

Chapter 10

INFORMAL ADMISSION TO HOSPITAL AND HOLDING POWERS

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A. INFORMAL ADMISSION TO HOSPITAL

10.01 Background

The Percy Commission recommended that mentally disordered persons should be admitted to hospital on the same basis as people who require treatment for a physical illness. Accordingly, it proposed that hospital care and treatment should be available to patients who are content to receive them without the use of compulsory powers and procedures or formal ascertainment; no special forms or certificates should have to be signed, no proof that a patient had given a valid consent to admission, and no requirement that he should give notice of his intention to leave hospital.¹ The 1959 Act adopted the recommendations of the Percy Commission and **informal admission** replaced the **voluntary admission** which then existed under the Lunacy Act 1890, together with the Mental Treatment Act 1930. (For the historical background see para. 1.08.2 *ante*). (As to the use of informal admission on patients who are unable to consent see para. 10.02A *post*.)

An informal patient can be admitted to any hospital, whether or not

¹ *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957* (1957) Cmnd. 169, HMSO, London, paras. 21-23.

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it is maintained principally for the reception and treatment of mentally disordered persons. For example, a mentally disordered person can be admitted to a district general hospital in the same way as he could to a mental illness or mental handicap hospital. (See further para. 3.02 *ante*).

10.02 The Legal Position of Informal Patients

10.02.1 Procedure

The procedure for informal admission, as originally recommended in the Percy Report, is not linked to the procedure prescribed for compulsory admission and is not laid down in detail in the Mental Health Act. Section 131(1) states that nothing in the Act should be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or nursing home without any formal arrangement rendering him liable to be detained or from remaining in hospital after he has ceased to be detained. Thus a person can be admitted to hospital for treatment for mental disorder, or he can stay in hospital after his liability to detention has expired, without any formality or obligation such as having to give notice of intention to leave. The only pre-requisites for an informal admission are that the patient assents to his admission or continued residence in hospital and that the hospital managers, as advised by the responsible medical officer and the therapeutic team, have made a bed available based upon the person's need for care and treatment.

Section 131(1) also applies expressly to "a patient who requires treatment for mental disorder." Can a person who is not mentally disordered be admitted to a mental hospital otherwise than in pursuance of section 131? Kennedy J held that "any adult can lawfully agree to enter a mental hospital for assessment" and the authorities are entitled to receive the person without acting unlawfully. Kennedy J found that the Mental Health Act does "not fill the field," and where it does not, the common law prevails.¹ (See para. 20.16.2 *post*). The patient's appeal was dismissed by the Court of Appeal.²

10.02.2 Minors

Section 131(2) provides that a minor who is between the age of 16 and 18, and who is capable of expressing his own wishes, can be admitted informally under the arrangements referred to in section 131(1). Such a person may be informally admitted notwithstanding any right of custody or control vested by law in his parents or guardian. Thus, once a person has attained the age of 16, if he wishes to be admitted to hospital for treatment for mental disorder, and if an appro-

¹ *R. v. Kirklees Metropolitan Council ex parte Cawley* (1992) 8 BMLR 110.

² (1993) 15 BMLR 6.

priate hospital is prepared to make a bed available, he can be informally admitted even if his parent or guardian objects.

The language in section 131(2) creates a statutory right of a minor age 16 or over to consent to informal admission to hospital. But there is nothing in the Act which expressly removes any existing common law right of a minor under the age of 16 to consent to informal admission. What, then, would be the legal position under the common law if a parent or lawful guardian wished to make arrangements for informal admission, but the minor under age 16 objected? Or if the minor wanted hospital treatment and the parent objected? The House of Lords in *Gillick v. West Norfolk A.H.A.*¹ held that a minor acting in accordance with a recognised strand of medical opinion could consent to medical treatment if she had sufficient maturity and intelligence to understand the nature and purpose of the treatment, and whether it is appropriate for her benefit and protection. (See para. 20.13.3 *post*).

