

Right to treat?

**Delivering physical
healthcare to people
who lack capacity and
refuse or resist treatment**

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Who we are and what we do

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health and incapacity law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have worked in healthcare, social care or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect.
- Have the right to treatment that is allowed by law and fully meets professional standards.
- Have the right to live free from abuse, neglect or discrimination.
- Get the care and treatment that best suits his or her needs.
- Be enabled to lead as fulfilling a life as possible.

Our work

- We find out whether individual treatment is in line with the law and practices that we know work well.
- Challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

Why we produced this guidance

The Mental Welfare Commission gives advice on how to use best legal and ethical principles in the care and treatment of a person with a mental illness, learning disability or other mental disorder. We keep track of the questions we are asked to see if there are common themes or if there are areas where it is difficult to give “correct” advice. In these situations, we try to collect the questions we are asked and produce a guide to good practice.

One type of question we are often asked is about getting people the care they need for physical health problems when they lack capacity to consent to treatment. This should be relatively straightforward where the person does not resist because the law is quite clear. If the person lacks capacity and resists or refuses treatment, it is not so easy to decide how to proceed. The following case is a good example:

Mrs E has dementia and suffers a fall. An ambulance is called. She has an obvious deformity of her wrist that is highly suggestive of a fracture. She refuses to go to hospital. The GP is called and is satisfied that she lacks capacity but cannot persuade her to get into the ambulance. We advised that they should do all they could to persuade her, using family and friends that she trusts. If this fails, she cannot be left with pain and deformity. A Sheriff or Justice of the Peace could grant a warrant to remove her to hospital. Treatment could be given in hospital under part five of the Adults with Incapacity (Scotland) Act 2000.

We heard of so many situations similar to this that we decided to produce this guidance. It will not cover every possible scenario. Each situation is different and we are always willing to give advice by telephone on individual cases. We hope that the general principles and case examples in this guidance give practitioners some assistance in a difficult area of law, medical ethics and clinical practice. In particular, the detailed case examples in appendix 1 show how the guidance might work for difficult clinical dilemmas.

In appendix 2, we have set out a quick guide to the process for making decisions on the use of force. Appendix 3 outlines the legal options available if force is needed. While these appendices can be used as a quick guide for reference, we strongly recommend that practitioners first read the whole of this guidance.

We have set out our interpretation of legislation and best practice. Clinicians may also wish to take their own legal advice and/or consult other relevant organisations such as professional defence organisations or professional regulatory bodies. Especially in urgent situations, the clinician must be the one to make decisions. Clear recording of the reasons for decisions will be essential in case of future challenge.

This guidance applies to adults (aged 16 or over) in Scotland. We have not addressed the care of children in this document, because the legal framework is different.

How we produced this guidance

We examined the relevant legislation to set out a range of options for providing treatment. We then put together several case examples based on situations drawn to our attention by practitioners. We invited a number of organisations to come to a consultation event where we gave them the legal framework and the case examples. In each case, we asked them:

1. Should practitioners intervene? If yes:
2. How do they provide treatment? And
3. How do they get the person to hospital (if necessary)?

What the law says

We looked at several areas of the law as it applies in Scotland. We looked at:

- The “common law” – the principle of necessity and the basic duty of care that practitioners have.
- The Adults with Incapacity (Scotland) Act 2000.
- The Mental Health (Care and Treatment) (Scotland) Act 2003.
- The Human Rights Act 1998.

We also had regard to the United Nations Convention on the Rights of Persons with Disability. In particular, article 25 requires that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. Article 12 of the convention also asserts the right to be able to give informed consent to treatment. People with mental illness and learning disability must receive information and support that helps them exercise this right.

Common law “principle of necessity”

Under common law, it is reasonable in an emergency to take necessary action to safeguard a person who is unable to consent and without treatment would come to significant harm. For example, a person who is knocked unconscious in an accident may be treated for their injuries if any delay to that treatment would risk the person’s life or be a serious risk to the person’s health.

This is equally true of someone who is incapable of consenting through mental illness, if the nature of their injury is such that any delay in treatment would lead to a significant risk to their health. This does not, however, prevent the operation of part five of the 2000 Act, discussed further below, where it is reasonable and practicable for the procedure under that provision to be used.

Adults with Incapacity (Scotland) Act 2000

There are several relevant provisions within the 2000 Act that have a bearing on the issue. Part one defines incapacity and outlines the principles that govern any intervention (benefit to the adult, least restriction of freedom, account taken of adult's past and present wishes, consultation with others where reasonable and practicable, encourage use of existing skills/development of new skills). Part two allows for the appointment of a welfare power of attorney who can be empowered to consent or refuse consent on an adult's behalf. Part five deals with medical treatment and part six allows for an intervention order or guardianship for welfare issues.

Parts five and six deserve greater explanation.

Part five of the 2000 Act

Part five defines medical treatment as "any healthcare procedure designed to promote or safeguard the physical or mental health of the adult". Under part five, the medical practitioner (or sometimes another healthcare professional) certifies incapacity in relation

to the medical treatment in question. This "section 47 certificate" authorises the practitioner or others under his/her direction to provide reasonable interventions related to the treatment authorised. The purpose of treatment is to safeguard or promote the physical or mental health of the adult.

