CAPACITY ASSESSMENT AND INFORMATION PROVISION FOR VOLUNTARY PSYCHIATRIC PATIENTS: A SERVICE EVALUATION IN A UK NHS TRUST

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ABSTRACT

A. BACKGROUND

Since the *Cheshire West* judgement, yearly applications for the Mental Health Act (MHA) and Deprivation of Liberty Safeguards (DoLS) have increased, though many patients are still admitted informally. To ensure lawfulness, informal admissions must be capacitous, informed, and without coercion. If fully capacitous consent is not obtained, then there is a risk of "de facto" detention and deprivation of liberty. Deprivation of liberty is only lawful through appropriate legal frameworks (DoLS for incapacitous, non-objecting hospital inpatients, or MHA otherwise). Use of such legal frameworks might be hampered by the perceived stigma associated with them, though this may not be in the best interests of the patient.

B. AIMS AND OBJECTIVES

We aimed to examine the assessment of capacity and provision of adequate information required for an informed voluntary psychiatric admission, and any evidence of possible coercion into informal admission. We postulate variable use of legal frameworks designed to empower patients and prevent illegal deprivation of liberty.

C. METHODS

A retrospective randomized sample (n=50) was obtained from psychiatric admissions between May 1st and August 31st 2015 to Coventry & Warwickshire Partnership NHS Trust. Clinical notes were evaluated for demographics, assessment of capacity and the provision of adequate information surrounding admission, and for the presence of documentation pertaining to a 'de facto detention' during the first week of admission.

D. RESULTS

Seventeen patients (34%) were detained on admission. At one week, nine further patients were detained. Eight of these patients were detained within 72 hours of voluntary admission. Capacity assessment was documented in 54% of these patients. The provision of adequate information was poor, at just 26%. None of the nine patients later detained within the first week were provided the required information on admission. Documentation pertaining to a 'de facto detention' was present in 21% of voluntary patients' notes at admission, and 24% at 24 hours. After 24 hours, the prevalence and frequency decreased over the first week.

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E. CONCLUSION

Both capacity assessment and provision of adequate information to allow an informed decision for voluntary admission were poorly documented. As none of the patients detained during the first week of admission were provided adequate information pertaining to the admission, it is not possible to discount the possibility of coercion into admission in this subgroup. The presence of documentation pertaining to 'de facto detention' was common, and may point toward a potential illegal deprivation of liberty. Our findings suggest that more needs to be done to ensure vulnerable individuals are not subject to illegal deprivation of liberty whilst under psychiatric care.

I. INTRODUCTION

Those with severe mental illness may be vulnerable, and are at risk of coercive hospital admission (Hoge et al, 1997). Once they remain as an inpatient, they are also at risk of deprivation of liberty (Poulson, 2002). To help prevent potential exploitation, legal frameworks are in place to empower and protect those patients most vulnerable due to their mental disorder, potentially due to impaired capacity or insight. The Convention for the Protection of Human Rights and Fundamental Freedoms, Article 5 states that all human beings have the right to liberty and security of person (Art 5(1), Council of Europe, 1950), save in certain circumstances, which include a mental disorder (Art 5(1)(e), Council of Europe, 1950) meeting the Winterwerp criteria. These criteria include 'reliable demonstration of unsound mind by an objective medical professional; of a nature or degree warranting hospital inpatient stay; and persistent (Winterwerp v Netherlands, 1979).

When a mentally disordered person is deprived of their liberty, it must be in accordance with a process set down in law, and the person must have speedy access to a Court (Art 5(4), Council of Europe, 1950). Currently, in England and Wales, there are three ways in which a mentally disordered patient can be lawfully detained in hospital should this be deemed necessary; via the Mental Health Act (MHA) (1983, as amended 2007), via the Deprivation of Liberty Safeguards (Mental Capacity Act 2005 as amended 2007, Schedule A1) (DoLS) or by order of the Court of Protection (CoP), as outlined in table 1. Each of these is a due legal process, with the necessary patient-orientated safeguards such as the right to appeal or second opinion.

