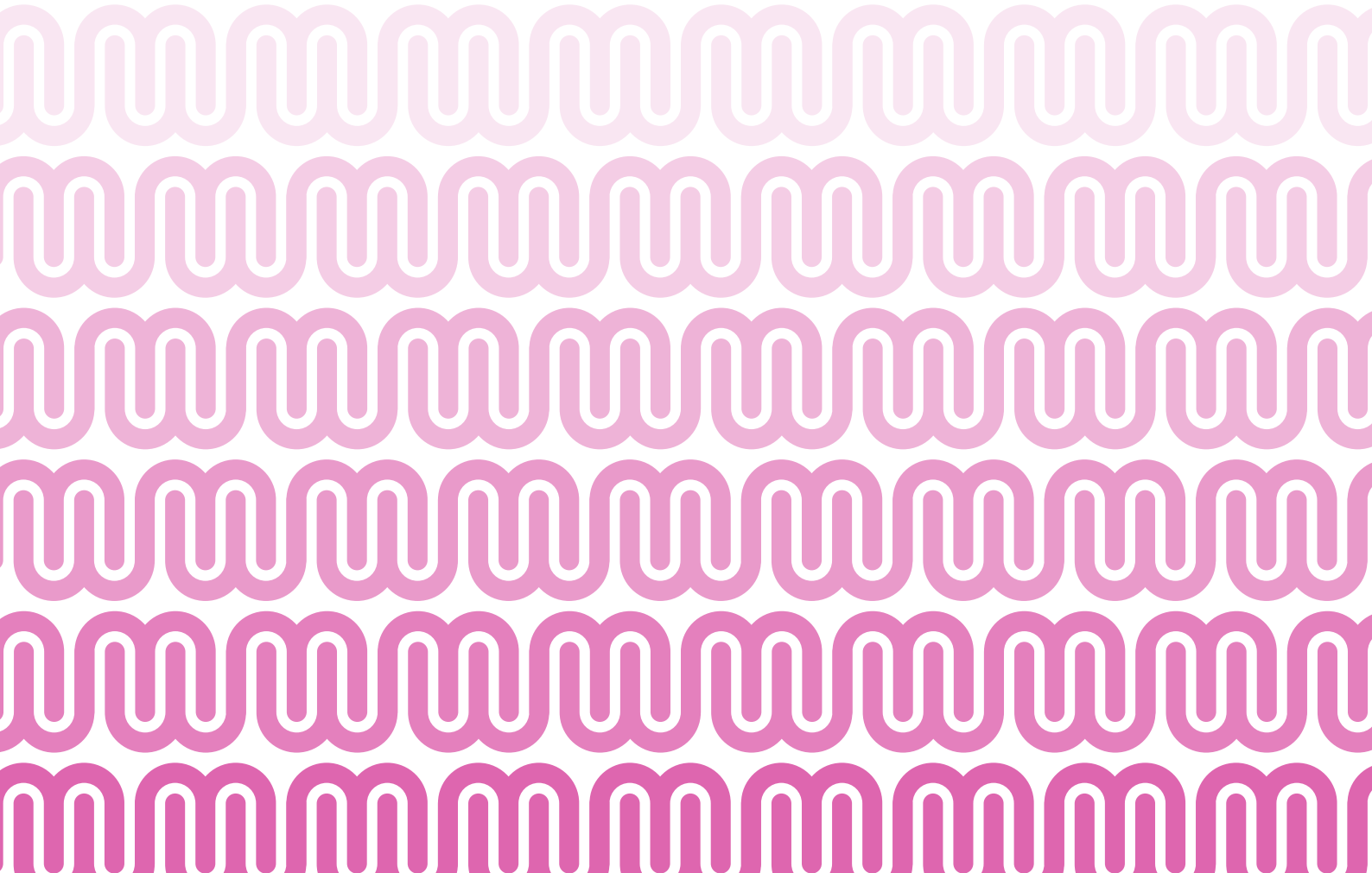
mental welfare commission for scotland

# Right to treat? Delivering physical healthcare to people who lack capacity and refuse or resist treatment

## Good practice guide

March 2024



# Our mission and purpose

## Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

## Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

## Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

## Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

# Contents

## Purpose of this guidance

The Mental Welfare Commission, pursuant to its duties under mental health legislation in Scotland, provides advice on how to apply legal and ethical principles in the care and treatment of people with mental illness, learning disability and related conditions. We keep track of the questions we are asked to identify common themes and we develop guidance to assist professionals and protect the welfare of people who may have reduced capacity to make decisions or require additional support due to the above conditions.