The authority is limited in a number of ways. Most importantly, it does not authorise force unless immediately necessary and only for as long as is necessary. Also, it does not specifically authorise the transport of the adult to the place of treatment. We have given previous guidance on mechanisms for conveying a person to hospital¹. We have reproduced some of this guidance in appendix 4.

If there is a welfare attorney or guardian with the power to consent to treatment, the section 47 certificate is still necessary. In addition, the attorney or guardian must be asked for consent unless it is impracticable to do so.

Treatment cannot automatically proceed if a welfare attorney or guardian or a person authorised under an intervention order with relevant powers has been consulted and refuses to consent. There is a mechanism for an independent opinion to resolve the disagreement. Treatment to save life or prevent serious deterioration can be given unless there an injunction against it. See section 50 of the Act.

Part six of the 2000 Act

Part six allows for intervention orders and guardianship. Both could be used to authorise a healthcare intervention although the Act and Codes of Practice do not provide

¹ http://reports.mwscot.org.uk/web/FILES/Consent_to_treatment/GPG_physical_illness.pdf

much guidance on why and how this power might be sought and used.

An intervention order covers a single intervention or a linked series of interventions. It could, in theory, be used for a single procedure or single course of treatment where part five cannot be used (i.e. if force is not immediately necessary). The Sheriff would need to grant the specific power to use reasonable force.

Welfare guardianship might be more suited to a foreseeable series of healthcare interventions, e.g. a chronic illness where the adult resists treatment. A welfare guardian cannot, however, place the adult in hospital for treatment of mental disorder against his/her will.

If the adult does not comply with the wishes of a welfare guardian, there is a mechanism for the Sheriff to issue a compliance order under section 70 of the act. However, the terms of section 70 appear to have been designed to allow the taking of the adult to a place of residence rather than to enable the provision of medical treatment where the adult resists. Also, the compliance order cannot be used to enforce the decisions of a welfare attorney or person holding an intervention order.

The code of practice for part 5 points to the use of an intervention order or welfare guardianship with a compliance order where the adult resists a physical healthcare intervention.

2.59 Where an adult lacks capacity and resists treatment for physical disorder, consideration should be given to an application for Welfare Guardianship.

This would allow the Sheriff to make an order that the adult complies with the decision of the guardian. Alternatively, in cases where the adult may recover capacity, it may be more appropriate to seek an intervention order to authorise the required treatment.

Also, the Act prohibits treatment if there is a part six application under way. Treatment may only be given for the preservation of life or to prevent a serious deterioration in the patient's condition.

[The Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#)

The 2003 Act has two broad mechanisms that are of relevance. These are detention in hospital and warrants for removal. The 2003 Act also has a list of principles and a list of grounds that need to be considered before compulsory treatment can be given.

Detention in hospital

If grounds are met, a person can be detained under an emergency or short-term detention certificate. One of the grounds relates to the provision of medical treatment (either giving treatment or determining what treatment is needed). This applies to treatment for mental disorder. The code of practice gives guidance that treatment for physical disorder that is a direct cause or consequence of mental disorder can be given under the 2003 Act. This guidance is based on a small amount of non-Scottish case law, which does not define "direct", "cause" or "consequence" in this context. While using the 2003 Act is an option here, it may not be necessary as some of our case examples in appendix 1 show. Physical disorders that are unrelated to the mental disorder are not covered by the 2003 Act.

Warrant for removal

This is covered by section 293 and could allow for a Sheriff or Justice of the Peace to issue a warrant for the removal of a person with a mental disorder to a place of safety. This can include a hospital and the person can be detained for up to seven days, although detention does not include other authority to treat under the 2003 Act. The warrant can authorise a mental health officer, police constable or any other specified person to enter the premises and remove the person.

The Human Rights Act 1998

The Human Rights Act is founded on the articles of the European Convention for Human Rights (ECHR). Under the Human Rights Act all legislation (including the Adults with Incapacity (Scotland) Act 2000; Adult Support and Protection (Scotland) Act 2007, Mental Health (Care and Treatment) (Scotland) Act 2003) must be interpreted in a way which is compatible with Convention Rights. Relevant articles of the ECHR include:

- Article 2 – the right to life. The right to life is an absolute right which means that there is a duty on the state/public authorities not to take away anyone’s life and a duty to take reasonable steps to protect life.
- Article 3 – the right to be free from torture and inhuman or degrading treatment. This means that treatment which is grossly humiliating or undignified and causes severe physical or psychological harm is prohibited. Whether treatment reaches this threshold depends on various factors including the age, physical or mental health of the individual and the relationships involved.
- Article 5 – the right to liberty and security of person. The protections under this means that nobody should be unnecessarily detained against their will except as set out in the range of circumstances in the legislation, with consideration of the alternatives and with the proper safeguards. “Deprivation of liberty” includes situations other than formal detention such as restrictions in a person’s home. Any person deprived of liberty must be able to challenge this in a court or tribunal.
- Article 6 – the right to a fair hearing. The protections of this right apply in circumstances where an individual’s civil rights are at stake and will apply to guardianship and capacity determinations. The person must have the right to legal representation and an independent opinion.
- Article 8 – the right to privacy and respect for family life. This right is broad in scope and covers protection of privacy, family relationships, physical and psychological well being including the right to autonomy. According to Article 8 case law, there should be a presumption in favour of capacity, support for capacity and positive measures to enable decision making while people have capacity. Interferences with this right are permissible where there is a legitimate aim and the interference is proportionate.