The logic of *Gillick* should apply equally to the decision of a competent minor regarding informal admission to hospital or psychiatric treatment, provided there was good medical evidence that the decision was in her best interests.²

It could be argued that a parent has a much stronger and ongoing duty to determine where the minor will reside. A decision to enter hospital is one which goes directly to the heart of parental rights and duties. Nevertheless, it's also a decision which the minor has a great stake in. If the minor is able to appreciate where her best interests lie, and she is following medical advice, there are good grounds in law and public policy to respect her choice.

Some serious questions are raised by the "informal" admission of a minor who is strenuously objecting. Not least of these is the fact that there is no legally established mechanism for reviewing the justification for informal admission and there is no formal periodic review—for example, by a Mental Health Review Tribunal—of the need for continued hospital care. In the United States, the Supreme Court has determined that an objecting minor has the right to a "due process" hearing to establish the justification for informal admission, but that it is sufficient for mental health professionals themselves to make the determination.³

¹ [1985] 3 W.L.R. 830.

² This question arose in a case involving a 12-year-old who was admitted to a mental hospital with the consent of the local authority while under the care of the authority. The minor objected to the admission and there was no evidence that she was mentally disordered within the meaning of section 131 of the Act. Kennedy J, however, found that the local authority was entitled to conclude the minor was not *Gillick* competent, and that the consent to admission was, under all the circumstances, reasonable. *R. v. Kirklees Metropolitan Council ex parte* (1992) 8 BMLR 110. His decision was upheld by the Court of Appeal (1993) 15 BMLR 6.

³ *Parham v. J. R.*, 442 U. S. 584 (1979).

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The Code of Practice (para. 30.5) states that parents or guardians may arrange for the admission of a child under the age of 16 to a hospital on an informal basis. However, an objecting patient cannot be admitted or kept in hospital on an informal basis against his will, provided a doctor concludes that the minor is competent to make the decision for himself.

An interested party, such as a social worker, who considers that informal admission of a child might not be in the child's best interests, could seek to make the child a ward of court (see para. 24.23 *post*). Under section 100 of the Children Act 1989 a local authority may also seek leave to ask the High Court to exercise its inherent jurisdiction with respect to children, if the conditions set out in section 100(4) are met.

A minor who is admitted to hospital informally by a parent or guardian should not be treated without the parent's or guardian's consent. Consent should be sought for each aspect of the child's care and treatment as it arises. "Blanket" consent forms cannot be used. (As to consent to medical treatment of minors see Code of Practice, paras. 30.7–30.8, and para. 20.13.3 *post*).

10.02.3 *Mental Health Act Commission*

At present the Mental Health Act Commission does not have jurisdiction to protect the rights and welfare of informal patients. However, by section 121(4) of the Act, the Secretary of State for Social Services may, at the request of or after consultation with the Commission and after consultation with concerned bodies, direct the Commission to keep under review the care and treatment (or certain aspects of the care and treatment) of informal patients. See para. 22.06 *post*).

10.02.3A *Code of Practice*

The Code of Practice is primarily concerned with detained patients. However, much of the Code is equally applicable to informal patients, and may set a standard of care and good practice¹ (See para. 22.14 *post*).

10.02.4 *Rights of informal patients*

In nearly every respect the legal position of informal patients is the same as that of non-psychiatric patients. Most significantly, informal patients can leave hospital at any time (subject to the holding powers provided for in section 5—see further paras. 10.04–10.05 *below*); and

¹ Department of Health and Welsh Office Code of Practice: Section 118 of the Mental Health Act 1983, EL (90) P 85/ LASSL (09) 5/ WHC (90) 38, para. 4. (May 1990)

they enjoy the ordinary common law right to choose whether or not to consent to treatment. (See further para. 20.18 *post*). The Mental Health (Amendment) Act 1982 removed two of the restrictions on the rights of informal patients which existed under the 1959 Act—the withholding of post (see para. 24.30 *post*), and the removal of alien patients from the United Kingdom (see para. 19.05 *post*). In addition, the legal position of informal patients in relation to electoral registration has been strengthened (see para. 24.06 *post*). The Amendment Act did not expressly exclude informal patients from the provisions of Section 139 of the 1983 Act as recommended in the 1978 White Paper.¹ (Section 139 concerns the right of access to a court—see para. 21.25 *post*). However, in *R. v. Runighian*,² the Warwick Crown Court held that section 141 of the 1959 Act was not applicable to informal patients, at least in the circumstances presented in that case (an alleged assault by a nurse). (See further para. 21.30 *post*).