We are often asked about steps to ensure people receive the care they need for physical health problems when they lack capacity to consent to treatment whilst protecting their rights. This is because as a general rule, medical treatment, including physical examination should not proceed unless the doctor has obtained the patient's consent. When someone lacks the capacity to provide consent, it is vital to ensure that there is a clear basis on which treatment takes place both for the healthcare professional providing the treatment and to safeguard the rights of the person. This guidance provides information to determine the basis on which to proceed or not.

**The S47 certificate of general authority to treat and exceptions**

In many cases, where a person does not object or resist to the treatment that would be of benefit to them and is the least restrictive method and is in keeping with their wishes and feelings (so far as these can be ascertained), the treatment can often proceed on the basis of a certificate of incapacity for that treatment under section 47 of the Adults with Incapacity Act 2000. In most circumstances section 47 provides what is called the 'general authority to treat'. However, If the person lacks capacity and resists or refuses treatment; or if the person has a proxy who disagrees with the treatment; or if the treatment is required urgently and there is no time to complete a section 47 certificate; it can be more difficult to determine how to proceed.

The following case is an 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 advise that they should do all they can 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 can be given in hospital under part five of the Adults with Incapacity (Scotland) Act 2000.*

We hear of so many situations similar to this that we produced this guidance note. It does not cover every possible scenario, as each situation is different. We are always happy to discuss individual cases and offer advice through our telephone advice line.

The general principles and case examples in this guidance give practitioners some assistance in a difficult area of law, medical ethics and clinical practice. 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 recommend that practitioners read the guidance fully. Appendix 4 sets out the appropriate authorities to move someone into hospital. Appendix 5 sets out a guide to how to proceed if there is a dispute about a treatment that the clinician feels is required for a person who lacks capacity and the person's welfare proxy.

We have set out our interpretation of legislation and best practice. In particularly difficult situations, 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. Clear recording of the reasons for decisions will be essential in case of future challenge and this may include the consultation with the wider professional team, the person about whom a decision is being made, those important to them, any person holding proxy powers in that regard, any professional bodies consulted (including the Commission).

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

Prior to producing the first edition of this guidance in 2011, 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 some of the case examples presented in this document. In each case, we asked them whether practitioners should intervene, how, and how might they get the person to a hospital (if needed).

This guidance was reviewed in 2022. The key legislation remains the same but we have updated the guidance to reflect recent developments within the field. The Covid-19 pandemic provided a focus on some aspects of the treatment of people who lacked capacity and this has been incorporated although we set out guidance specifically in relation to vaccination for people with reduced capacity in 2021 through our Covid Advice notes[1] and again in 2022[2]. At the time of writing the Scottish Mental Health Law Review is working towards making recommendations on review of the Mental Health (Care and Treatment) (Scotland) Act 2003, and may also consider changes required to the 2000 Act and the Adult Support and Protection Act 2007 to ensure that these pieces of legislation work better together.

