Consent to treatment (Mental capacity and mental health legislation)

Informed consent applies when a person can be said to have given consent based on a clear appreciation and understanding of the facts, and the implications and consequences of an action. English law necessitates that before any medical professional can examine or treat a patient, they must obtain informed consent to do so [1].

Consent can be either explicit (specific consent to carry out a specific action) or implied (not expressly given by a patient but inferred from their actions, the facts and circumstances of a particular situation, and sometimes a patient's silence or inaction). Generally there is no legal requirement to obtain written consent but it may be advisable in some circumstances.

A consent form documents that some discussion about the procedure or investigation has taken place but is only evidence of a process, not the process itself. Any discussion should be recorded in the patient's medical notes.

The Mental Capacity Act (2005) formalises the area assessing whether the patient is mentally capable of making the decision, and the Mental Health Acts (1983 and amended in 2007) describe the very limited circumstances when a patient can be forced to be hospitalised for assessment and/or treatment against their wishes [2].

See also the separate Consent to Treatment in Children (Mental Capacity and Mental Health Legislation) article.

General principles of consent[1] [3]

Consent must be obtained before any examination, treatment or care for competent adult patients. It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

Consent must be given voluntarily and not under any form of duress or undue influence from health professionals, family or friends. Consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid - the point of the form is to record the patient's decision and the discussions that have taken place.

To demonstrate capacity individuals should be able to:

- Understand what the medical treatment is, its purpose and nature and why it is being proposed.
- Understand the benefits, risks and alternatives.
- Understand the consequences of not receiving the proposed treatment.
- Retain the information and be able to weigh up the pros and cons in order to arrive at a decision.
- Communicate the decision.

All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able. Competent adult patients are entitled to refuse treatment, even where it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act. Patients can change their minds and withdraw consent at any time, as long as they have the capacity to do so.

Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient. It is important that the patient be given continuing opportunities to ask further questions and to review the decision.

All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.

Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action. Patients need sufficient information before they can decide whether to give their consent. If the patient is not offered as much information as they reasonably need to make their decision and in a form they can understand, their consent may not be valid.

Doctors must start from the presumption that all adult patients (anyone aged >16 years) have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements. A patient who has a mental disorder does not necessarily lack the competence to consent to treatment.

Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible. Patients may be competent to make some health care decisions, even if they are not competent to make others. Unexpected decisions do not prove the patient is incompetent; such decisions may indicate a need for further information or explanation.

The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.

Emergency treatment

- Consent needs to be sought for emergency treatment for competent patients.
- If consent cannot be obtained, doctors should provide medical treatment that is in the patient's best interests and is immediately necessary to save life or avoid significant deterioration in the patient's health.

- However, there may be clear evidence of a valid advance refusal of a particular treatment, indicating that treatment should not be given.
- If a patient has appointed a welfare attorney, or there is a court-appointed deputy or guardian, this person, where practicable, must be consulted about treatment decisions.

Best interests

A number of factors should be considered, including:

- The patient's own wishes and values (where these can be ascertained), including any advance decision.
- Clinical judgement about the effectiveness of the proposed treatment, particularly in relation to other options.
- Where there is more than one option, which option is least restrictive of the patient's future choices.
- The likelihood and extent of any degree of improvement in the patient's condition if treatment is provided.
- The views of the parents, if the patient is a child.
- The views of people close to the patient, especially close relatives, partners, carers, welfare attorneys, court-appointed deputies or guardians, about what the patient is likely to see as beneficial.
- Any knowledge of the patient's religious, cultural and other non-medical views that might have an impact on the patient's wishes.

Adults who are not competent to give consent

- A patient's **capacity to make decisions should be assumed to be present** (don't make assumptions that the patient is unable based on diagnosis, appearance or behaviour, etc).
- The patient's ability to make decisions should be optimised before concluding they are incapable. Ensure they have adequate time, repeat information as necessary, and use any appropriate communication aids available - eg, interpreters, sign language, etc.

