What are the essential elements to take into account when determining whether a person has capacity to consent to informal admission to a psychiatric hospital?

As Approved Mental Health Professionals (AMHPs), we are trained to use the least restrictive alternative. This phrase only formally arrived on the Mental Health Act scene in 2008 with the publication of the most recent Code of Practice. But as Approved Social Workers (ASWs) before that time, we were very clearly expected to follow the least restrictive route, even though the words did not appear in any legislation or guidance at the time.

**But how do you measure levels of restriction?**

Historically, it seems that professionals believed the existence of a set of section papers, authorising detention, indicated a higher level of restriction than if the person remained an informal patient, who is, in theory, free to leave the ward whenever they wish. But of course there's the rub. The existence of section 5 of the Mental Health Act (MHA) has meant that once a patient is admitted to a psychiatric ward, they are not simply 'free to leave' in the way that (most) patients in general hospitals are. If the nurses or the doctor believe the person would be at risk if they left the ward, they can invoke one of the "holding" sections of the MHA and prevent the person from leaving the ward whilst a formal Mental Health Act assessment is arranged to consider potential detention under the MHA. Many AMHPs will have come across messages in the patient notes stating "if the patient attempts to leave, place on s5(2)". Surely this is a clear indication that in fact they are not at all free to leave and are 'de facto detained', as it has more recently become known.

In the last few years, there has been an acknowledgement of the explicit conflict within the law created by the use of section 5. The more canny doctors and nurses now suggest "if the patient attempts to leave, consider s5(2)". While using the word 'consider' appears to at least allow for discretion when the situation arises, the message is clear that it is felt that the patient should not be allowed to leave the hospital and steps should be taken if any
attempts to leave are made.

This conflict was specifically recognised in a recent Supreme Court judgment when Lord Dyson commented that the hospital is able to exhibit considerable control over an informal psychiatric patient, and that “[the patient’s] position was far closer to that of such a hypothetical [detained] patient than to that of a patient undergoing treatment in a public hospital for a physical illness.”

All this has, for many years, been done with the best of intentions. After all, we are all aware of the considerable stigma attached not just to mental ill health, but for people who have needed to be admitted to psychiatric hospital, and worse still for anyone who has been "sectioned". The downside of not being formally detained is of course, the patient cannot challenge the fact that they have lost their liberty.

Detention and Patient Rights:

Detention under the Mental Health Act brings with it some very specific rights: the right to appeal to an independent tribunal in each period of detention; the right to non-means tested legal representation and the right to an Independent Mental Health Advocate (IMHA). These, combined with the additional safeguard of the person's nearest relative who has the right to order the person's discharge by giving the hospital 72 hours written notice, create a suite of checks and balances to make sure a person’s rights are observed and any formal detentions are proportionate and necessary.

In my view, the enactment of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) has been instrumental in bringing this issue to the fore. DoLS has clarified that the threshold for objection to being in psychiatric hospital, or receiving psychiatric treatment is much lower than many doctors and ASWs/AMHPs have considered for many years. The much closer investigation of eligibility for DoLS and the labyrinthine Schedule 1A of the amended Mental Capacity Act has made professionals look much more closely at the threshold for objection, certainly for people lacking capacity to
consent to their admission, treatment and care. Linked to this is the increasing focus of CQC inspections of mental health wards through which issues of capacity are finally (and appropriately) increasing their profile in mental health services.

Consent and Informal Admission:

I am aware of the debates within services around whether all informal patients should have a formal assessment of capacity on admission. But is this not undermining the first key principle of the MCA; the assumption of capacity?

Some argue that the fact that a person is sufficiently mentally disordered to warrant admission to a psychiatric ward is enough to set aside the presumption of capacity, thus requiring a full assessment. However, research suggests that there is a significant number of informal inpatients who have capacity to consent to their admission. Owen et al (BMJ 2008) suggested between 32% and 46% of psychiatric inpatients lacked capacity to consent to admission. This means that 54% - 68% had capacity to consent. The Count Me In census 2010 (CQC 2011) estimated an even lower level of incapacity for informal inpatients: just 25%. Surely this does not support the call for routine capacity testing of all psychiatric inpatients?