[1] Covid Advice Note, Mental Welfare Commission, March 2021 Covid-19 Mental Welfare Commission Advice Note, version 24 (19 March 2021) | Mental Welfare Commission for Scotland (Commissionscot.org.uk)
[2] Vaccination for people with mental illness, learning disabilities, dementia and associated conditions - position statement, Mental Welfare Commission, February 2022

## What this guidance is based on

We consider the use of the following principles, legislation and conventions:

- Common law and the principle of necessity ;
- The Adults with Incapacity (Scotland) Act 2000[3] and associated codes of practice;
- The Mental Health (Care and Treatment) (Scotland) Act 2003[4] and associated codes of practice;
- Adult Support and Protection (Scotland) Act 2007;
- The Human Rights Act 1998[5] that provides rights and freedoms guaranteed under the European Convention on Human Rights (ECHR);
- The United Nations Convention on the Rights of Persons with Disability (The UNCRPD) that was ratified by the UK Government in 2009. Although the principles are not currently incorporated in domestic Scots law it does have influence. Article 12 of the UNCRPD requires that appropriate measures are taken to ensure that people with a disability (this includes people with a learning disability) are provided the support they need to exercise their legal capacity[6].

After reviewing keys aspects of the legislation above, we provide a guide to making decisions about whether an intervention should take place and what legislative mechanism might be appropriate.

**Common law "principle of necessity" and acting in an emergency**

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. The treating physician may argue that the consent was implied, i.e. if the person were conscious the person would want their life saved.

This is equally true of someone who is incapable of consenting through mental illness, if the nature of their physical injury is such that any delay in treatment would lead to a significant risk to their health.

The Common Law principle of acting in necessity is NOT replaced by the 2000 Act. They both have their place. However, wherever it is reasonable and practicable for the procedure or intervention to take place under a statutory process (most commonly, the AWI 2000) that provision should be used.

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[3] The Adults with Incapacity (Scotland) Act 2000
https://www.legislation.gov.uk/asp/2000/4/contents

[4] The Mental Health (Care and Treatment) (Scotland) Act 2003
https://www.legislation.gov.uk/asp/2003/13/contents

[5] The Human Right Act 1998
https://www.legislation.gov.uk/ukpga/1998/42/contents

[6] Legal capacity is the formal ability to hold and exercise rights and have duties- it does not depend on mental capacity which is the capability to make a particular decision of relevance to the person: as a simple example: someone may not have the mental capacity to make a decision but had previously made their view clear through an advance directive or statement and this would be upheld (they retain their legal capacity to exercise their rights)

The decision about whether there is time to complete a section 47 and follow the processes involved is one for the practitioner. Clearly in some situations it would be impractical and risky to a person to delay urgent life-saving treatment, however where there is time, or as soon as there is an opportunity to follow statute for any further intervention- practitioners should use statutory safeguards. A decision that there is not time to use a statutory process to authorise treatment must be justifiable and common law should only be invoked when there is no procedure prescribed by law that can be used.

What is important in invoking the principle of necessity under common law as the basis on which to proceed is that the clinician should only do what is necessary and not undertake any other procedures because it is convenient to do so at that time. If a procedure is not urgent and informed consent might be obtained later- it would be prudent to wait.

> *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.*

# Adults with Incapacity (Scotland) Act 2000

There are several relevant provisions within the 2000 Act that have a bearing on treatment of physical disorder for people with a mental health condition that has led to a reduced capacity. Part one of the Act defines incapacity[7] 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. More detail on these two parts are provided next.

Part six allows for intervention orders and guardianship orders to be granted by the sheriff. An intervention order may include powers in relation to medical treatment. A welfare guardianship order may include the powers to consent or withhold consent to medical treatment.

## 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 their 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. (See Appendix 4 for details on this)

Although the definition of treatment could be taken to mean examination and investigation - we think that a section 47 certificate is not ordinarily necessary to examine a person but there may be an argument in some situations that it should be used particularly if the patient resists, and the relevant examination is immediately necessary.

Similarly, we do not think that the certificate is necessary to authorise X-rays or taking blood samples unless the patient resists and these are immediately necessary.

[7] A person is incapable if they are unable act on, make, communicate, understand and retain the memory of the relevant decision due to mental disorder (as defined in the 2003 Act) or due to inability to communicate because of physical disability or neurological impairment. A person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid.

The certificate is generally issued for up to a year. However, in some conditions in can be issued for up to three years. Our 2021 guidance on section 47 certificates with the links to the relevant recommended Scottish Government forms (local forms that use the same frame of words may be available to the practitioner) is available from the link in the footnote below[8] .

