN Convention on the Rights of Persons with Disabilities (UNCRPD) is a human rights treaty that aims to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities’.7 Although not formally incorporated into UK law, the UNCRPD was ratified by the UK government in 2009 and has influenced politics8, academic debate9, and judicial opinion.9

The UNCRPD remains a controversial document that is at odds with many aspects of UK mental health law, principally because it opposes differential treatment grounded by the presence of a disability. But it provides global context to the shifting attitudes towards mental health and the right to self-determination.

**Liberty**

Civil liberties are rights and freedoms guaranteed by governments to their citizens, and, particularly in western states, the primary responsibility of government is often regarded as being the duty to protect and safeguard its citizen’s lives.10 The shape of UK law has been strongly influenced by the European Convention on Human Rights (ECHR)11, a document signed by member states of the Council of Europe to protect the human rights of citizens in the wake of the second world war. The ECHR was ‘domesticated’ as part of UK law by the Human Rights Act 1998 (HRA 1998).12 The convention contains a number of ‘Articles’ which oblige states to protect specific rights. For the purpose of this paper, the key rights considered are:

- Article 2 – Life
- Article 5 – Liberty and Security
- Article 8 – Respect for Private and Family Life

Liberty is not an absolute right and restrictions on, or deprivation of, liberty may be justified to protect people. Mental health services are regularly confronted with this dilemma when having to consider the potential risks associated with mental disorder, which in some cases requires admission to hospital under the MHA; a form of preventative detention based on risk assessment.

**Estimation of risk**

Most clinicians would agree that the assessment of risk pervades mental health services.13 The definition of risk itself is complex, with some arguing that the term is not only a measure of danger but is also influenced by the perceived ‘outrage’ that a hazard may cause.14

Mental health legislation in almost all European countries is influenced by ‘risk thinking’.15 The statutory criteria of the MHA 1983 require someone to be detained on the grounds of their risk to themselves or others, and leave is often granted with specific conditions to mitigate risk.

The ethical principles of medicine begin with the injunction that doctors make the care of the patient their first concern, and in doing so manage risks associated with their health. However, managing the risk they pose towards others is a more contentious issue. Most philosophical accounts of responsibility conclude that adults are not responsible for the actions of another unless the other person is:

(a) Mentally incapable of making their own decisions, or
(b) In the legal custody of another person.

The latter condition applies to all people detained under the MHA, and so, it has been argued that psychiatrists are responsible for the behaviour of patients who are detained involuntarily.16

Remaining objective while aiming to avert tragic outcomes such as suicide or violence is probably an impossible task, and clinicians, like all humans, are vulnerable to cognitive biases and errors in reasoning: perceived risk and actual risk tend to be very different things.17

However, rather than considering the risk of self-harm, suicide, or violence, the COVID-19 pandemic presented a new dimension to risk assessment – one in which the health of the wider inpatient population, healthcare staff, and the general public also had to be considered.

**The Mental Health Act 1983 and Section 17 leave**

In England and Wales, the MHA 1983 is the primary legislation governing the detention and treatment of those suffering from mental disorder.18 The MHA 1983 includes the powers to detain people and safeguard to protect the rights of those detained under its provisions. It has also been shaped by the ECHR, which permits preventative detention if necessary for the treatment of those with ‘unsound mind’.11 The MHA 1983 allows the authorising body to grant leave of absence from hospital to persons detained under the act if such leave is considered therapeutic in nature.

In England and Wales, guidance on the use of the MHA 1983 is contained in the Mental Health Act Code of Practice (hereafter, the ‘Code’).19

The Code acknowledges that leave can present risks but advises that these risks should be balanced against any
potential benefits. The Code also states that hospital managers cannot overrule a doctor if they decide to grant leave to a patient. It advises that any ‘blanket restrictions’19 that apply to all patients in a particular setting should be avoided. However, it accepts that in some circumstances, blanket restrictions may be necessary for the protection of patient safety, or the safety of others.19 In these circumstances, there must be a clear justification for these restrictions, and they cannot be imposed for the convenience of the healthcare provider.

Section 17 (s.17) of the MHA 1983 outlines the conditions in which a person detained under the act can leave hospital lawfully (see Figure 1).19

As inpatients progress towards discharge, it is common practice to allow periods of leave in which patients are free to visit their local community for an agreed duration. The responsible clinician (RC) is the Approved Clinician with overall responsibility for their care and is usually the primary treating consultant psychiatrist. For detained patients, periods of leave can be authorised by the RC under s.17 of the MHA.