Mental Health Act (1983) (MHA)	Deprivation of Liberty Safeguards (2009) (DoLS)	Inherent Jurisdiction of the High Court (Court of Protection (CoP))
Section 2 (assessment order) lasts up to 28 days Sections 3&37 (treatment order) last up to 6 months, but second opinion required to administer treatment after 3 months	Allow detention of incapacitous, compliant patients in hospitals or care homes Introduced following "Bournewood judgment"	Reserved for complicated cases where MHA or DoLS cannot be used

Emergency holding powers (Section 5) for patients already in hospital, last up to 72 hours For application, 'MHA assessment' carried out involving psychiatrist uninvolved with the case, a doctor who knows the patient and approved mental health practitioner[a] Includes right to appeal and a second opinion Those on treatment sections subject to section 117 aftercare[b]	Include the right to appeal by patient or 'relevant representative' to Court of Protection To be detained in *hospital* the patient must be fully compliant with all aspects of care (if not the MHA must be used instead).	

Table 1: legal deprivation of liberty in England and Wales at a glance

a Approved mental health practitioner might be from a range of backgrounds, for example general practitioner or social worker.

b The duty of Health and Social Services to provide funding for continued patient care.

The nature of what constitutes 'deprivation of liberty' has been repeatedly re-examined over the last few decades, leading to the three means of lawful detention as described above. This began with the 'Bournewood' Case (R. v Bournewood Community and Mental Health NHS Trust, 1997, EWHC Admin 850), in which a man (HL) with severe learning difficulties was an "informal" psychiatric inpatient. He was compliant with care and treatment, and for this reason, the hospital decided not to apply the MHA, which was the only legal means for detention available to them at that time. His carers argued that he was "unlawfully detained" because he was not allowed to leave the ward or to have his carers visit him, and sought a judicial review of the hospital's decision.

The High Court decided that HL was not unlawfully detained, because he had not attempted to leave and had therefore not been forcibly restrained. At the Court of Appeal, it was decided that the patient had been unlawfully detained, and should have been detained under the MHA (R v Bournewood Community and Mental Health NHS Trust, 1997, EWCA Civ 2879).

On further appeal in the House of Lords (R. v Bournewood Community and Mental Health NHS Trust, 1998, UKHL 24) the decision was overturned again. The House of Lords said that for there to be unlawful detention there must be actual rather than potential restraint. They were also worried that if the Court of Appeal decision were to stand, tens of thousands of informal patients would be detained under the MHA, with considerable financial costs and excessive stigmatization.

However, this case was then brought to the European Court of Human Rights (HL v UK 45508/99, 2004, ECHR 471), which made the final judgment that the distinction between 'actual' and 'potential' restraint was irrelevant, and that HL *had* been deprived of his liberty. Furthermore he had been kept in hospital under the common law "doctrine of necessity", which the Court said was not a "procedure set down in law" required under Article 5. DoLS arose out of this judgment; the Mental Capacity Act (2005) was amended to include DoLS. (Mental Capacity Act 2005 as amended 2007, Schedule A1). DoLS created a legal process for the detention of passively compliant, incapacitous patients, and introduced various safeguards for such patients.

More recently, important judgments have occurred in high profile court cases such as '*P v Cheshire West'* and '*P & Q v Surrey County Council',* involving vulnerable individuals residing outside of hospital. The Supreme Court (P v Cheshire West 2014), in its ruling on the above cases, defined what constitutes a deprivation of liberty, in what it called the "acid test". If a person is under "constant supervision and control" and he or she is "not free to leave at any time", then the person is, by definition, deprived of their liberty. Baroness Hale, in the leading judgment, said '*a gilded cage is still a cage*', meaning that even if all agree that a patient's care and treatment is in their best interests, the patient is still being deprived of his liberty.