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 that is impracticable. The 2000 Act says that a s47 certificate does not confer authority to treat if there is a welfare proxy, the person issuing the certificate is aware of that, and they do not obtain the proxy's consent (the exception is where it would not be reasonable or practicable for them to consult the welfare proxy)[9].

> *Case example - A man with dementia has a chest infection. His GP proposes to treat him with antibiotics. He is incapable of consenting to this treatment. There is no section 47 certificate in place to authorise it. His daughter is his welfare guardian and has the power to consent or withhold consent to medical treatment. The GP plans to consult her. However, she is on a long-haul flight and cannot be contacted. The GP completes a section 47 certificate and commences antibiotic treatment without the welfare guardian's consent, as obtaining her consent is not practicable. The GP should consult the welfare guardian and seek her consent when she is contactable again and doing so would be reasonable and practicable. If they do not do so, the authority of the section 47 certificate will not continue to apply.*

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 any such disagreement. The dispute resolution procedures are in section 50 of the 2000 Act (please see Appendix 5 for steps to be taken with regards to this process). This involves the practitioner who wishes to treat the person contacting the Mental Welfare Commission. We then appoint an independent practitioner 'a nominated practitioner' who will meet parties and determine whether the particular treatment or intervention should take place or not. There is a further appeal process to the Court of Session if there remains disagreement. However, treatment to save life or prevent serious deterioration can be given unless there an injunction against it.

The *non-provision* of treatment cannot be made a subject of disagreement with an appeal to the Commission for the appointment of a nominated practitioner i.e., the proxy cannot *require* that the practitioner provide a particular treatment. If a disagreement arises in these circumstances, this is not grounds to trigger the section 50 dispute resolution process. In that circumstance, we have suggested that proxies ask for a clinical second opinion at the Health Board. They would also have a right to make a complaint via the NHS complaints procedure, if that is appropriate.

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[8] TreatmentUnderSection47oftheAdultsWithIncapacityAct_April2021.pdf (Commissionscot.org.uk)
[9] s50(2) of the 2000 Act https://www.legislation.gov.uk/asp/2000/4/section/50

There are certain safeguarded treatments that cannot be undertaken on the basis of the general authority to treat. These treatments are set by regulations[10] under section 48 of the 2000 Act and currently include: sterilisation where there is no abnormality of the reproductive system, surgical implantation of hormones to reduce sex drive (these require authorisation by the Court of Session), and drug treatment to reduce sex drive, abortion, electroconvulsive therapy (ECT) for mental disorder[11] and any procedure that the medical practitioner responsible for the treatment considers that will likely lead to sterilisation (these require authorisation by a second opinion appointed doctor by the Mental Welfare Commission). The most common treatment from the above is ECT and we provide more detail on ECT for people with incapacity next.

Perhaps somewhat confusingly, where ECT is used as a treatment for physical disorder[12], this can be given under section 47[13].

However, for the majority of ECT indications, i.e., mental illness- it cannot be given as mental health treatment under the authority of a section 47 alone and requires an additional section 48 authorisation certificate (for those lacking capacity and not subject to the 2003 Act)

In the situation where ECT is required for a patient not treated under the 2003 act and who does not resist, the responsible doctor should complete a section 47 certificate for ECT. However there is no authority to give ECT until and unless a second opinion doctor organised to visit by the Commission issues a section 48 certificate to authorise ECT (except in an emergency). The Commission should be contacted urgently to arrange this visit. The second opinion doctor will determine whether or not to authorise ECT.