10.02A Use of Informal Admission on Patients who are Unable to Consent

It had been commonly assumed that an informal admission to hospital was appropriate even if the patient could not express a positive willingness to be admitted. Under this conventional view, an informal—as opposed to the old voluntary—admission would allow the “non-volitional” or “non-protesting” patient to be treated in hospital without the use of formal compulsory powers. (For a discussion of the use of compulsion on “willing” patients, see para. 11.02 *post*.)

The Court of Appeal in *L. v. Bournemouth Community Mental Health NHS Trust* rendered a far-reaching decision that casts doubt on this conventional position. The case involved a patient who was being treated for mental disorder in hospital, purportedly under an informal admission. The patient could not speak and was unable to express either consent or dissent to detention. The court found that the patient was, in fact, detained: “a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving.” (See further, para. 21.02.4 *post*.) According to the court, section 131 does not confer authority to detain a patient who is incapable of giving consent. Informal admission under the Act “addresses the position of a patient who is admitted and treated with consent.” If a patient who is incapable of either providing or refusing consent is to be detained, the hospital must first take steps to secure his admission under the compulsory provisions of the Mental Health Act.³

¹ DHSS *et. al.* (1978) *Review of the Mental Health Act 1959*, Cmnd. 7320, para. 7.10.

² [1977] Crim. L. Rev. 361.

³ *L. v. Bournemouth Community Mental Health NHS Trust*, The Independent 5 December 1997, The Times 8 December 1997, Court of Appeal (Civil Division) (Transcript: Smith Bernal).

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The detention also was not justified under the common law doctrine of necessity: "The right of a hospital to detain a patient for treatment for mental disorder is to be found in, and only in, the 1983 Act, whose provisions apply to the exclusion of the common law principle of necessity. (See further, para. 21.11 *post*.)

The decision in *L. v. Bournemouth Community Mental Health NHS Trust* raises the question whether informal admission is legally appropriate in any case where the patient is unable to give consent. It had previously been considered good practice to restrict the use of compulsory admission to those cases where the person objects to the admission or there is another clear justification not to admit on an informal basis. Should *Bournemouth* be limited to its facts, involving a patient who could express no view at all, or was the court suggesting that patients must give legally effective consent prior to an informal admission? Given the history of the Act, and the decision to move from "voluntary" to "informal" admission, it is likely that Parliament intended not to require formal consent procedures. Many patients with limited capacity (*e.g.* dementia or severe mental impairment) are informally admitted to hospital, and there would be concern among mental health professionals if these patients had to be subject to formal compulsion.

B. APPLICATION IN RESPECT OF PATIENTS ALREADY IN HOSPITAL

10.03 In-Patients who can be made Subject to an Application for Compulsory Admission

An application for compulsory admission to hospital under Part II can be made in respect of an informal patient notwithstanding that he is already an in-patient in hospital (s. 5(1), (6)).¹ Section 5(1) does not provide authority for applications for compulsory admission to be made in respect of patients who are already in hospital under compulsory powers (s. 5(6)) except as follows: an application for admission for treatment under section 3 can be made in respect of a patient detained under an application for assessment; and a patient who is admitted under an application for assessment in case of emergency under section 4 can have the application "converted" into one for admission for assessment under section 2 (s. 4(4)). (See further para. 11.04.3 *post*). Note that an application for admission for assessment cannot follow another application for assessment. (See further para. 11.05.4 *post*). Where an application is made in respect of a patient already in hospital, it is treated for the purposes of Part II as if the patient were admitted to the hospital at the time when that application was received by the managers (s. 5(1)).