Decisions on intervention: a principle-based approach

In considering decisions in individual cases, we identified a process for decisions that apply to all situations. This process takes into account human rights legislation and the principles of the Adults with Incapacity (Scotland) Act 2000.

1. It must be determined whether or not the person lacks capacity

In law, there is a presumption in favour of capacity. The presence of a mental illness or learning disability does not automatically mean that a person lacks capacity to consent to treatment. Also, disagreeing with a suggested line of treatment does not necessarily mean that the person lacks capacity. It is important to assess capacity in relation to the treatment decision that the person is facing. "Presumption in favour of capacity" must be interpreted with care. It does not mean that a person is "assumed to have capacity unless there is a certificate that states otherwise". A presumption of capacity can be challenged if there is evidence to the contrary.

Clinicians should study our guidance on Consent to Treatment². It explores these issues in greater detail. It gives examples of refusals of treatment and asserts the right of the individual to make decisions that appear unwise, but not as a consequence of mental

disorder. Also, the Code of Practice for part five of the 2000 Act contains some helpful guidance on assessing capacity. In particular, the clinician must present information about the treatment in a way that the person can understand and should make sure the person has time and support to make the decision. Good communication is essential and the involvement of speech and language therapist will assist people with communication difficulty. "Easy-read" or pictorial descriptions of treatment may be useful. The clinician must also remember that capacity can fluctuate.

If the person is deemed to lack capacity, practitioners should, where possible, try to find out if there is any person with the power to consent to treatment. There may be a welfare guardian or attorney or person holding a relevant intervention order with the power to consent to medical treatment. It is good practice for general practitioners and hospital wards to record this information in case it is necessary to contact the welfare proxy. If the person has capacity, his/her right to refuse treatment must be respected, even if refusal is likely to lead to death³.

2. Practitioners must be satisfied that treatment should be given

Any intervention must be necessary and must be likely to be of benefit to the person (i.e. there should be a reasonable expectation that benefit will outweigh potential harm). Sometimes benefit is easy to establish, e.g. the person who has symptoms of a heart attack and needs treatment. In other cases, benefit is less clear.

² http://reports.mwscot.org.uk/web/FILES/MWC_ConsentToTreatment_Web.pdf

³ Re B (adult: refusal of medical treatment) (2002) 2 All England Reports 449

Case example: Mrs A was a lady with dementia admitted to a general hospital ward. She had not been formally diagnosed but dementia is fairly obvious when her family described her history. She was refusing food and had become depressed. The visiting psychiatrist thought she lacked capacity and advised use of the 2000 Act to insert a feeding tube. The patient refused and the ward team felt uncomfortable with this level of invasiveness in someone who was not capable and not giving consent. They decided not to intervene and the patient died. The psychiatrist was concerned about this decision.

In this case, the decision on intervention depended on the likelihood of benefit. If this was a person with advanced dementia, research and guidance indicate that artificial feeding is only likely to cause discomfort and distress and is unlikely to be of benefit. If there may be a treatable depression, then intervening with artificial nutrition in the short term could be of benefit and Mrs A may be able to regain a good quality of life. It would have been important for all the practitioners to discuss the likelihood of benefit from intervening and to involve Mrs A (if possible) and her family in the discussion. Ultimately, the decision is for the consultant in charge of her care.

Even though a person lacks capacity to consent to treatment, it is an important principle of the 2000 Act that his/her views must be taken into account. It is also important to be aware of past wishes. If the reason for refusal is understood, e.g. because of previous unpleasant experiences, it might be possible to negotiate alternative ways

of providing treatment. Where capacity fluctuates, the person might consider making an advance statement when capable.

Advance directives, especially refusals of treatment, do not have a formal status under the 2000 Act. In England and Wales, the Mental Capacity Act (2005) states the circumstances where an advance directive is to be obeyed. There is no equivalent section in the 2000 Act in Scotland. However, the principles of the Act include the duty to take into account the past and present wishes of the adult. This includes taking account of an advance statement. Case law⁴ has ruled that treatment given despite an advance refusal can be unlawful. For people treated under the 2003 Act, the status of advance statements relating to treatment for mental disorder is clear and there are procedures for giving treatment that is in conflict with the statement.

Also, a person who has capacity can appoint a welfare attorney with the authority to consent to treatment. The attorney may give, or refuse, consent. In our view, a welfare attorney cannot authorise the use of force. If there is no welfare attorney or guardian, practitioners should find out the views of others who know the person well wherever it is reasonable and practicable to do so.

3. Force should only be used if necessary

Refusal and resistance may be based on a lack of understanding. Healthcare professionals have a duty to give information in a way that the person can understand. Even where the person lacks capacity,

⁴ For example, *Re T, (adult: refusal of medical treatment)* (2004) EWHC 1279 (Fam)

well-presented information can overcome resistance to a necessary procedure. It is particularly important to involve others who know the person well, e.g. relatives and carers. Explanation, support and reassurance by someone the person trusts is often enough to overcome resistance. Also, where the person has a specific fear of hospitals or specific procedures, there should be attempts to “desensitise” the person’s fear by gradual exposure and measures to combat anxiety. This will not be possible in an acute situation but may be helpful for recurrent problems.