ECT can be given as emergency treatment prior to the second opinion doctor visiting if this is needed for the preservation of the life of the adult or the prevention of serious deterioration in the adult's medical condition. The Regulations are clear about this and require that the treating doctor **must** notify the Commission within seven days if emergency treatment is given. In practice, on the rare occasions when this happens we are notified and expect to be notified on the day this happens to ensure that the second opinion doctor we arrange is fully aware of the acuity of the situation. Section 48 safeguards are covered in a supplement to the code of practice.[14]

## 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 much guidance of 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

[10] https://www.legislation.gov.uk/ssi/2002/275/contents/made
(and amendment regulations: https://www.legislation.gov.uk/ssi/2002/275/contents/made)
[11] The term used here 'mental disorder' is from the Regulations.
[12] Rare, but ECT is sometimes used for some neurological conditions e.g., Parkinson's disease.
[13] It is beyond the scope of this guidance to consider the border (increasingly blurred) between physical and mental disorder. Suffice to say that the advances in neurobiology can make this difficult to determine in some cases. We are happy to provide independent advice in such situations.
[14] https://www.scot.nhs.uk/sehd/mels/HDL2002_50.pdf

be used (i.e. if force is not immediately necessary but is likely to be foreseeably necessary, perhaps repeatedly for a particular treatment course or for a period of time in a predictable manner). The Sheriff would need to grant the specific power to use reasonable and proportionate force, including restraint.

A welfare guardianship might be more suited to a foreseeable series of healthcare interventions, e.g. a chronic illness where the adult resists treatment for physical disorder. A welfare guardian cannot, however, place the adult in hospital for treatment of mental disorder against their will (that would require detention under the 2003 Act).

Where the person with incapacity to consent resists the physical healthcare intervention, the code of practice for part 5 of the Act (paragraph 2.59) directs towards a welfare guardianship with an order made by the sheriff that the adult must comply with the decision of the guardian, or the use of an intervention order. Where the adult is likely to recover capacity to make the decision it may be more appropriate to apply for an intervention order rather than a welfare guardianship. [15]

If an application is being made for a welfare guardianship with powers to authorise medical treatment, and force would be needed to deliver the treatment, specific powers to authorise reasonable force to provide that treatment could be applied for. Clearly, this would require comprehensive assessment and demonstration of need, with full account taken of the principles of the 2000 Act.

If an adult subject to a welfare guardianship does not comply with the wishes of the guardian, there is a mechanism for the Sheriff to issue an order under section 70 of the Act that the adult must comply with the decision of the guardian. However, we note that 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, section 70 cannot be used to enforce the decisions of a welfare attorney or a person holding an intervention order.

> *Case example – a person with learning disability has cancer. They do not understand the condition and resist 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 person to comply, especially if they refuse to attend. The local authority has the duty to apply for welfare guardianship where there is nobody else willing to do so.*

The Act prohibits the practitioner from providing a treatment under the general authority to treat (a section 47 certificate) if they are aware that there is a part six application (i.e., an application for an intervention order or welfare guardianship) underway that would provide the proxy the power to refuse or consent to the treatment in question.

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[15] Code of practice for practitioners authorised to carry out medical treatment or research under part 5 of the Adults with Incapacity (Scotland) Act 2000 https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/

In that situation, the treatment in question, may only be given for the preservation of life or to prevent a serious deterioration in the patient's condition (s49) until the application is determined, unless there is already a court-order prohibiting that treatment (in that case, it cannot be given).

We note that this was an area of discussion in the *G v West Lothian*[16] case in which the Sheriff Principal considered that in this situation (a person requiring treatment whilst application for welfare guardianship was underway) an interim welfare guardianship (with the powers to consent) was the mechanism to ensure treatment was provided rather than intervention orders, or invoking the Mental Health Act.

We think that there needs to be further clarity in the interpretation of the law as we consider that for treatments that do not amount to the preservation of life or prevention of serious deterioration in the person's medical condition, but are necessary for their wellbeing, having to seek an interim guardianship pending a full guardianship (with wide welfare powers) might be disproportionate and cause undue delay for treatments especially where there are no disagreements between the clinical team and the applicants[17]. However our view here is not a definitive legal one and we would suggest any clinician in this situation to discuss with the Central Legal Office and with ourselves.

[16] http://www.39essex.com/wp-content/uploads/2015/04/MC-Newsletter-April-2015-Scotland.pdf

[17] The Commission believes that the purpose of section 49 is to ensure that a particular treatment is not given to a person when there is an application underway providing the proxy the ability to refuse or consent to this treatment. We do not believe that the intention is to prevent *any* treatment under section 47, just the relevant treatment.

