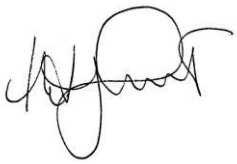
S131 INFORMAL ADMISSION

Policy number and category	**MHL08**	**MHL**
Version number and date	**6**	**April 2021**
Ratifying committee or executive director	**Mental Health Legislation Committee (MHLC)**	
Date ratified	**October 2021**	
Next anticipated review	**October 2024**	
Executive director	**Medical Director**	
Policy lead	**Head of Mental Health Legislation**	
Policy author ***(if different from above)***		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

POLICY CONTEXT:

For the admission of all informal patients with capacity consenting to their admission; this policy sets out procedures which must be followed.

POLICY REQUIREMENT (see Section 2)

- This policy provides guidance on the management of the admission of informal patients.
- All informal patients will be made aware of their rights
- If there is ever any doubt over the capacity of an informal patient, a formal capacity assessment will be undertaken

Contents Page consisting of:

1. Introduction:

1.1 Rationale (why):

1.1.1 For the purposes of this policy the term Informal patient will be used to identify patients not detained under the Mental Health Act 1983 (MHA) or the Mental Capacity Act 2005 (MCA)/ Deprivation of Liberty Safeguards (DoLS) who have the capacity to consent to their hospital admission.

1.1.2 BSMHFT has a duty to provide safe and appropriate treatment for all inpatients, regardless of legal status, balancing the management of risk against the principles of least restrictive treatment.

1.1.3 Section 131 of the Mental Health Act 1983 (MHA) emphasises the freedom for patients to be admitted without any formal restrictions. The same section also allows for patients to remain in hospital after they have stopped being detained under another section of the MHA.

1.1.4 This policy promotes good practice through adherence to the MHA Code of Practice guiding principles: Least restrictive and maximising independence; Empowerment and involvement; Respect and dignity; Purpose and effectiveness; and Efficiency & equity.

1.2 Scope (when, where and who):

1.2.1 This policy covers all patients who are inpatients within our Trust who are not detained under the MHA or DoLS and should be read in conjunction with the Mental Capacity Act (MCA) Policy and DoLS Procedures

1.2.2 This policy covers all areas of BSMHFT where informal patients reside but does not apply to Prison Healthcare services.

1.2.3 Some locations within the Trust have locked doors

1.2.4 It is important that patients are made aware that any security measures in place are there to protect them and all patients

1.2.5 Informal patients have the legal right to leave the ward at any time, unless there is any other appropriate lawful authority to detain them (please see section 3 of this policy for further detail).

1.2.6 They will be informed of the arrangements in each specific area of the Trust and how patients can exit from the ward

1.2.7 A poster will be displayed on the exit door from the ward in areas where doors are locked and an information leaflet will be supplied to every informal patient on admission detailing the patient's rights and the process to be followed to exit the ward

1.3 Principles (beliefs): this presents the major underlying beliefs on which the policy is based.

1.3.1 Section 132 of the MHA outlines to hospital managers their responsibilities to provide information to patients detained under the MHA and to ensure they are fully informed and supported in exercising their statutory rights.

1.3.2 However, the MHA makes no requirement of hospital managers to explain to patients their rights as informal patients except in relation to the Human Rights Act (1998).

1.3.3 As a Trust, we need to ensure that all our patients, regardless of their legal status are kept well informed of their rights whilst an inpatient in order that patients' rights are protected in line with the Human Rights Act (DOH 1998).

1.3.4 Informing informal patients of their rights should be managed so that it is a positive experience

1.3.5 'The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.'

2 **The policy** (What):

2.1 For the admission of all informal patients – mentally capable, consenting to their admission - the procedures in Part 3 must be followed.

2.2 This policy relates specifically to the admission of informal patients. During their inpatient episode it is recognised that informal patients are not subject to the same legal restrictions nor entitled to the same processes designed to safeguard their rights, as those detained under the Mental Health Act or Mental Capacity Act including Deprivation of Liberty Safeguards. It is important therefore to ensure that informal patients are given the same level of service as those whose freedoms are restricted under mental health legislation. This includes but is not limited to engagement, assessment, care planning, treatment / therapy, MDT input and reviews, and discharge planning.

3 **The procedure**:

3.1 On admission all informal patients should be given an information leaflet and informed of their rights as an informal patient (Appendix 2). They should also be given an induction to the ward to which they are being admitted (as per local admission procedure).