Case example: Because of a previous painful experience, a person with learning disability was afraid to have his toenails cut. Several radical solutions were suggested, including complete removal of the nails and the nail beds. We thought the first step must be to help the person overcome his fear. Daily foot care, supported by a person he trusts in a relaxing setting should be possible, starting with simple foot massage before building up to filing the nails. If that fails, mild sedation could be used.

Where mental illness results in refusal of treatment, maximising the benefit of treatment for mental illness may be an important step in the process.

Case example: A man with a severe mental illness has a “basal cell carcinoma” on his face. Without treatment, this will become malignant and spread. He believes this gives him special powers to read people’s minds. While an intervention order may be needed to treat the lesion (see below), it is important to offer the best possible treatment to improve his mental health. Otherwise, the removal of the lesion may have a bad effect on his mental health.

4. Any use of force must be lawful and proportionate

a) Lawful

Where a person lacks capacity to consent to a physical healthcare procedure, we would expect the medical practitioner primarily responsible for the person’s care (or, in some situations, another healthcare practitioner) to certify incapacity, except in emergency situations. The use of restraint or other force is an interference with the patient’s right to physical integrity, and as such should only be on the basis of law, in pursuit of a legitimate aim, and should also be the least restriction necessary to achieve that aim (i.e. it should be proportionate). We have already stated that the “section 47 certificate” cannot authorise force except where immediately necessary and only for as long as is necessary. The case examples in the appendix to this guidance give some examples of the legal authority for some procedures. Briefly, the best legal options are:

- The common-law principle of necessity in emergency situations (to convey the person to hospital and/or provide immediate treatment).

Case example: A woman with dementia collapses at home with severe chest pain. Examination strongly suggests that she is having a heart attack. Transfer to hospital for immediate treatment can be justified under the principle of necessity. Once she is there, emergency treatment can be given under the necessity principle and, when appropriate, ongoing treatment would be authorised by a section 47 certificate of incapacity.

- The use of reasonable force using a section 47 certificate under the Adults with Incapacity (Scotland) Act 2000 where treatment is not an immediate emergency but still urgent and where there is no time to obtain authorisation under part six of the 2000 Act. If the person refuses to attend hospital, there may be a need for a warrant for removal under section 293 of the 2003 Act.

Case example: A woman with learning disability who has been drinking heavily and has jaundice and rectal bleeding. This indicates liver disease that could be fatal if not treated but she does not understand the significance of this. A mental health officer can ask a Sheriff (or Justice of the Peace if more urgent) for a warrant under section 293 to remove her to hospital for seven days. Treatment in hospital can be given under a section 47 certificate of incapacity.

- An intervention order under part six of the 2000 Act for a single episode or course of non-urgent treatment. This cannot be enforced by a compliance order. If in doubt about whether an intervention order would be sufficient, it may be better to apply for welfare guardianship. The Sheriff would then have the option of appointing a guardian or authorising a person to use reasonable force under an intervention order.

Case example: In the case of the man with severe mental illness who has a basal cell carcinoma, a single, non-urgent procedure is needed. If he continues to resist, an application to the Sheriff for an intervention order may be necessary.

- Welfare guardianship under part six of the 2000 Act where the need for treatment is likely to be ongoing. This may need to be enforced by a compliance order under section 70 of that Act.

Case example: A woman with learning disability has cancer. She does not understand the condition and resists all treatment. There will be difficult decisions on options for treating the cancer with surgery, radiotherapy or drugs. A welfare guardian can consent to treatment and the Sheriff can order the woman to comply, especially if she refuses to attend. The local authority has the duty to apply for welfare guardianship where there is nobody else willing to do so.

- Administration of treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 may be appropriate only where the physical disorder is a direct cause or consequence of the mental disorder.

Case example: A man with mild dementia has a chest infection that has made him very confused. He has hallucinations, a high fever and refuses all treatment. In this case, the chest infection is the cause of an acute delirium and the 2003 Act can be used to admit him to hospital. In this case, the 2003 Act can be used to treat both the delirium and the infection that is causing it.

b) Proportionate

The clinician must decide if the use of force is proportionate to the objective of treatment. He/she must consider the likely result of deciding not to use force, and therefore denying the person the best clinical treatment. Also, it would be inappropriate

to use large amounts of force for relatively small likely benefit. This will not be an easy decision. Clinicians must consider the difference between best treatment using significant force, and less effective treatment where the need for force is much lower.

Case examples:

A woman with mild dementia has a diagnosis of early stage bowel cancer. Surgical intervention is likely to be curative. Delaying surgery could result in serious problems if the cancer spreads. She agrees to surgery at first, but forgets the information she has been given and refuses on the day of the operation. If measures to support and reassure her fail, it would be reasonable, under a section 47 certificate of incapacity, to use sedation and minimal necessary force to allow surgery to proceed.

If the same woman had early breast cancer, surgery may still offer the best option for her. However, there are other measures, including hormonal treatment, that are viable alternatives. There is less justification for the use of force, as it may not be proportionate to the objective of benefit and quality of life.