10.04 Doctor's Holding Power (s. 5(2))

The hospital managers have the power to detain an in-patient in a hospital for up to 72 hours, if the registered medical practitioner in charge of the treatment of the patient² furnishes a written report under section 5(2). It must appear to the doctor that an application ought to be made under Part II of the Act. The report should be in the form prescribed in the Regulations (reg. 4(1)(g), Form 12), and should be delivered immediately to the managers.³ The patient can be detained for up to 72 hours beginning with the time the report is furnished to the managers, thus giving time for the completion of formalities for

¹ An emergency application, however, should only be made in cases of genuine urgent necessity. It would be rare for a patient already in hospital to need admission urgently particularly as short term holding powers are available under s. 5.

² For a definition of "medical practitioner in charge of treatment" see para. 6.17.4 *ante*. The Mental Health Act Commission has advised that he should be a consultant. Letter from the Chairman, Viscount Colville of Culross to all District Health Authority Chairmen, 28 Sept. 1983, MHAC, CPC/2. Informal advice given by the Commission in this way, while valuable, does not have the force of law.

³ Reports under s. 5 may need to be received outside normal office hours. Reports under s. 5(2) (unlike s. 5(4)) do not take effect until delivered to the person authorised to receive them. Therefore, the managers should ensure that suitable officers or classes of officers are authorised to receive documents at all times. See DHSS (1983) *Memorandum on the Mental Health Act 1983*, para. 65.

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making an application for admission for assessment (s. 2) or treatment (s. 3).

The operation of the doctor's holding power was examined by McNeill J in *McDougall v. Sefton Area Health Authority*.¹ This was an application for *habeas corpus* for the release of a patient who, after the expiration of a 28 day admission for assessment, was purported to be detained under a doctor's holding power pursuant to section 5(2). The doctor in charge of treatment made no attempt to gather the necessary recommendations and application for an admission for treatment, but used the holding power to provide time for the local authority to make an application to the County Court for the appointment of an acting nearest relative pursuant to section 29(4) (see para. 8.05 *ante*). The doctor signed the appropriate form to exercise his holding power (see B. 33 *post*), but he failed to deliver it to the managers.

McNeill J held: (1) section 5(2) is specifically directed at providing time for making an application for admission (including the recommendations of two medical practitioners), whereas in this case it was used to provide time for an application to displace the nearest relative under section 29(4); (2) section 5(2) requires receipt of the report by the managers. "Furnishing a report under Section 5(2) impinges on the personal liberty of the subject and I am not satisfied here that a report was furnished to the managers"; and (3) the section 29 (4) procedure for extending the period during which a section 2 patient may be detained (see para 8.05 *ante*) can be invoked only before the expiration of the 28 day period (see ss. 2(4), 29(4)).

This case raises interesting questions of law. A holding power can be exercised only if the doctor in charge of treatment believes that an "application ought to be made" under Part II of the Act. The Act does not specify what action he must take to secure that an application is made. Clearly the doctor in *McDougall's* case believed that an application should be made; and, since the nearest relative was objecting, a sensible course would be to obtain an order for an acting nearest relative. Since the patient was no longer subject to detention for assessment, section 29(1), not 29(4), was the appropriate procedure.

It would appear from the Act that if the doctor in charge of treatment has a genuine belief that an application ought to be made, the appropriate procedure for arranging that application is being followed, and the appropriate form under section 5(2) is delivered to the manager, then the holding power would be lawful.

The doctor's holding power cannot be renewed, but circumstances can arise where, subsequent to its use and the patient's reversion to informal status, its use can be reconsidered. (Code of Practice, para. 8.3.)

¹ High Court, Liverpool, QBD, April 9, 1987.