There is evidence to demonstrate that the process of rehabilitation improves long-term outcomes and reduces the risk of relapse.20 However, if an RC’s ability to grant leave is adversely affected, then there is the potential for prolonged periods of detention, delayed discharges, and severe restrictions of liberty.

Although the legislative details of the MHA 1983 and s.17 leave are specific to England and Wales, the challenges posed are of broader relevance and would potentially apply to any jurisdiction with similar mental health legislation provisions in which agreed periods of leave line the route towards discharge from an inpatient mental health service.

COVID-19

COVID-19 led to widespread restrictions on freedom of movement, including the use of ‘lockdowns’ (see Figure 2).21 This legislation was introduced on a background of pre-existing Public Health protection powers.

The most important measures are contained within the Public Health (Control of Disease) Act 1984 (as amended) together with the Health Protection (Local Authority Powers) Regulations 2010 and the Health Protection (Part 2A Orders) Regulations 2010.22 These powers are available to local authorities and can be exercised without judicial oversight or application to a justice of the peace. Such powers can require a person to undergo medical examination; be taken to hospital (and be detained in hospital); be kept in isolation; and be made subject to restrictions on who they can have contact with.22

In a way not dissimilar to mental health legislation, public health protection powers have also been shaped by the ECHR, which includes ‘prevention of the spreading of infectious diseases’ within its exemptions on rights to liberty outlined in Article 5.11 Their application also turns on risk assessment; however, in the case of public health interventions, the risk assessment is specifically graded in terms of severity of illness, certainty of diagnosis, transmissibility, and the effectiveness of any proposed intervention.22

The Coronavirus Act proposed a wide range of potential legislative changes in response to the pandemic, including emergency changes to the current MHA legal framework.23 However, this was only ever to be implemented in a ‘worst-case scenario’ in which the effects of the pandemic may have impeded access to essential care.24 This never came into place, and on 30/09/20, it was announced in parliament that the government would seek to remove the MHA emergency provisions from the Coronavirus Act.24

COVID-19 and Mental Health Services

Mental health services have had to consider their own restrictions and navigate the borderlands between promoting the autonomy of their patients while mitigating the risk of infection.

The mortality rate associated with COVID-19 infection increases with age and medical comorbidity25, and conditions such as diabetes, obesity, and lung disease have been identified as key factors in COVID-19-related deaths.26 These comorbidities are over-represented within the inpatient mental health population.27

In addition to providing care for a higher-risk population, managers of inpatient mental health services must contend with institutional challenges associated with curbing the disease. Many inpatient units in the UK typically consist of wards with shared bathrooms and communal areas where patients can interact with each other. In rehabilitation settings, ward environments are often designed to feel less institutional: wards may have shared living spaces, kitchens, and pool tables. Although these facilities serve to provide an environment that promotes health and well-being, they also increase the potential for the spread of infection.

Those experiencing mental illness may also present unique challenges in terms of behavioural dysregulation. For instance, those in the acute stage of a manic episode are unlikely to conform to social distancing measures, while cognitive impairment may limit understanding regarding the risk of transmission and the rationale for social isolation.28

The combination of these demographic factors and institutional challenges provides the potential for severe outbreaks of COVID-19 within inpatient mental health units, therefore complicating the assessment of risk in advance of granting leave. The movement of patients to and from the community is in direct opposition with the public health principles of restricting movement and shifting social mixing patterns to reduce disease transmission.29
Although clinicians need to consider the therapeutic benefits of s.17 leave, a patient introducing infection on their return could have drastic ramifications.

**COVID-19 and Section 17 leave**

During the first year of the COVID-19 pandemic, several mental health services suspended all s.17 leave for patients detained under the MHA, in response to government restrictions on movement in line with public health advice in relation to infection control.3

The Care Quality Commission (CQC), the UK’s inspector of Health and Social Services highlighted this issue in their annual report, *Monitoring the Mental Health Act in 2019/2020.*3 The report outlined several instances in which mental health services had applied blanket restrictions on s.17 leave in response to the pandemic. In some cases, this applied to patients with unescorted leave and specific concerns were raised about the potential for such restrictions to delay discharges from hospital.