Force may be necessary to provide basic care. For example, a person with dementia who develops incontinence may resist interventions to provide basic hygiene and skin care. Bathing and showering with the use of force or restraint may cause distress, and may need to be less frequent than might be ideal. On the other hand, the person may suffer and be stigmatised because of poor hygiene. Caregivers must strike a balance and only use force where necessary and proportionate. Repeated use of force is likely to need formal legal authority.

The use of force must also be not degrading, and least likely to restrict the person's freedom. Physical or mechanical restraint must be as gentle and unobtrusive as possible while ensuring that the person and others are safe. Appropriate sedation can be helpful if anxiety is influencing the person's actions. It may be appropriate to give covert sedation in some cases but only where this is in line with our guidance. Our publications on "Rights, Risks and Limits to Freedom"⁵ and "Covert Medication"⁶ will be helpful.

Case example: We heard of a person who needed an infusion of a drug via a drip while in an accident and emergency department. The person objected but the treatment was necessary and legally authorised via a section 47 certificate. The person's hands were handcuffed to the bed rails while the drug was administered. While this degree of restraint may have been necessary, it took place in view of other patients and their families. We thought this could be ruled to be degrading treatment under article three of ECHR and/or a disproportionate interference with the individuals Article 8 rights to a private, home and family life. See the case of Mr X in appendix 1 for our views on how this should have been managed.

⁵ http://reports.mwcscot.org.uk/web/FILES/Frredom_restriction_restraint/Rights_Risks.pdf

⁶ <http://www.mwcscot.org.uk/nmsruntime/saveasdialog.asp?IID=786&SID=742>

Conclusions and further recommendations

This guidance should help practitioners give necessary physical healthcare to people who lack capacity and refuse or resist. In a complex area of law and best practice, we think this is the best guidance that we can give at present. We have brought this to the attention to officers of the Scottish Government who helped us greatly in producing this guidance and who share our concerns about the complexity of the problems clinicians face.

We think that the law and associated existing guidance needs some attention here. In the course of our discussions over this guidance, we identified some concerns. These were:

- The definition of medical treatment under the 2000 Act is “Any healthcare procedure designed to promote or safeguard the physical or mental health of the adult”. This could be taken to mean examination and investigation. This needs interpreted with common sense at present – we think that a section 47 certificate is not necessary to examine a person but there may be an argument that it could be used if the patient resists. Also, we do not think that the certificate is necessary to authorise X-rays or taking blood samples unless the patient resists. We think the definition is too broad and needs amended or clarified.
- A local authority duty to apply for a part six order under the 2000 Act if no other application is being made. We hear that some local authorities are reluctant to apply where the application relates to medical treatment in the scenarios we described. We think they have the duty to apply but guidance from the Scottish Government might be helpful.
- There are problems with the compliance order under section 70 of the 2000 Act. Its purpose was not in relation to forcible medical treatment. There may be a need to revisit parts 5 and 6 of the 2000 Act to identify a clearer route to provide physical healthcare for people who lack capacity and actively refuse or resist.
- There is a problem with section 49 of the 2000 Act. It states that, if an application for medical treatment powers under part six of the Act has been made, but not yet determined, then the adult can only be given treatment to save life or prevent serious deterioration in his/her condition. If the treatment is disputed by the adult or the proposed guardian or holder of an intervention order, this would be the correct procedure. We do not think it was the intention of the legislation to apply this requirement to all treatments. In particular, we do not consider it appropriate to withdraw treatment that is of benefit to the adult pending the outcome of the application for guardianship. We have recommended that this section should be revised.

Appendix 1: Some further case examples

We have given case examples in the main text of this guidance to illustrate specific points. We thought it might be helpful to illustrate the whole process with some complex cases, based on real situations that have come to our attention. The specific guidance in these examples is only an indication of what our consultees thought was best in the individual cases. Every situation is different and we are happy to be contacted for advice in individual cases.

Mr X

Mr X presents with repeated acts of self-harm. He generally agrees to go to hospital (or presents himself) but sometimes refuses treatment. He takes a large overdose of paracetamol and calls a friend to tell her. An ambulance is called and he reluctantly agrees to go to hospital. Blood tests show his paracetamol levels are so high that urgent treatment with the antidote Parvolex via an intravenous infusion (or “drip”) is needed, without which he risks acute liver failure and death. He tries to pull drips out and needs physical restraint to stop him doing so. He says he wants to die.

1. Does he lack capacity?

This is a difficult assessment in an urgent situation. He states that he wants to die but his actions appear to show that he is at least ambivalent. Given this information, there is enough to suggest that, at least temporarily, his capacity is impaired.

2. Should the treatment be given?

Without the infusion, he may well develop liver failure and die. In the acute situation, the presumption must be in favour of saving his life. His present and past wishes are important. As already mentioned, his behaviour is not totally consistent with his expressed wish to die. An examination of the outcome or similar recent attendances might help.

He harms himself on a regular basis and it may help to discuss treatment options in advance with him. He may wish to make an advance statement when he is capable of doing so. This would guide practitioners when they are considering intervening in future episodes of self-harm. Advance statements may not be easy to find in urgent situations. Any decision to act against an advance refusal of treatment must be made with great caution. The reasons must be documented clearly.