- **Patients are allowed to make unwise decisions**; the clinicians have to demonstrate the patient is incapable of processing the information and making the decision before acting against their wishes.
- Decisions subsequently made on behalf of patients 'without capacity' always need to be in the patient's best interest and also need to be the least restrictive on their basic rights and freedoms [4].
- No one can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests.
- **'Best interests' go wider than best medical interests** and include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare.
- People close to the patient may be able to give you information on some of these factors.
- Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.
- If an incompetent patient has **clearly indicated in the past while competent** that they would refuse treatment in certain circumstances (an 'advance refusal') and those circumstances arise, **you must abide by that refusal**.

Advance care planning

People who understand the implications of their choices can state in advance how they wish to be treated in the future, for a time when they may no longer have the capacity to make such decisions for themselves. An advance care plan can be a written document, a witnessed oral statement, a signed printed card, a smart card or a note of a particular discussion recorded in the patient's file.

There is further information in the separate Advance Care Planning article.

Mental Health Act relevant to consent

The Consent to Treatment Provisions are dealt with in Part 4 of the Mental Health Act (MHA), which applies to[2]:

- Treatments for mental disorder.
- All formal patients except those who are detained under sections 4, 5, 35, 135 and 136. The Act does not apply to those people subject to Guardianship or Supervised Discharge, who have the right to refuse treatment, except in emergencies.

Where a person has been deemed to have given their consent to treatment under Section 57 or Section 58, the person can withdraw that consent at any time. The treatment must then stop and the appropriate procedures be followed, unless discontinuing treatment would cause 'serious suffering' to the patient, in which case the treatment can be continued.

Definition of Mental Disorder

The 2007 Act abolished the categories of mental disorder and redefined it as “any disorder or disability of the mind”.

Below are some examples of disorders that could fall within this definition but the list is not exhaustive:

- Affective disorders, such as depression and bipolar disorder.
- Schizophrenia and delusional disorders.
- Neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive-compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders.
- Organic mental disorders such as dementia and delirium (however caused).
- Personality and behavioural changes caused by brain injury or damage (however acquired).
- Personality disorders.
- Mental and behavioural disorders caused by psychoactive substance use (but there are exclusions).

- Eating disorders, non-organic sleep disorders and non-organic sexual disorders.
- Learning disabilities
- Autistic spectrum disorders (including Asperger's syndrome).
- Behavioural and emotional disorders of children and adolescents.

NB: Learning Disabilities. Someone with a learning disability and no other form of mental disorder may not be detained for treatment or made subject to guardianship or Community Treatment Orders unless their learning disability is accompanied by abnormally aggressive or seriously irresponsible conduct on their part.

Professional Roles

The Responsible Clinician (RC) is the approved clinician who has overall responsibility for the care of a patient. Only a doctor may make recommendations for detention in hospital under section 2, 3 or 4. The law still requires that one of the two doctors is approved under section 12 of the Act. It is only after the patient has been admitted that an approved clinician from a different professional background would be able to take responsibility for a patient's care and make decisions about the continued use, or the ending, of compulsion.

Nearest Relative

Unlike a person's next of kin, the Nearest Relative (NR) is defined by Section 26 of the MHA. There is no choice about who the nearest relative is. It is the person who comes highest on the list below:

- Husband, wife or civil partner or a partner who has lived with the patient for more than six months.
- Eldest child.
- Eldest parent.
- Eldest brother or sister.
- Eldest grandparent.
- Eldest grandchild.
- Eldest aunt or uncle.

- Eldest nephew or niece.
- Someone who has ordinarily resided with the patient for at least five years.

Section 57: Treatment requiring consent and a second opinion

- Some treatments are deemed so potentially hazardous that someone cannot automatically be given them even if they do consent.
- Three people (one doctor and two others who cannot be doctors) have to certify that the person concerned is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it.
- These three people are appointed by the Care Quality Commission (CQC). The treatments which fall into this category are:

    - Any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue.
    - The surgical implantation of hormones for the purposes of reducing the male sex drive.