These cases have major implications for those working in a mental health setting. For example, applications under the MHA have risen year on year, perhaps in part due to concerns over potentially unlawful deprivation of liberty (Care Quality Commission, 2014). Even more concerning is that since the "Cheshire West" ruling by the Supreme Court, DoLS applications in England increased tenfold, from 13,700 in 2013-14 to 137,540 in 2014-15 (Health and Social Care Information Centre, 2015).

Nonetheless, many patients *are* still admitted informally (i.e. not admitted under a legal framework). Severity of mental illness aside, there may be other reasons for this. Firstly and perhaps most significantly, a capacitous patient may be strictly consenting to have their liberty deprived, though this may be hard to envisage. Secondly, MHA assessments carry a financial burden. Thirdly, detention under the MHA carries stigma. Though there have been improvements (Thornicroft et al, 2013), mental illness is adversely portrayed in the media (Weinrich, 2014), and public perception of those with mental illness remains negative (Schomerus, 2012). Even when discharged from the MHA, patients may be met with foreign travel restrictions, insurance premium increases, and increased difficulty in obtaining employment (Stuart, 2006).

This is despite the Mental Health (Discrimination) Act (2013), which aimed to combat the stigma attached to having been detained under the MHA. It removed the blanket ban on such individuals participating in jury service, amended rules that might remove individuals as directors of public or private companies 'by reason of mental health', and removed legislation under which a Member of Parliament would automatically lose their seat if they are detained under the MHA for greater than six months. These are all positive steps in the reduction of the potential societal disadvantage that might be experienced by patients with mental illness.

The MHA has numerous safeguards to protect patients. In addition to the right to appeal, to a second opinion about treatment, and to advocacy, it notably includes an important role for the Approved Mental Health Professional (AMHP). The AMHP is an

independent mental health professional, but *not* a doctor, with special training and expertise in mental health and law. The role of AMHPs is "to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the 'least restrictive option and maximising independence' guiding principle" (MHA Code of Practice, Department of Health, 2015). The AMHP makes the final decision about detaining a patient under the Act ("making an application") albeit supported by two medical "recommendations".

Despite advances in combatting stigma, and despite the safeguards built into the MHA to protect patients, some suggest that detention under the MHA should be used only when a patient in a psychiatric hospital is actively trying to leave. A guiding principle of the MHA is the "least restrictive" principle – "where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained" (MHA Code of Practice, Department of Health 2015). Some argue that keeping a patient informal is the 'least restrictive' option, an option that carries the least possible harm. Some go further and argue that mental health professionals, with their ability to detain individuals, are 'suborned as agents of social control' (Mullen, 2005).

As mentioned, an informal (voluntary) patient should make a fully informed decision to be admitted. Without this there is a risk of coercion into admission and a subsequent unlawful deprivation of liberty.

In 2014, the Royal College of Psychiatrists (R.C.Psych.) published a response following '*P v Cheshire West'* and '*P & Q v Surrey County Council'*, outlining a list of nine pieces of information a patient should have in order to consent to admission, some of which are outlined in figure 1.

That the person will be expected to remain on the ward, most likely for at least 24 hours

The possibility of having some personal items confiscated, and personal searches

That the nursing staff must be informed of plans when the person requests to leave the ward

That the nursing staff may refuse to agree to allow the person to leave the ward.

Fig. 1 Examples of information to be provided to patients as outlined in R.C.Psych. document

The response also reiterates the concept of 'de facto detention'. That is, the patient remains 'voluntary' in the full knowledge that they would be detained if they attempted to leave. Such an admission runs a serious risk of representing an unlawful deprivation of liberty, removes access to the safeguards of the MHA (for example appeal to a tribunal), and could be construed as paternalistic.

Other authors have examined extra-legal deprivation of liberty in other legal jurisdictions; in Denmark (Poulson, 2002) and the USA (Hoge et al, 1997). We could find no similar recent work in England and Wales.