10.04.1 *Nominated deputies*

The medical practitioner in charge of treatment of a patient in a hospital may nominate one (but only one) other registered medical practitioner on the staff of that hospital to act for him for the purposes of section 5(2) in his absence (s. 5(3)). (The Code of Practice, para. 8.14 advises that only consultant psychiatrists should nominate deputies.) The delegation of authority for the purposes of section 5(2) must be made personally by the doctor in charge of treatment, and not by the managers or any other person in his absence. The person with delegated authority should, insofar as possible, be a senior doctor; in mental illness and mental handicap hospitals it should be another consultant or senior registrar.¹

The Code of Practice (para 8.14) lays down the following safeguards for the nomination of deputies: (a) the nominating doctor must be satisfied that if the nominated deputy is a junior doctor, he has sufficient guidance and training; (b) the deputy must, wherever possible, contact the nominating doctor before using section 5(2); (c) the deputy should report the use of section 5(2) to his nominator as soon as possible; and (d) all relevant staff should know who is the nominated deputy for a particular patient. It is unlawful for one nominated deputy to nominate another.

10.04.2 *In-patients*

The doctor's holding power is exercisable in respect of any in-patient, except one who is already liable to be detained under Part II (s. 5(6)). The in-patient need not be receiving treatment for mental disorder; the power can be used, for example, in respect of a patient receiving treatment for a physical illness in a general hospital if the statutory criteria are met.

An in-patient is defined as one who has understood and accepted the offer of a bed, who has freely appeared on the ward, and who has co-operated in the admission procedure. Section 5(2), for example, cannot be used for an out-patient attending a hospital's accident and emergency department. (Code of Practice, para. 8.4).

10.04.3 *Assessment and monitoring*

The doctor's holding power is expressly for the purpose of assessing the patient for a possible application under Part II of the Act. Accordingly, a patient held under section 5(2) should be discharged from the order immediately once an assessment is made and a decision is taken not to make an application; or the doctor decides that no assessment needs to be made.

¹ See Letter from the Chairman, MHAC, CPC/2 (September 28, 1983).

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The health authority and local social services authority should ensure that once the holding power is invoked an ASW and doctors are available for immediate assessment of the patient. The managers must also monitor the use of the power to ensure it is being exercised lawfully and according to high professional standards. It is the managers' responsibility to ensure that patients held under section 5(2) are provided with the information to which they are entitled under section 32. (Code of Practice, paras. 8.1, 8.3, 8.7, 8.12).

10.04.4 *The doctor's role*

Section 5(2) can be used for in-patients being treated for physical or mental disorders. Where a report is provided by a consultant other than a psychiatrist, the consultant should make immediate contact with a psychiatrist. The psychiatrist should see the patient as soon as possible to determine whether he should be detained further.¹ When a patient is receiving treatment both for a physical illness and a mental disorder the doctor in charge of treatment for the purposes of section 5(2) is the psychiatrist.

Section 5(2) should be invoked only if an application for admission under Part II is not practicable or safe.²

The patient's doctor or nominated deputy can only use the power immediately after personally examining the patient. It is unlawful for a doctor to sign a section 5(2) form and leave it on the ward for others to submit to the managers if the need arises.

The patient can be lawfully held under section 5(2) only after the managers, or person authorised by the managers, are in receipt of a duly completed form (Form 12). The period of detention commences at the moment Form 12 is received.

The patient being held under section 5(4) cannot be treated without consent under Part IV of the Act (see para. 20.18 *post.*) The patient can only be treated as allowed under the common law (see paras. 20.10–20.11 *post.*) (Code of Practice, paras. 8.8–8.11).

10.05 Nurse's Holding Power (s. 5(4))

The hospital managers have the power to detain an in-patient who is receiving treatment for mental disorder in hospital if a nurse of the prescribed class (s. 5(7)) furnishes a written report under section 5(4). The class prescribed are nurses registered in parts 3, 4, 5, 6, 13,

¹ Department of Health (1983). Memorandum on the Mental Health Act 1983, para. 31.

² Section 5(2) technically is not an admission under the Act. It is a power to detain while an assessment is made to determine if an application for admission ought to be made.