3. Is force necessary?

Alternatives to force were hard to find. Someone he trusts could be with him for support and expert mental health nursing could reduce the risk of further self-injury by pulling the drip out. If he is determined, there may be no alternative to force. Sedation may be used if clinically appropriate, although if this results in him becoming “compliant” but not capable of consenting to treatment, then it should be continued under the terms of section 47 of the 2000 Act.

4. Force must be lawful and proportionate

Emergency treatment can be justified under the common law principle of necessity and formal legal measures are usually unnecessary. It is different if treatment is ongoing, e.g. an infusion continuing for several hours or sometimes days. He is considered to lack capacity so treatment can be given using a section 47 certificate under the 2000 Act. In this case, it can be argued that force or detention is immediately necessary and therefore lawful under the Act. However, the meaning of “immediately necessary and only for as long as is necessary” has not been tested in court. If Mr X repeated wishes or attempts to leave, and if the grounds are met, detention under the 2003 Act should be considered. According to the code of practice for the 2003 Act, Mr X could be given treatment for the physical damage caused by self harm under the terms of the 2003 Act.

Proportionate use of force could involve hands-on restraint or mechanical restraint using, for example, arm splints and bandages. Handcuffs would be a last resort but might be necessary in extreme situations. It must be done in a way that is least restrictive and distressing and must not be degrading. A private area out of sight of other patients and passers-by is highly desirable.

Mr Y

Mr Y has bipolar disorder and is detained in hospital under the mental health act. He is also diabetic. When manic, he does not stick to his diet and refuses to take insulin. It would need to be administered by force. In the short term, he risks immediate illness if his diabetes goes out of control. Also, his psychiatrist considers that poor diabetic control worsens his mental state. In the long term, there are permanent consequences of poor diabetic control.

1. Does he lack capacity?

Assessment of capacity is decision-specific and it should not be assumed that he lacks capacity because of his mental illness. Many people with diabetes do not stick to advice. If it is clear that he loses judgement because of a manic episode, then it is likely that he has lost capacity, at least temporarily.

2. Should the treatment be given?

His health would be at risk in a very short period of time if he does not receive his insulin. It is important to understand why he refuses. If it is due to mania, optimal treatment of his mental illness is important (principle of maximum benefit in the 2003 Act).

When he is mentally well, it would be important to discuss how his diabetes is treated if he becomes manic and refuses treatment. An advance statement would be a useful guide, as would the appointment of a welfare attorney. He cannot consent in advance, though. His advance statement is a useful guide on a principle basis but it cannot be taken as “advance consent” if he is now resisting.

3. Is force necessary?

Giving injections of insulin by force will be distressing for him and carries risks to him and others. Again, expert mental health nursing and the support of people he trusts may help to avoid or minimise the need for force.

4. Force must be lawful and proportionate

Immediate treatment using the necessity principle would only be acceptable in an emergency situation, e.g. if he goes into a diabetic coma. Otherwise, in the short-term, it should be authorised by a section 47 certificate under the 2000 Act. While poor diabetic control may worsen his mental state, it is not a direct cause or consequence of his mental illness and it is not appropriate to use the mental health act. If forcible treatment is likely to be needed for a longer period, there is a case for applying to the Sheriff for welfare guardianship. Anyone can do this but the local authority has the duty to do so if no other application is being made.

Force must always be the minimum necessary. There may be a need to compromise between ideal diabetic control and “good enough” control. Reducing the frequency of injections by using long-acting insulin may help. It is important that this is done safely, with expert advice and with access to expert medical assistance if control is poor.

Ms Z

Ms Z has learning disability. She was scheduled for breast screening but refused to attend. She was thought incapable but the amount of force needed to get her to attend was thought to be excessive, not proportionate and not worth the distress it would cause. She always refuses examination.

She developed a breast carcinoma. She did not come forward when a lump developed. It was diagnosed during an examination of her chest when she has a chest infection. She had refused an operation to remove it and the clinical decision was not to proceed as the lesion was quite advanced.

The lesion is now open, bleeding and obviously causing her pain. She refuses active treatment of her bleeding sore. She is in significant discomfort but she did not appear to understand that the lesion is the cause. She adamantly refuses to go to hospital and force may be needed if she is to be treated.

1. Does she lack capacity?

Having a learning disability does not necessarily make Ms Z incapable. In this case, it is especially important to make sure that she has enough information about breast cancer, the need for screening and the need for treatment. Presenting this information in a way that she can understand is a skilled task and may need help from learning disability specialists, especially psychologists and speech and language therapists. She may be afraid or simply not able to understand complex information.

2. Should the treatment be given?

Breast screening is important and there is a risk of indirect discrimination if she is not given information and support to help her come forward for screening. Ultimately, if she does not agree to it, then it would not be appropriate to proceed. There may be a problem if screening reveals potential disease and if she is likely to lack capacity to consent to treatment for it. There should be plans in place for this possibility.

Treatment for the disease is necessary to save life and/or relieve discomfort and distress. The actual treatment should be based on the principles of the 2000 Act. If she will not accept surgery, then considering alternatives is important, e.g. hormonal treatment or radiotherapy. Primary care and community staff are unlikely to know the details of the treatment that could benefit the person, so full assessment of capacity may not be possible until the person has met the specialist. They should discuss with the specialist about what the options are, and explore the possibility of specialist assessment in a familiar setting.