In light of Cheshire West and the changing definition of 'deprivation of liberty', we wished to examine voluntary admissions for the risk of 'de facto detention'. We suspected that some 'voluntary' patients may not be giving fully informed consent to

admission, and that mental health professionals may still be reluctant to use the MHA, despite the safeguards it offers for both patients and professionals.

II. AIMS AND OBJECTIVES

The aim of the study was to examine the possibility of coercion into 'voluntary' admission in psychiatric patients.

The objectives were firstly to ascertain whether capacity to consent for admission was adequately assessed, and whether those patients admitted as voluntary were provided with sufficient information to be able to make an informed decision to come into hospital.

Secondly, the study examined the demographics and prevalence of psychiatric diagnoses of admitted patients, and the prevalence of use of the MHA for newly admitted patients during the first week of admission. We hypothesize that a 'quick switch' from informal to formal admission soon after admission may reflect an initial coercion into informal admission.

Thirdly, we assessed whether informal patients may have been subject to a 'de facto detention' during the first week of admission.

III. METHODS

A. Study location & trust policy

The study was completed at Coventry and Warwickshire Partnership NHS Trust, United Kingdom, during the four-month period between May 1st – August 31st 2015. Adult inpatient mental health services in the trust comprise of three acute psychiatric units, The Caludon Centre in Coventry (112 beds), St. Michaels Hospital in Warwick (41 beds), and The Pembleton Unit in Nuneaton (12 beds) with adult rehabilitation services provided at multiple sites (40 beds), for a catchment area of around 850,000 people. As with most mental health trusts in the UK currently, the trust is close to or meeting inpatient capacity at all times.

The MHA Code of Practice (Department of Health, 2015) states that when a patient needs to be in hospital, informal admission is usually appropriate when a patient who has the capacity to give or to refuse consent, is consenting to admission. However, there is no trust guideline currently outlining whether this should be assessed by nursing staff, or by the admitting doctor. There is no national or Trust guideline outside of the aforementioned publication by the Royal College of Psychiatrists on ensuring patients admitted informally are given adequate information on what an admission will be like, including the "rules" of the institution.

B. Eligibility Criteria

All patients admitted to adult inpatient mental health services, both acute and rehabilitation, in the Coventry and Warwickshire Partnership Trust between May 1st 2015 – August 31st 2015 featured as the sampling frame. There were no specific inclusion criteria for diagnosis or length of admission to help prevent selection bias.

C. Ethics

The study was approved by Coventry and Warwickshire Partnership Trust as a service evaluation and as such did not need formal ethical approval from an NHS Research Ethics Committee. Data was collated in an anonymized format from routine clinical records, by the lead author.

D. Method

A sample size of 50 was achieved via the randomization function of Microsoft Excel from a spreadsheet containing details of all patients that met eligibility criteria outlined above. The sample size was chosen based upon guidance from the National Audit Office (National Audit Office, 2001). Clinical notes were analysed by the authors, firstly, for the diagnosis (either provisional or established) alongside demographic information including age, sex and length of admission. Documentation pertaining to the admission was analysed for evidence that a) capacity to consent to admission was assessed at the time of admission, and b) information surrounding the reality and rules of an admission were appropriately explained to the patient.

Next, the clinical notes were assessed (either from consultant ward round notes, nursing observations or clinical assessment by doctor) at specified frequencies (0hrs, 24hrs, 48hrs, 72hrs, 1 week) from admission for legal status, any change in such, and any evidence of a 'de facto detention' as documented in the clinical notes of informal patients. This was assessed by the presence of documentation such as 'if the patient tries to leave the ward, for section 5(2)'. Descriptive statistics were used to illustrate findings.

E. Results

i. Demographics

The sample included a roughly even split amongst sexes (24m, 26f). Mean age was 46.28 (statistical range 64).

ii. Diagnosis on admission

Figure 2 outlines the spread of diagnoses (established or main differential) amongst study subjects. The majority (46%) of admitted patients included in the study were diagnosed with psychotic illness. This broadly mirrors other published literature on psychiatric admission statistics (Thompson et al, 2004).