3.2 This information can then be used by the patient to inform their decision making regarding their willingness to remain in hospital and accept treatment

3.3 All informal patients will be formally assessed for their capacity to consent to the admission and to any proposed treatment plan. These are separate assessments specific to each decision.

3.4 This will be done using the Trust's Mental Capacity Assessment Form 2 on RiO

3.5 By testing capacity and emphasising their rights to refuse treatment and leave hospital, any concerns that the patient's consent is implied and not informed, will be addressed.

3.6 All informal patients will be offered the opportunity to make an Advance Statement which is a clear preference of wishes. For further details please read in conjunction the MHL03 Advance Statements and Advance Decisions Policy

3.7 All informal patients will also be assessed for capacity to consent to treatment at the point of first administration of medication using the Trust's Mental Capacity Assessment Form 3B on RiO

3.8 The issue of the patient's capacity must be regularly reviewed at the Multi-Disciplinary Team (MDT) meeting / ward round. The outcome should be recorded on the individual's MDT review form on RiO

3.9 All steps must be taken (where appropriate) to ensure that the patient retains contact with the family, friends, carers and others interested in their welfare

3.10 If in an exceptional case there are good clinical reasons why contact with family / carers is not appropriate / safe it should be ensured that this is properly documented and explained to the people it affects

3.11 If there is a dispute or disagreement about the admission/treatment/ care plan, or if circumstances change to this effect then the appropriateness of the following options should be considered in a multidisciplinary forum:-

- Request a second medical opinion
- Discharge
- Consider the use of the Mental Health Act

3.12 Please read this policy in conjunction with the Trust MHL14 MCA Policy for further guidance on patients who may lose capacity

3.13 16-17 year olds with capacity to consent (to be read in conjunction with ch19 MHA CoP)

3.14 Where a young person aged 16 or 17 has capacity (as defined in the MCA) to consent to being admitted to hospital for treatment for mental disorder, they may either consent, or refuse to consent, to the proposed informal admission

3.15 If a young person has the capacity to consent to informal admission and gives such consent, they can be admitted, irrespective of the views of a person with parental responsibility (who cannot prevent the admission).

3.16 If the young person with capacity does not consent to the admission, then a person with parental responsibility cannot consent on their behalf.

3.17 In some cases, the young person may be unable to decide whether or not to agree to their admission to hospital. This might be because, despite every effort in helping the young person to make this decision, the young person finds the decision too difficult to make.

3.18 It will not be possible for a person with parental responsibility to consent on their behalf because s 131 of the MHA only allows informal admission on the basis of parental consent if the young person lacks capacity within the meaning of the MCA.

3.19 Where the young person does not consent to their admission to hospital, but the admission is thought to be necessary, consideration should be given to whether the criteria for admission under the MHA are met. If it is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken

3.20 16-17 year olds who lack capacity to consent (To be read in conjunction with ch19 MHA CoP)

3.21 Where a young person aged 16 or 17 lacks capacity it may be possible for them to be admitted informally, in accordance with the MCA, unless the admission and treatment amounts to a deprivation of liberty

3.22 In cases where the MCA cannot authorise informal admission, but the admission is thought to be necessary and detention under the MHA is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken

3.23 Informal admission of under 16s who are not Gillick competent

3.24 This term refers to a child under the age of 16 who is considered to have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention that requires consent, including admission to hospital and who is therefore competent to consent to the admission.

3.25 Where a child is not Gillick competent then it may be possible for a person with parental responsibility to consent, on their behalf, to their informal admission to hospital for treatment for mental disorder

3.26 If parental consent can be relied upon and consent is given by a person with parental responsibility, then the child may be admitted and treated as an informal patient

3.27 If it is not considered appropriate to rely on parental consent for the proposed admission, for example because the consent of a person with parental responsibility is not given, the child cannot be admitted and treated informally.

3.28 In such cases, consideration should be given to whether admission under the MHA is necessary.

3.29 If the MHA is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken

3.30 Further advice can be sought from the Trust's Legal Department or the Trust Head of Mental Health Legislation.

3.31 All MCA forms are on RiO

3.32 Facilitation of Leave

3.33 Although informal patients are free to leave whenever they wish, any informal patient or resident of the Trust leaving the ward/residential unit could potentially be at risk of harm to, or from, themselves, other people or the environment. For full guidance please read in conjunction with Trust Policy C56 Section 17 Leave of Absence.