Legal guidance was published by both NHS England30 and the Royal College of Psychiatrists24, specifically addressing the issue of s.17 leave. The guidance explained that patients deemed to have capacity to understand public health advice such as social distancing measures should be assumed to be able to comply with such advice and be granted leave, unless there is evidence to the contrary.30 The guidance described how extended restrictions on leave had the potential for psychological harm, especially for those with a history of trauma.24 It suggested that while the risk of COVID-19 may occasionally justify the restrictive practice, healthcare providers should always use ‘the least restrictive methods possible’ and any restrictions should end at the ‘earliest opportunity’.30 This contradicted the actions of some services highlighted in the CQC report that maintained restrictions long after the public lockdown eased.3 The CQC report also stated that mental health services should continue to facilitate leave as much as possible, while remaining in line with public health guidance. The report referred to pre-existing guidance on ‘blanket restrictions in mental health wards’, advising that the ‘default position’ is that they should be avoided, unless they can be justified as necessary and proportionate.31

This guidance appears to reflect a landscape in which the promotion of autonomy serves as a core component of ethical and legal decisions. Yet in practice, decisions are rarely simple. The Royal College of Psychiatrists’ ethical advice on COVID-19 acknowledges that, ‘individual needs and preferences are not automatically considered secondary to collective or community needs’ and that decisions may need to be made based on the best interests of all, not just the individual, ultimately concluding that ‘each case turns on its own merits’.32

Arguably, the ethical dilemmas presented will become more challenging as the prevalence of COVID-19 diminishes and the risk–benefit ratio of community leave becomes more finely balanced. COVID-19 has also become an emotive topic that has divided many, with some calling for tougher restrictions, while others protest the perceived abuses of fundamental freedoms.33

Remaining objective amongst this political landscape, and indeed our evolving understanding of the illness itself, has not been straightforward.

**COVID-19: Ethical and legal challenges for the Mental Health Act**

Despite the risks associated with COVID-19, the pandemic occurred amidst a time of changing attitudes towards

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**Community Leave**

**Section 17**

According to section 17 of the MHA, the Responsible Clinician (RC) may grant to any patient who is for the time being liable to be detained in a hospital under this Part of this Act leave to be absent from the hospital subject to such conditions (if any) as that clinician considers necessary in the interests of the patient or for the protection of other persons.

A person detained under the MHA may initially be granted short periods of leave, such as 30 minutes. However, this can increase to several days. The MHA Code of Practice advises against granting leave beyond 7 days. Patients who are able to safely utilise leave for 7 days should be considered for discharge.

**Figure 1.** Community leave.
mental disorder and autonomy, with documents such as the UNCRPD questioning the legitimacy of preventative detention.\textsuperscript{34} Just as many people questioned the justification of the lockdowns, many patients questioned the infringements on autonomy that some services employed during the pandemic.\textsuperscript{3}

Some patients argued that their use of leave was an ‘essential’ element of their daily routine and preventing them from carrying out tasks such as shopping for necessities was unfair, given that members of the public were not stopped from doing so.\textsuperscript{3} The ‘lockdown laws’ also allowed the public to utilise two hours outdoors for exercise. Although outdoor spaces should generally be available within mental health units, they remain within the confines of security fencing and the authors have personal experience of patients stating that stepping outside the fence is a profoundly different experience. The restrictions could be considered as discriminatory in the way they compound restrictions of liberty on those already detained under the MHA 1983. Similar restrictions were not widely imposed upon patients in non-mental health services.

The available case law regarding hospital leave does not specifically address the dilemmas faced during the pandemic, but does reflect the changing attitudes towards autonomy and the consideration of risk when granting leave.

In 2012, following the death of a patient by suicide, the Supreme Court of the United Kingdom accepted that an NHS trust had breached the positive obligation to protect life imposed by Article 2 by allowing the patient to utilise leave despite there being a recognised suicide risk (\textit{Rabone v Pennine Care NHS Foundation Trust}.\textsuperscript{35}) In her judgement, Lady Hale commented that the state had a ‘special duty’ to protect vulnerable individuals, with the decision apparently favouring the view that right to life outweighed the promotion of patient autonomy.

However, in recent years, similar cases have reached differing conclusions in the European Court of Human Rights: even following suicides, the Court has held that healthcare providers were right to provide leave in order to promote patient autonomy (see \textit{Hiller v Austria}\textsuperscript{36} and \textit{Fernandes de Oliveira v Portugal}.\textsuperscript{37})

In the case of \textit{Hiller v Austria}, the Court’s judgement included specific reference to hospital leave, stating: ‘The Court considers that from a Convention point of view, it is not only permissible to grant hospitalised persons the

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**Figure 2.** The lockdown laws.
maximum freedom of movement but also desirable in order to preserve as much as possible their dignity and their right to self-determination. It also follows from the case-law on Article 5 of the Convention that a deprivation of liberty must be lifted immediately if the circumstances necessitating it cease to exist or change (see, for example, Winterwerp v. the Netherlands)... or must be scaled down to the extent which is absolutely necessary under the given circumstances.\textsuperscript{36}