Whilst I do not support the call for routine capacity testing of all informal inpatients, I believe it would be a mistake to throw the baby out with the bathwater. Some way of ensuring that consent has been given is indeed necessary as a means of reducing the risk of de facto detention that can so easily happen with the section 5 Sword of Damocles hanging over the informal patient.

Why not therefore adopt the practice which is established beyond debate for consent to treatment decisions? It is standard practice for doctors when discussing treatment options with patients, to discuss what the treatment involves, the risks and benefits, whether there are reasonable alternatives and what will happen if the treatment does not go ahead. Only if doubts arise as
to the ability of the patient to give consent, will an assessment of capacity be required.

However, what are the salient points which need to be considered regarding admission to psychiatric hospital? Surprisingly, this question appears never to have been addressed in case law and there is a very little written about it.

Consent & Psychiatric Hospitals

I believe it is helpful that a Court of Protection case started to examine this issue earlier this year. L is a woman in her 30's with a learning disability, who had suffered traumatic experiences not only at home, but also in foster and institutional care, including at Winterbourne View. For reasons which do not need to be explained here, an application was made to the Court of Protection to determine firstly, whether or not L was being deprived of her liberty, and secondly, when assessing whether or not L had capacity to consent to her accommodation in the hospital in circumstances which amount to a deprivation of liberty, what information is relevant to the decision.

Now this comes very close to the information that should be considered for any patient being admitted to an acute psychiatric bed. The additional factor in this discussion is the existence of a deprivation of liberty. However, as already discussed, the threshold between voluntary admission and an objective deprivation (de facto detention) is not always easy to identify. In the judgment, Justice Baker declined to create a prescriptive list of factors which should always be considered, noting each person's individual situation is specific to them. He felt it was important for the clinician to "consider the concrete situation and assess the person's level of understanding about that situation."

He went on to identify, on the facts of this particular case, the following information as relevant:

1. that the person is in hospital to receive care and treatment for a mental disorder;
2. that the care and treatment will include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood;
3. that staff at the hospital will be entitled to carry out property and personal searches;
4. that she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision;
5. that if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.

Clearly these five factors are specific to L and should not be generalised to every patient who is admitted to hospital, but I believe this is a useful starting point for identifying what key factors should be considered when assessing whether any patient can consent to admission to a psychiatric ward. I would like to suggest some key factors which should normally be considered in these circumstances, as a catalyst for further discussion and potential development of guidance for staff on ensuring consent. Some of the factors will simply mirror the ones outlined by Justice Baker, while others will reflect some of the suggestions advanced by counsel for the Official Solicitor in the case.

1. that the person will be admitted to a mental health hospital for the purpose of care and treatment for a mental disorder;
2. that the doors to the ward will be locked;
3. that staff at the hospital will be entitled to carry out property and personal searches;
4. that the person will be expected to remain on the ward at least until being seen by a doctor, and most likely for at least the first 24 hours of their admission;
5. that the person will be required to inform the nursing staff whenever they want to leave the ward, providing information about where they are going and a time of return;

6. that the nursing staff may refuse to agree to the person leaving the ward (including use of the Mental Health Act) if the nursing staff believe that the person may be at risk (from themselves, or from other people) or may pose a risk to others if they leave the ward;

7. that if the person leaves the ward without informing the staff, or fails to return at the agreed time, the staff will call the police who will make attempts to find them;

8. that the person's description will be recorded by staff for the purpose of 7 above;

9. In addition, it is important to include the likely consequences of the person not being admitted. This will of course vary with each individual and their personal circumstances.

If the person appears unable to understand or weigh any of these factors, then a formal assessment of capacity will be needed. It does not necessarily mean that the Mental Health Act must be used, as it may be appropriate to admit the person informally, in their best interests. However, it is important to be clear whether the person has given capacitous consent to admission, or lacks capacity, in which case another person will have to make the decision in their best interests.

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i I am using the term ‘informal’ to include all psychiatric inpatients who are not subject to detention under the Mental Health Act. Some people differentiate ‘voluntary’ (those with capacity to consent to their care arrangements) from ‘informal’ (those lacking capacity)

ii Section 5(4) for nurses, section 5(2) for doctors

iii Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2 (para 34)


v A PCT v LDV [2013] EWHC 272 (Fam)