Palliative care and pain management is an important right. Ms Z must not be denied this if she lacks capacity, especially if it is important to treat serious suffering.

3. Is force necessary?

There may need to be a balance between “ideal” forcible treatment and treatment that is less than ideal but more acceptable. Force should be avoided where possible and specialists should be willing to visit her at home initially rather than forcing her to come to hospital if she is afraid. This might ease the way to further treatment. The support of family and support staff she knows and trusts will help.

4. Force must be lawful and proportionate

Immediate treatment under the necessity principle is not appropriate here. There is a disease process and interventions should be planned and considered as part of an overall approach.

Once the disease is present and it is clear that she will not agree to treatment, even with best support and explanation, then there is a good case for welfare guardianship to make sure she gets the best treatment possible and her rights are upheld.

If she refuses to attend hospital and there is no alternative, the welfare guardian could ask the sheriff for a compliance order under section 70 of the 2000 Act. If there is no welfare guardian, a warrant for removal under the 2003 Act may be needed.

Minimum necessary use of force may involve sedation and pain relief. If she refuses, it may be appropriate and least forceful to administer medication covertly, in line with our good practice guidance.

Appendix 2: Quick guide to making decisions on the use of force

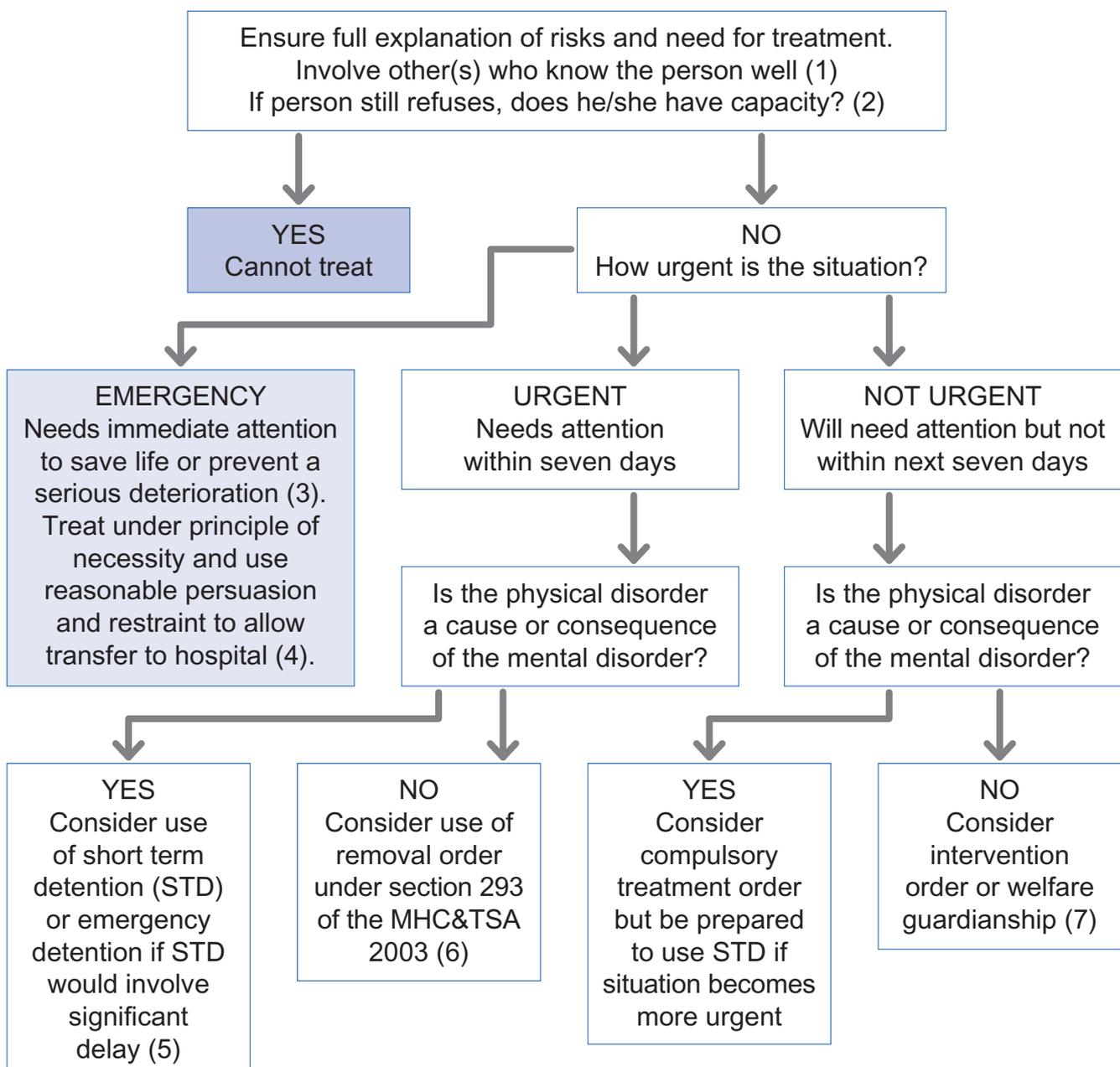
Step in process	Issues to consider
Does the person lack capacity?	<ul style="list-style-type: none"> • Assess in accordance with the definition of incapacity in the Adults with Incapacity (Scotland) Act 2000. • There is a presumption in favour of capacity, but this can be challenged if there is evidence to the contrary. • Use communication aids and help from speech and language therapy to help people understand information. • Capacity can fluctuate. Wherever possible, choose a time and place that is most comfortable and give the person enough time and support to make decisions. • People with capacity cannot be forced to have treatment if they refuse, even if serious deterioration or death will result.
Is the treatment necessary?	<ul style="list-style-type: none"> • Be clear that the likelihood of benefit for the person outweighs the likelihood of harm, especially if force is likely to be needed. • Apply the principles of the 2000 Act. Take the person's past and present wishes into account and consult relevant other where appropriate. • Take special notice of any advance directive and the views of any person with the legal authority to consent or refuse consent on the person's behalf.
Is force necessary?	<ul style="list-style-type: none"> • Give as much explanation as possible and enlist the support of those who know the person best. • Work to "desensitise" fear of hospital and medical procedures. • If mental illness is causing incapacity and refusal of treatment, maximise the benefit of treatment for mental illness, if possible. • Consider sedation, including covert sedation (in line with MWC guidance) to reduce or eliminate the need for force.
Is the force required proportionate to the purpose of the intervention?	<ul style="list-style-type: none"> • Force is only appropriate if the likely benefit justifies it. • Do not use force if the benefit is outweighed by the distress that the use of force involves, but beware of denying the person important treatment. • Consider alternative treatments that require less force or no force.
Is the use of force lawful?	Use appendix 3 to decide on the most appropriate legal intervention and document clearly the legal basis for using force.