Diagnosis	*n*
Schizophrenia and related diagnosis	23
Depression/Suicidal Ideation	11
Bipolar Affective Disorder	9
Personality Disorder	3
Substance Misuse	2
Anorexia	1
Organic Illness	1

Fig 2. Diagnosis on admission amongst study participants

iii. Length of Admission

Length of admission is outlined in figure 3. The majority of patients in the sample were discharged from hospital within six weeks.

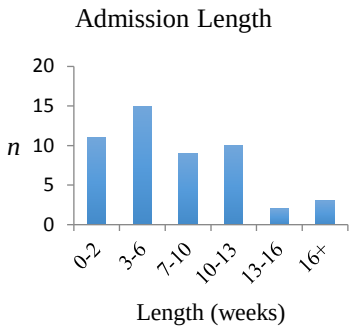

Fig 3. Length of admission amongst study subjects

iv. Legal Status and discharges

Seventeen patients (34%) were detained on admission. At seventy-two hours, a further eight patients had been detained. Three patients were discharged home during the first seven days. At seven days, one further patient had been detained (56% total of remaining admitted patients). No patients were discharged from the MHA during the first seven days. DoLS were not used in our sample.

v. Capacity assessment and information provided on admission

A formal capacity assessment was documented in twenty-seven patients (54%), though this was higher in patients detained on admission (82% of detained patients). Only thirteen (39%) of informal patients had a capacity assessment documented.

Information pertaining to the reality and rules of an inpatient admission was provided to thirteen patients (26%). Again, this was more common for detained patients (59%) than patients admitted informally (10%).

None of the nine patients detained during the first week of admission had documented evidence that information relating to the reality and rules of a mental health inpatient admission had been explained.

vi. 'De facto detention'

As visible in table 2, the presence of documentation pertaining to 'de facto detention' was prevalent during the first week of admission. Prevalence was highest either at or soon after admission, and gradually declined in frequency and prevalence over the first week.

Time	0hr	24hr	48hr	72hr	1wk
N	7	7	5	4	2
total voluntary	33	29	26	23	21
%	21	24	19	17	10

Table 2: 'De Facto detention'

IV. DISCUSSION

In this study, admissions into acute mental health beds were assessed for the possibility of coercion into voluntary admission. We present several findings of note. Firstly, capacity assessment and the provision of information pertaining to the reality of a mental health inpatient stay were poorly recorded, especially amongst patients admitted informally. Capacity assessment and the provision of information were better, though still lacking, in patients admitted under the MHA. This may be an issue of poor documentation, rather than an absence of seeking and gaining valid informed consent. However, we cannot exclude the possibility that some admissions were subject to

coercion into informal admission. These results echo those from previous pre-Cheshire West work (Poulson et al, 2002; Hoge et al, 1997), suggesting that coercion into admission and extra-legal deprivation of liberty are still commonplace in the mental health population. It is possible that this is a reflection of an inherent wish of professionals to avoid endowing patients with the potential weight of stigma that might still be attached to the use of the MHA, as previously mentioned.

It may be true that had a larger number of voluntary patients had the reality of inpatient admission explained to them, some might have refused admission. In this case, the difficult but nonetheless vital decision of 'what to do next' (i.e. could the patient be managed in the community with maximal community support available) could have been addressed. It seems plausible that better performance on information-giving in the "sectioned on admission" group stems from the formal, legal nature of such an admission.

None of the patients detained during the first week of admission had information on the 'reality of inpatient admission' explained to them when they were admitted. It seems plausible that their detentions under the MHA occurring at such a short frequency from admission reflects an initial coercion into admission, which was then challenged by the patient.