In the case of Fernandes de Oliveira v Portugal, the Court explicitly referenced the UNCRPD and stated that ‘the therapeutic desire to create an open regime where the patient retained the right to move about freely...is in line with the international standards which have been developed in recent years on treating psychiatric patients’.\textsuperscript{38}

These judgements point towards a more balanced approach when considering the positive obligations engaged by Articles 2 and 5 of the ECHR. Importantly, the ECHR prohibits arbitrary detention and any decision to restrict movement must be based on sound reason and subject to regular, independent review.\textsuperscript{11}

However, there are also sound ethical justifications for restricting autonomy and freedom in response to an infectious disease. In 2007, the World Health Organisation (WHO) published guidelines for public health ethical considerations in response to pandemic influenza.\textsuperscript{39} The guidelines included ethical principles that should be applied when enforcing social distancing and restrictions of liberty. It stated that measures that limit individual rights and civil liberties must be reasonable, necessary, and proportional.\textsuperscript{39} The WHO acknowledged that in the early stages of a pandemic, the effectiveness of specific interventions can be hard to judge, which makes it difficult to assess whether such interventions are reasonable or necessary. However, interventions that restrict movement may initially be the only tools available to combat the spread of disease and mathematical modelling has supported the view that these restrictions can have a significant impact on mortality rates.\textsuperscript{40}

On the basic principle of preventing harm to others, suspending s.17 leave in this context may therefore be justified if it prevents exposed people from infecting others. Although COVID-19 may be novel, these ethical issues are not, and the same principles of applying quarantine could also be applied to that of suspending s.17 leave. These were succinctly captured in the United Nations (UN) ‘Siracusa Principles’ which demand that coercive public health measures be ‘legitimate, legal, necessary, non-discriminatory and represent the least restrictive means appropriate to the reasonable achievement of public health goals’.\textsuperscript{41}

Bearing in mind the vulnerability of patients within mental health services to the virus, and the potential for viral transmission within inpatient mental health units, the suspension of leave was arguably the least restrictive route towards the reasonable achievement of public health goals. There is also relevant case law that justifies the imposition of restrictions on hospital inpatients to maintain the ‘safe running’ of a service. It is commonly agreed that the power to detain individuals for treatment of mental disorder is accompanied by other powers, such as routine searches (see Auld LJ in R v Broadmoor Special Hospital Authority, ex parte S, H and D\textsuperscript{45}) and the House of Lords has accepted that the power to detain brings with it powers of control (see Pountney v Griffiths.\textsuperscript{43}). These cases illustrate that, while individual rights must be respected, healthcare providers also need to consider the wider aspects of managing an inpatient service, and restrictions may be justified if they are necessary to maintain patient care.

Although decisions to suspend leave may have been justified, the jurisprudence established by the European Court of Human Rights has established that greater scrutiny should be given to any measures which remove an already deprived sense of autonomy.\textsuperscript{44} Following Munjaz v United Kingdom,\textsuperscript{45} the court reinforced the notion of both ‘residual liberty’ and ‘residual privacy’ – that those detained by the state still have rights under ECHR Articles 5 and 8, and any interference which engages with these rights should be carefully considered, especially for those who are already detained. Even following such scrutiny, healthcare providers do not have licence to impose unlimited restrictions and the response must be proportional to the risk posed.

Proportionality

The WHO and UN both refer to the justification of public health measures, stating that interventions should be reasonable and proportional. The ECHR also has proportionality listed as one of its key principles. The ECHR has noted that ‘inherent in the whole of the Convention is a search for a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual’s fundamental rights’.\textsuperscript{46}

Proportionality requires healthcare providers to carefully consider any interventions they impose which infringe on convention rights: they must ‘balance the severity of the interference with the intensity of the social need for action’.\textsuperscript{47} Disproportionate actions are not justified, even if the aim is legitimate, and more substantial interferences require greater justification.\textsuperscript{47} The European Court developed a test of proportionality, often referred to as the Huang Test\textsuperscript{47}:

- Does the policy (or measure) in question pursue a sufficiently important objective?
- Is the rule or decision under review rationally connected with that objective?
• Are the means adopted no more than necessary to achieve that objective?
• Does the measure achieve a fair balance between the interests of the individual(s) affected and the wider community (i.e. a question of whether a measure constitutes a proportionate means of achieving a legitimate aim)?

