Treatment of patients who lack capacity

Implications of the L. *v.* Bournewood Community Trust ruling

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The case of L. *v.* Bournewood Community Trust concerned an autistic man without the capacity to consent to admission, who was admitted informally to a learning-disability hospital. The Court of Appeal (and therefore the law at present) held that he was unlawfully detained, and that patients who lack capacity to consent to hospital admission cannot receive treatment for mental disorder as informal patients. The judgement may be overturned following further review in the House of Lords.

The National Health Service (NHS) Executive has informed health authorities, trusts, social services departments, the Mental Health Act Commission and the relevant Royal Colleges that "the judgement has very significant implications for the management of patients who lack the capacity to consent – particularly people with a learning disability and those suffering from dementia". Patients lacking this capacity "cannot be informally admitted to hospital for assessment or treatment of a mental disorder even if they do not dissent" (Brown, 1997). The NHS Executive states that those who lack capacity and fulfil criteria for admission under Section 2 or 3 of the 1983 Mental Health Act (MHA) should be detained, and that this applies to both prospective admissions and current patients.

The NHS Executive defines capacity to consent to admission (or to treatment) as the abilities "to take in and retain the information material to the decision, especially as to likely consequences of having or not having the treatment", and "to weigh the information in the balance as part of a process of arriving at the decision". Such consent must be "voluntary and continuing". Treatment according to the MHA (Section 145) includes nursing care and psychological treatment as well as physical treatments, habilitation and rehabilitation under medical supervision.

Most hospital patients with a learning disability or dementia would fail the test of capacity, as would many patients with psychoses (particularly schizophrenia and delusional depression). Current practice is for consent to be assumed in the absence of dissent. This judgement, therefore, mandates a radical change in practice with implications in terms both of resources and of distress to patients and their families.

In the year to March 1997, 620 learning-disability patients in England and Wales were detained under the MHA (Department of Health figures, further details available from the author upon request). As there are now approximately 8000 in-patients in learning-disability hospitals (many of whom lack the capacity to consent), MHA-related work in assessing capacity to consent and (usually) detaining them would increase 10-fold. There will be a similar increase for patients with dementia (14% of total psychiatric in-patients; Smith *et al*, 1995). We estimate that full implementation would result in at least a three-fold increase in the number of detained people with 'mental illness' (9595 in the year to March 1997; Department of Health figures, further details available from the author upon request).

It is impossible to see how the financial, medical, legal and social service resources for this can be identified within current budgets. The initial section assessment requires two medical practitioners (who cannot both work for the same hospital) and a social worker. In addition, all sections must be reviewed regularly by clinicians, independent doctors, the MHA managers and/or mental health review tribunals.

This problem could theoretically be addressed by allocating extra funds to mental health. In contrast, there is no obvious solution to the distress caused to people with a mental illness or mental impairment and their carers, who wish to remain in or be admitted to hospital but because