Appendix 3: Legal use of force

Urgency and nature of treatment	Best legal option
Is treatment immediately necessary to save life or prevent serious deterioration?	Give immediate treatment under common law principle of necessity and reassess.
Is treatment necessary in the short to medium term and cannot wait for Court authorisation?	Certify incapacity under section 47 of the 2000 Act. Force can be used, but only “where immediately necessary and only for as long as is necessary”. Make clear records of necessity. If likely to be needed on an ongoing basis, consider application for a welfare intervention order or welfare guardianship.
If the treatment can wait for Court authorisation, is it a single episode or linked series of episodes of treatment?	Consider an application for a welfare intervention order. The Sheriff would need to specifically authorise the use of force in the order. Alternatively, apply for welfare guardianship, in which case the Sheriff might, as an alternative, authorise an intervention order.
If the treatment can wait for Court authorisation, is it an ongoing treatment or a combination of unrelated treatments?	Consider an application for welfare guardianship. If a welfare guardian has been appointed, or already exists, a compliance order under section 70 of the 2000 Act may be needed to authorise force. If the person has appointed a welfare attorney, force cannot be used unless specified in the document. Even then, we recommend applying to the Sheriff for a direction as to the use of the power (section 3 of the 2000 Act).
Is the treatment for a physical disorder that is a direct cause or consequence of a mental disorder?	If the person is subject to treatment under mental health legislation, it can be argued that the Mental Health (Care and Treatment) (Scotland) Act 2003 gives authority for treatment. Unless the 2003 Act is needed for other reasons, it is not necessary to use it to provide treatment in these circumstances and the other legal option outlined above can be used.

Appendix 4: Removal to hospital (see also notes on next page): reproduced from MWC guidance on hospital treatment for physical illness in the absence of consent

Flow chart: Person with apparent mental disorder appears to need treatment for physical disorder but refuses to attend hospital



Appendix 4 continued

Notes

1. This is explored in the Mental Welfare Commission's good practice guidance on consent to treatment http://reports.mwcscot.org.uk/web/FILES/MWC_ConsentToTreatment_Web.pdf
2. A medical practitioner should assess capacity. Definition of incapacity (Adults with Incapacity (Scotland) Act 2000): Incapacity means being incapable of acting, or making decisions, or communicating decisions, or retaining the memory of decisions by reason of mental disorder or inability to communicate due to physical disorder.
3. For example:
 - Person has taken an overdose, is becoming drowsy and is in serious danger if not treated immediately.
 - Person has acute chest pain possibly a myocardial infarction and needs immediate hospital attention.
4. Practitioner should discuss this with ambulance staff to ensure that everyone understands and agrees the necessity for immediate treatment. Once in hospital, a person who lacks capacity can be treated under part 5 of the Adults with Incapacity (Scotland) Act 2000. The medical practitioner completes a certificate of incapacity under section 47. This certificate does not authorise force or detention unless it is immediately necessary and only for as long as is necessary.
5. An approved medical practitioner and a mental health officer should be contacted. Emergency detention should only be considered if both cannot attend within a safe timescale.
6. Mental Health Officer applies to the Sheriff for a warrant. If urgent, he/she can apply to a Justice of the Peace <http://www.opsi.gov.uk/legislation/scotland/acts2003/30013-aj.htm#293>
7. Presently, the Adults with Incapacity Act and associated codes of practice are unclear on the correct procedure to follow for non-urgent physical health interventions that the adult with incapacity actively resists. The best advice is to apply for welfare guardianship – the Sheriff may take the view that, on the basis of this application, an intervention order will surface.



Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwscot.org.uk
www.mwscot.org.uk

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