Section 58: Treatment which requires consent or a second opinion

- Applies to people who are detained under certain Sections without their consent, or in cases where the person is not able to give their informed consent to that treatment.

- The treatments which fall under Section 58 requirements are:

    - Medication for the person's mental disorder: if three months have gone by since the person first had the treatment during their current period of detention under the Act. In the first three months the treatment can be given without consent and without the Section 58 requirements being necessary. The three-month period starts when medication for the mental disorder is first given.
    - Electroconvulsive therapy (ECT).

- If the person is capable of understanding the nature, purpose and likely effects of the treatment and consents to it, the Responsible Medical Officer (RMO) has to certify in writing that understanding and consent are present.
- If the person concerned is capable of understanding the nature, purpose and likely effects of the treatment and does not consent to it, or is not capable of understanding the nature, purpose and likely effects of the treatment and therefore cannot consent to it, then a doctor is appointed by the CQC to give a second opinion. This is the second opinion appointed doctor (SOAD).
- The SOAD must consult two people who have been professionally involved in the patient's medical treatment, one of whom must be a nurse, whilst the other can be neither a doctor nor a nurse.
- The certificates must state the plan of treatment in precise terms - eg, a range of doses of medication or number of treatments of ECT. If the plan of treatment is to be changed, new certificates are required.
- The provisions of Section 58 do not prevent treatment being given in an emergency, as set out in Section 62.

Section 62: Urgent treatment

The requirements of Section 57 and Section 58 do not have to be followed when urgent treatment is required:

- To save the patient's life.
- To prevent a serious deterioration in the patient's condition, as long as the treatment is not irreversible.

- To alleviate serious suffering, as long as the treatment is neither irreversible nor hazardous.
- To prevent the patient from behaving violently or being a danger to self or others, as long as the treatment is neither irreversible nor hazardous and represents the minimum interference necessary.

Section 37: Hospital Orders made by the Courts

- This Section allows a Court to send a person to hospital for treatment, or to make the person subject to Guardianship, when the outcome might otherwise have been a prison sentence. The Order is instead of imprisonment, a fine or probation.
- The person concerned:
    - Will have been convicted by a Magistrates Court or Crown Court of an offence which could be punished with imprisonment (except in the case of murder, where the Court has to impose a sentence of life imprisonment in all cases).
    - May not have been convicted but may be before a Magistrates Court, charged with an offence which could lead to imprisonment if the person were convicted. Without convicting the accused person, the Court can make a Hospital Order under Section 37 if the person has mental illness or severe mental impairment.
- The initial period is six months, beginning on the date of the Order. The Order can be renewed under Section 20 for six months and then annually.

- The Court has to be satisfied:
    - That the person has at least one of the four types of mental disorder, on the basis of evidence supplied by two doctors (with both doctors agreeing on at least one of the types); **and**
    - That the nature and degree of the mental disorder makes it appropriate for the person to be detained in hospital for medical treatment (that the treatment is likely to alleviate or prevent a deterioration of the person's condition in the case of psychopathic disorder or mental impairment); **and**
    - That making a Section 37 Order is the most suitable way of dealing with the person and that a specific hospital is willing and able to admit the person within 28 days.

Section 61: Review of treatment

- Where a plan of treatment is being carried out under Section 57, or under Section 58 without consent, the RC has to provide a report to the CQC if the period of detention is renewed under Section 20.
- The CQC may demand a report at any other time if it wishes.
- The CQC can cancel the certificate under which treatment is being given.
- In the case of people subject to Restriction Orders a report on the treatment being given has to be provided for the CQC:
    - Six months after the restriction order or direction is made; **and**
    - At times when the RMO reports to the Home Office on the person's current condition.

Further reading

- Violence and aggression: short-term management in mental health, health and community settings; NICE Guideline (May 2015)
- Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation; NICE Clinical guideline (Dec 2016)

- Mental capacity; General Medical Council (GMC) - Ethical guidance

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