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[3]

- Consent must be obtained before any examination, treatment or care for competent adult patients.
- Consent must be given voluntarily and not under any form of duress or undue influence from health professionals, family or friends.
- 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. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the fetus.
- 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.
- Patients need sufficient information before they can decide whether to give their consent – eg, information about the benefits and risks of the proposed treatment, and alternative treatments. 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.
- Consent is a continuing process rather than a one-off decision. It is important that the patient be given continuing opportunities to ask further questions and to review the decision.
- Patients can change their minds and withdraw consent at any time, as long as they have the capacity to do so.
- All people aged 16 and over are presumed, in law, to have the capacity to consent to treatment unless there is evidence to the contrary. A patient who has a mental disorder or impairment does not necessarily lack the competence to consent to treatment.
- 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.
- Unexpected decisions do not prove the patient is incompetent; such decisions may indicate a need for further information or explanation.
- Patients may be competent to make some health care decisions, even if they are not competent to make others.
- 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.

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[^5]

See also the separate Advance Care Planning article.

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.

- In England and Wales, advance care plans are covered by the Mental Capacity Act. The decision should comply with the provisions of the Mental Capacity Act if it is to be legally binding.
- Any person can make an advance decision, including an individual under the age of 18. In the case of young people under the age of 18, advance care plans should be taken into account and accommodated, if possible, but do not necessarily have the same status as those of adults.
- An advance decision can be of two main types:
  - A statement authorising or requesting specific procedures.
  - A clear instruction refusing some or all medical procedures (also called an advance directive).
- An advance refusal is legally binding providing that the patient is an adult, the patient was competent and properly informed when reaching the decision, it is clearly applicable to the present circumstances and there is no reason to believe that the patient has changed his or her mind. If an advance decision does not meet these criteria but appears to set out a clear indication of the patient's wishes, it will not be legally binding but should be taken into consideration in determining the patient's best interests.
- Advance requests or authorisations do not have the same binding status but should be taken into account in assessing best interests.
- Where the patient's advance decision relates to a refusal of life prolonging treatment, this must be recorded in writing and witnessed. The patient must acknowledge in the written decision that they intend to refuse treatment even though this puts their life at risk.
- Advance care plans can be overruled if the individual is being treated compulsorily under mental health legislation. However, a valid and applicable advance refusal of treatment for conditions that are not covered by the compulsory powers of the legislation will be binding.
- In England and Wales, an advance decision is superseded if the patient subsequently gives someone lasting power of attorney to make that decision.

**Mental Health Act relevant to consent**

The Consent to Treatment Provisions are dealt with in Part 4 of the Mental Health Act, which applies to:

- 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.

**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 Mental Health Act Commission. 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 Mental Health Act Commission to give a second opinion.
- The appointed doctor 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, so long as the treatment is not irreversible.
• To alleviate serious suffering, so long as the treatment is neither irreversible nor hazardous.
• To prevent the patient from behaving violently or being a danger to self or others, so 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 RMO has to provide a report to the Mental Health Act Commission if the period of detention is renewed under Section 20.
• The Commission may demand a report at any other time if it wishes.
• The Commission 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 Commission:
  • 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 & references
• Violence and aggression: short-term management in mental health, health and community settings; NICE Guideline (May 2015)
• Vulnerable adults and confidentiality; British Medical Association
1. Consent guidance: patients and doctors making decisions together; General Medical Council
2. Mental Health Act 2007
3. Consent tool kit; British Medical Association
5. Advance decisions to refuse treatment: a guide for health and social care professionals; National Council for Palliative Care and NHS End of Life Care Programme (2013)

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Author: Dr Colin Tidy
Peer Reviewer: Dr John Cox
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