4 Responsibilities

Post(s)	Responsibilities	Ref
Responsible Clinician (RC)	To assess for capacity to consent to treatment	
Admitting professional (doctor or nurse)	To assess for capacity to consent to admission	
Joint responsibility of the named nurse and RC	To ensure that capacity issues are regularly reviewed as per the guidance	3.7 and 3.8
MDT	To ensure contact with family, friends and	

	carers is maintained where appropriate	
Nurse and RC	To decide whether an Independent Mental Capacity Advocate (IMCA) is needed	
RC	Responsibilities regarding resolution of dispute or disagreement about the admission/treatment/ care plan	3.11
All Staff	Must follow the word and spirit of the Act	
Service, Clinical and Corporate Directors	Must follow the word and spirit of the Act	
Policy Lead	Ensure the policy is kept up to date with any legislative / case law changes	
Executive Director	The Medical Director has overall responsibility for ensuring compliance with and timely review of this policy	

5 Development and Consultation process:

Consultation summary	
Date policy issued for consultation	April
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**
MHLC	October 2021
PDMG	September 2021

6 Reference documents

Department of Health (1998) Human Rights Act.
https://www.legislation.gov.uk/ukpga/1998/42/schedule/1

Mental Capacity Act 2005
https://www.legislation.gov.uk/ukpga/2005/9/contents

Mental Health Act 1983
https://www.legislation.gov.uk/ukpga/1983/20/contents

Deprivation of Liberty Safeguards (DoLS)

https://www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards

MHL03 Advance Statements and Advance Decisions Policy
http://connect/corporate/governance/Policies/Advance%20Statements%20and%20Advance%20Decision.pdf

MHL14 Mental Capacity Act Policy
http://connect/corporate/governance/Policies/Mental%20Capacity%20Act%20Policy.pdf

C56 S17 Leave of absence policy
http://connect/corporate/governance/Policies/S17%20Leave%20of%20Absence%20Policy.pdf

7 Bibliography:

8 **Glossary** consisting of:

Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to make a particular decision (e.g. to consent to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
Consent	Agreeing to allow someone else to do something to or for you, particularly consent to treatment. Valid consent requires that the patient has capacity to make the decision and that they are given the information they need to make the decision and that they are not under any duress or inappropriate pressure.
Detained Patients	Unless otherwise stated, a patient who is detained in hospital under the MHA, or who is liable to be detained in hospital
DoLS	Deprivation of Liberty Safeguards - The framework of safeguards under the Mental Capacity Act 2005, as amended by the Mental Health Act 2007, for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves
Gillick Competent	This term refers to a child under the age of 16 who is considered to have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention that requires consent, including admission to hospital and medical treatment, and who is therefore competent to consent to that intervention. See also competence to consent
Guiding Principles	The principles set out in the MHA and the MCA which have to be considered when decisions are made under the respective Acts
IMCA	Independent Mental Capacity Advocate. An advocate able to offer help to patients who lack capacity under arrangements which are specifically required to be made under the Mental Capacity Act 2005
IMHA	Independent Mental Health Advocate. An advocate available to offer help to patients under arrangements which are specifically required to be made under the MHA
MCA	The Mental Capacity Act 2005 is an Act of Parliament that governs decision making on behalf of people who lack capacity.
MHA	Mental Health Act
RC	Responsible Clinician - The Approved Clinician (AC) with overall responsibility for a patient's case.

9 Audit and assurance consisting of:

9.1 The MHA / MCA is monitored on a monthly basis by Ward Managers; and reported on by Clinical Nurse Managers / Matrons on a monthly basis to the MH Legislation Manager, who reports to the NED for MHL monthly and the MHL Committee, a subcommittee of Trust Board, quarterly

9.2 Review of Serious Incidents

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Capacity to consent to treatment assessment first dose of medication	HMHL	MHA MCA Monitoring tool	Monthly	MHLC

10 Appendices consisting of:

Appendix 1: Equality Impact Assessment

Appendix 2: Informal Patient Information Leaflet

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	**S131 INFORMAL ADMISSION POLICY**		
Person Completing this proposal	**LOUISE MCLANACHAN**	**Role or title**	**HEAD OF MENTAL HEALTH LEGISLATION**
Division	**Corporate**	**Service Area**	**n/a**
Date Started	**APRIL 2021**	**Date completed**	**August 2021**
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
To ensure informal admissions are managed in line with legislation and that informal patients are kept informed of their legal rights			
Who will benefit from the proposal?			
Staff and informal patients			
Impacts on different Personal Protected Characteristics – *Helpful Questions:*			
Promotes equality of opportunity *Eliminates discrimination* *Protects and promotes human rights*			