14 of the register maintained under section 7 of the Nurses, Midwives and Health Visitors Act 1997. These are first and second level nurses trained in nursing persons suffering from mental illness or those suffering from learning disabilities and nurses qualified following a course of preparation in mental health or learning disabilities nursing.¹ (See further para. 6.19 *ante*). The power is not exercisable in respect of a patient already liable to be detained under Part II of the Act (s. 5(6)). It can be exercised only in respect of a patient receiving treatment for mental disorder; it **cannot** be used, for example, in the case of a patient receiving treatment for a physical illness in a general hospital.

It must appear to a nurse of the prescribed class that: (i) the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital; and (ii) that it is not practicable to secure the immediate attendance of a doctor who can exercise a holding power under s. 5(2). It is the personal decision of the nurse, and he cannot be instructed to exercise the power by anyone else.

The nurse must record the foregoing information in writing in a form set out in the Regulations (reg. 4(1)(h), Form 13). This recording has the effect of making the patient **immediately** liable to be detained in the hospital for a period of six hours, or until the earlier arrival of a practitioner having the power to exercise a doctor's holding power under section 5(2). The reasons for invoking the power should be entered in the patient's nursing and medical records, and a local incident report sent to the managers. (Code of Practice, para. 9.4).

Once that medical practitioner has arrived, the nurse's holding power lapses, even if the six hour period has not yet expired. The doctor is free either to exercise his power to hold the patient further, or he can decide not to exercise his power (*e.g.*, by persuading him to remain in hospital on an informal basis). The written record made by the nurse must be delivered by that nurse (or a person authorised by him) to the hospital managers (or someone authorised to act on their behalf) as soon as possible after it is made (s. 5(5)). (As to the delivery of documents, see reg. 3 and para. 6.13 *ante*). The nurse or another nurse of the prescribed class must record, in the form set out in the Regulations (reg. 4(5), Form 16), the time at which the patient ceased to be detained under section 5(4) by virtue of the expiry of six hours from the time the report is made or the arrival, if earlier, of a practitioner having the power to hold the patient under section 5(2).

Two differences from the doctor's holding power should be noted:

¹ The Mental Health (Hospital, Guardianship and Consent to Treatment) Amendment Regulations 1998, S.I. No. 2624; The Mental Health (Nurses) Order 1983, S.I. No. 2625). These amendments reflect the change of "mental handicap nursing" to "learning disabilities nursing."

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- (i) the nurse's holding power can be exercised only in respect of an in-patient receiving treatment for **mental disorder**, not any in-patient; and
- (ii) the authority to detain under a nurse's holding power begins at the time the report is made, and does not have to wait until the report is delivered to a person authorised to act on behalf of the managers.

10.05.1 *Assessment*

The nurse must make a professional judgment as to whether it is urgently necessary to hold the patient until a doctor arrives. The nurse should first try to persuade the patient to remain in hospital until the doctor arrives. If the patient cannot be persuaded to remain voluntarily, the nurse should assess the risk to health and safety if the patient is allowed to leave the hospital, including the likelihood of suicide, dangerous behaviour, or serious deterioration in health. The nurse should consider all relevant information including any messages recently received from relatives, friends, or other patients, the patient's past and current behaviour, including any unusual changes in behaviour, and information ascertained from other members of the multidisciplinary team.

An assessment should always precede a decision to exercise a nurse's holding power except in cases of extreme urgency. (Code of Practice, paras. 9.2–9.3).

10.05.2 *Restraint*

The nurse should explain in private to the patient the need for using section 5(4). The nurse is entitled to use the minimum force necessary to prevent the patient from leaving hospital and from harming himself or others. (Code of Practice, paras. 9.6–9.7). The use of restraint is examined further in Chapter 21 *post*.

10.05.3 *Management responsibility*

Section 5(4) is intended for use only in medical emergencies. The doctor should respond to the emergency by coming to the ward as soon as possible. If the doctor has not arrived within six hours the nurse should contact the consultant or the Unit General Manager (UGM), and the managers should be informed. The UGM or one of the managers should supervise the patient's leaving after six hours if the doctor is not yet in attendance.