The Huang Test provides a structured approach to proportional decision-making, but may not address the complexities faced during a pandemic, with some experts arguing that proportionality is not an exact science.46 In the case of COVID-19, the proportionality of any healthcare intervention will be relative to the available information regarding the virus and the alternative methods of mitigating the risk of infection. In the early stages of the pandemic, the suspension of leave may have been proportional given the spiralling death rates in other European countries, the limited understanding of the virus, and the lack of evidenced treatment. However, future decisions about restrictions of movement will become more nuanced as our understanding of the virus grows, and, crucially, we now have several effective vaccines. The central question is how we may calibrate future restrictions while aiming to maintain respect for patient rights and the principles of the MHA 1983?

Public health emergencies and restrictive practice: Adaptations for future care

Before suggesting how a healthcare service might adapt, it is worth considering some final ethical principles which have been established in the context of public health emergencies. Experts have stressed the importance of ‘reciprocity, transparency, non-discrimination, and accountability, or the right to a due process to challenge one’s quarantine’.49 Similarly, the WHO has advocated the importance of ‘trust…communicating to the public early, dialogue with the public, and planning’.39 All these principles could be transposed onto decisions about s.17 leave. Recommendations for how they can translate into effective changes in decision-making are discussed below.

Reciprocity involves a relationship between parties (in this case, patients and healthcare providers) that is characterised by mutual action. This implies that society should support those facing disproportionate burdens. If patients adhere to the restrictions of liberty that are imposed on them, they should receive additional support for their mental health and well-being – this may involve the provision of improved access to outdoor space and therapeutic facilities. This perspective also mirrors the concept of relational autonomy, which often serves as a key aspect to the recovery model within healthcare.50 Mental health services should utilise advances in technology to screen and track infection, thereby potentially reducing the need for widespread isolation measures.51 The use of virtual software for meetings between patients and visitors can also minimise the disruption that any isolation measures may cause.52

The potential consequences for freedom and liberty that public health emergencies pose to inpatient mental health units is an additional reason why those detained within these services should be prioritised for advances in treatment such as new vaccines.

Transparency requires healthcare providers to ensure that their decision-making processes are open and accessible to patients, through clear and frequent communication.39 Inpatient service newsletters can provide a clear update on the restrictions being imposed and the rationale for why they are needed. Patients may also benefit from attending a forum in which issues regarding pandemic-related restrictions can be discussed with medical directors. Mental health services in England and Wales often appoint patient representatives who advocate on behalf of their peers with managers.53 A similar model could be adopted during a pandemic so that the needs of patients are directly discussed and negotiated. These actions may lead to direct improvements in decision-making regarding restrictions, but there are also likely to be wider benefits in improving patient trust in healthcare providers. This process may provide an opportunity for patients to challenge isolation measures if they are considered arbitrary, or disproportionate to the risks posed. Policies regarding the restriction of s. 17 leave should also explicitly address the issue of discrimination and ensure that any decisions are reasonable, made on objective grounds, and have a legitimate aim.54

As detailed above, during the first wave of the pandemic in 2020, decisions were often made without clear guidelines. An ongoing process of ethical and legal guidance revision is necessary so that advice regarding restrictions of liberty remains in keeping with our understanding of the threats posed by Covid-19. The rapidly changing nature of pandemics also means that services must develop a more responsive approach to complex ethical scenarios. Local clinical ethics committees may need to meet more often so that new issues arising are considered and addressed promptly.

To avoid arbitrary decisions and ensure a proportional response, a decision-making framework should be developed to help judge how and when to impose or ease particular restrictions. The content of such a framework is beyond the scope of this paper but it should prompt healthcare providers to consider the level of risk, yet balance this against the infringement on patient autonomy. It should also involve consideration of alternative non-restrictive measures that may diminish the risk of viral transmission. The Huang Test may help to structure decisions regarding the proportionality of any response. Decisions to suspend leave may be justified by the vulnerability of the patient group demographics and the potential risk of viral transmission, especially if medical treatment approaches are limited.
Conclusion

The COVID-19 pandemic has resulted in an unprecedented challenge for mental healthcare services with clinical decisions being informed by complex ethical and legal issues. Although the pandemic has been an unheralded public health emergency, there is a wide body of ethical literature and case law that informs decisions about restrictions on liberty that have been imposed. Protecting the health of patients is at the forefront of any clinician’s mind, but shifting attitudes to the rights of persons with disabilities, and greater respect for patient autonomy has meant that weighing up health and liberty is often finely balanced.

The effects of COVID-19 are not over, and clinicians and managers should be supported in making ethical and non-arbitrary decisions regarding restrictions such as the suspension of leave. This should involve a transparent dialogue that maintains the health and safety of both patients and staff, while paying full respect to their human rights.

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