Please click in the relevant impact box or leave blank if you feel there is no particular impact.				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	**x**			
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				

Disability	**x**			
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	**x**			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	**x**			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	**x**			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	**x**			
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	**x**			
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	**x**			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				

Transgender or Gender Reassignment	**x**			
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	**x**			
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				x
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
How will any impact or planned actions be monitored and reviewed?				

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

As an informal patient you have agreed to come into hospital voluntarily and be a patient on this ward.

It is likely that you know you are unwell and need to be given help and support.

On the ward you will sometimes be referred to as an informal or voluntary patient, because you are not detained under the Mental Health Act 1983 (MHA).

Because of your informal status, you have certain rights during your stay on the ward. Equally, you have some responsibilities as well. The purpose of this leaflet is to give you some background information about the rights and responsibilities of informal patients.

YOUR RESPONSIBILITIES AS AN INFORMAL PATIENT

Agreeing to these responsibilities will ensure that your time on the ward is well spent and so enable you to return to your own private life as soon as possible.

On admission to the ward, every patient is encouraged to participate fully with their named nurse and other members of the clinical team in the development of their own treatment plan leading to a planned discharge.

Participation includes:

- Being actively involved in your own treatment plan, including therapeutic activities on the ward; and
- Sharing any concerns about your treatment with the clinical team.

YOUR RIGHTS AS AN INFORMAL PATIENT

As an informal patient you are not subject to any restrictions on leaving the ward. It would be appreciated if you can co-operate with ward staff should you wish to leave the ward area or discharge yourself.

While you are an in-patient we continue to have a duty of care towards you.

As an informal patient you also have a right to refuse your proposed treatment. This includes any medication that might be prescribed to you while on the ward. Despite this right, it is hoped that you would discuss the reasons for this refusal as outlined above.

As an informal patient, you are not subject to statutory powers and cannot be held on the ward against your will. However, there are some important related issues:

- Where ward exit doors are locked there may be a number of reasons for this. However it is certainly not to prevent you from leaving and you have a right to request them to be opened to allow you to leave
- Clinical staff have a responsibility for ensuring that the whereabouts of all current inpatients are known at all times (e.g. to comply with fire safety and Health and Safety Regulations)
- If you decide to leave, this may be on a short term basis (a few hours during the day), long term (including a stay

away from the ward overnight) or permanently (discharge).

DISCHARGE

- If you are discharging yourself then, we would ask that this doesn't happen without prior consultation with your doctor or named nurse where possible.
- On discharge, you may be offered follow up care in the community. Your discharge plan will be given to you and a copy sent to your General Practitioner
- You also need to be aware that your family and carers might have a need to be informed you are leaving so they can ensure support arrangements are in place
- Medication for you to take home may need to be organised, as well as other practical considerations such as food and money.

IF THERE ARE CONCERNS ABOUT YOU LEAVING

If clinical staff consider your decision to leave may be unwise they may explain their concerns so that you may take these into account.

You have the right to insist on leaving hospital. You will then be allowed to leave unless there is a good reason to keep you here under the Mental Health Act (1983) (for this to happen you need to meet the legal criteria for detention).

Under Section 5 of the Mental Health Act both doctors and nurses have the power to prevent you from leaving the ward if there are serious concerns and you insist on leaving. Concerns include the possible harm that may occur to you or others and your overall welfare. This is to allow time for a Mental Health Act Assessment to be completed.

If these powers are implemented there are systems under the Act which are used to protect you and your rights and you will be informed of these if they are going to be applied to you.

MENTAL CAPACITY ACT 2005 (MCA)

Some patients who are not detained under the MHA but have difficulty making decisions may be subject to the provisions of the Mental Capacity Act 2005.

Having mental capacity means being able to make your own decision about something.

If staff think you are unable to make a decision and the result of the decision might cause you harm, then the MCA allows them to take steps in your best interest to prevent this. If the MCA applies then in certain circumstances staff may be able to prevent you from doing some of the things described above.

Staff are trained in issues of mental capacity and have information they will be happy to share with you and/or your family.