Finally, there was a reasonably high prevalence of 'de facto detention' in our sample. This contradicts guidance provided by the Royal College of Psychiatry. Interestingly, the highest prevalence of 'de facto detention' appeared either at admission or soon after admission, which provides further evidence that a subset of patients may have been inappropriately admitted as voluntary patients, when perhaps the severity of their mental state may have impaired their capacity or judgment making ability. A quick comparison of the rates of conversion from voluntary to legally detained reveals that more voluntary patients were subject to a 'de facto detention' than were converted to formal detention under the MHA at all measured time points, suggesting that a proportion of patients subject to a 'de facto detention' remained informal. This raises the possibility that this subset of patients may therefore have been subject to an extra-legal deprivation of liberty.

V. LIMITATIONS

There are several important considerations to make when viewing these results. Firstly, the sample size is relatively small which may limit generalizability, and increase the risk of type II error. A further study conducted on a larger sample size would help to improve the power of the study and therefore strengthen any conclusions drawn from it.

Secondly, we have used a switch from informal to formal admission within the first week as a surrogate marker for the possibility of an initial coercion into admission, though this may not be the case. It is wholly possible that a patient with the necessary information about their admission may capacitously agree to come in voluntarily and then change their mind, or even become more unwell necessitating use of legal frameworks. However, it is noticeable that in our sample, all of the informal patients later detained within the first week had documented evidence that information about the admission had been provided to them.

Thirdly, our work does not feature anyone admitted under DoLS. Future work may consider stratified sampling to ensure a representative sample of patients detained under DoLS.

Fourthly, the retrospective nature of the study relies purely on documentation quality in the generation of results. The findings are therefore wholly reliant on detailed, accurate documentation, and it is therefore possible that our results do not accurately reflect actual practice. Thus, a prospective study might be a more effective means in accurately assessing suitability for formal detention under a legal framework.

Fifthly, it is possible that patients bearing longer psychiatric histories, with multiple previous admissions, may be given less information on admission than a patient suffering their first psychiatric episode. The presence of previous admissions was not assessed in the study, and may be pertinent for future work. However, some might argue that even in such cases, assumptions should not be made and patients should still be offered the relevant information.

Finally, we are unable to prove whether any discrepancy in use of the MHA for newly admitted patients is a result of differing beliefs around best practice, or around the stigma associated with formal detention under a legal framework. Our findings might therefore pave the way for further qualitative work, which may try to capture any inherent cultural beliefs that may exist within the healthcare system.

VI. CONCLUSION

It is vital that all patients admitted to inpatient mental health services as voluntary patients make a free decision to be admitted, and are deemed capacitous to make the decision. They must be provided with enough information for the decision to be considered informed. Without this there is a risk of coercion and extra-legal deprivation of liberty.

Furthermore, the provision of information and assessment of capacity must be adequately documented, so that professionals and organizations can defend themselves against allegations of unlawful deprivation. Our findings suggest that currently, these standards are not being adhered to.

With these findings considered, a guideline, pro forma or flow-chart to guide staff into adhering to best practice and the documentation of such might help. Based upon these findings, the specified trust has now incorporated a pro forma into policy, to be completed by the admitting clinician, ensuring that the patient has capacity to consent to admission and has been provided with adequate information on the likely reality of an inpatient stay.

The stigma faced by patients with mental illness is real, and may well be amplified by a history of detention under the MHA. This may weigh heavy on the minds of those professionals tasked with decisions surrounding legal frameworks in the admission of acutely unwell psychiatric patients. Whilst our findings highlight the possibility of coercion and extralegal deprivation of liberty in voluntary patients, it is likely that the

professionals involved believed they were acting in the patient's best interests. Yet, there is evidence that stigma around mental health issues is dissipating, albeit slowly, and as such, misgivings about using the MHA may be misplaced. Equally importantly, the law is evolving with respect to deprivation of liberty issues and this cannot be ignored. The MHA exists to protect patients and has safeguards to empower them. Without these safeguards in place, patients are disempowered, unprotected and arguably more stigmatized. We argue that more education about capacity law and the MHA is required for all mental health professionals, in order to improve practice and ultimately lessen stigma.

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