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

The 2003 Act has two broad mechanisms that are of relevance here. These are treatment following detention in hospital and warrants for removal. The 2003 Act also has principles that must be considered and criteria that must be met before compulsory treatment can be given.

## Treatment for a physical disorder following detention under the Mental Health Act

If criteria are met, a person can be detained under the relevant order of the mental health act or the 1995 Act e.g., an Emergency Detention Certificate, Short term detention certificate, Compulsory treatment order, assessment order, treatment order or compulsion order. Although treatment cannot be provided under an EDC unless an emergency (under section 243, notified to the Commission on a T4 form) treatment can be provided on the other orders subject to safeguards provided by the Act.

The question that arises here is what constitutes treatment for mental disorder[18] e.g., would it be lawful to enforce the treatment of a physical side effect of a psychiatric medication under the mental health act? What about treating the infection that arises from a cut due to self-harming (that arises in the context of personality disorder? Or treating an overdose in a similar context?

All of the above questions, and many like these, have been put to the Commission. Designated Medical Practitioners appointed by the Commission to authorise treatment in certain situations are often asked variations on some of these questions too.

We take the view that where treatment is provided *for mental disorder or in consequence of the patient having a mental disorder,* this treatment falls within the meaning of treatment that can be provided under the 2003 Act.

Obviously where someone has capacity to consent to treatment for a physical disorder (whether or not a consequence of the mental disorder) that route should be followed.

Where a person cannot consent due to lack of capacity to make that decision, it does appear that for medical treatment of a physical disorder that is a manifestation of the mental disorder or a consequence of mental disorder- there are two routes available: treatment under AWI 2000 or treatment under the MHA 2003.

We take the view that wherever there is resistance or objection to treatment for a mental disorder or for a physical disorder that is a consequence of the mental disorder this treatment (please see footnote for definition of treatment) should be under the MHA 2003[19]. Where there

[18] the term used here 'mental disorder' is from the Act

[19] Medical treatment under the MHA 2003 (s329) is defined as *'medical treatment means treatment for mental disorder; and for this purpose 'treatment' includes nursing, care psychological intervention, habilitation (including education, and training in work, social and independent living skills), and rehabilitation'.* The code of practice illuminates this further (1.21) and states *medical treatment includes pharmacological and physical interventions*

is no objection/resistance than that treatment might proceed under the AWI 2000 subject to the safeguards present within this Act.

This is because under subsection 47(4) of the 2000 Act, "medical treatment" includes any procedure or treatment designed to safeguard or promote physical or mental health. The code of practice clearly states in section 2.47 that it is not always necessary to detain an informal patient who is incapable of consenting for treatment of a mental disorder (and that would include the treatment of physical disorder resulting from the mental disorder). If the person resists or objects it would be appropriate to consider the mental health act. The Code of practice states that in difficult cases, consult the Mental Welfare Commission.

These issues about determining the appropriate treatment authority are not unique to Scotland. In the recent Independent Review of the Mental Health Act in England and Wales, under the chapter Deprivation of Liberty: MCA or MHA (the Mental Capacity Act 2005 (MCA) is the corresponding legislation to our AWI), the report describes how for the incapacitous, non-objecting patient treatment is facing a 'lottery' of which legislation follows and whilst it is attractive to use the MHA because it has greater safeguards (similar to the legislation in Scotland) to use the MHA might be an overreach of compulsory powers. The report recommends that in the future only the MCA should be used when a person lacks capacity but does not object to treatment for mental disorder. They also suggest further safeguards so that there are greater protections under the MCA.

In England and Wales, there have been a series of judgements on the use of section 63 of the MHA that provides that treatment can be given for physical issues under the MHA for the sequelae of a mental disorder[20,21].

*(such as ECT) in addition to psychological and and social interventions (including occupational therapy) made with respect to mental disorder.*

The reader might note the differing definitions of treatment in the 2003 Act and 2000 Act. Whilst the *2003 Act allows for the treatment of sequelae of mental disorder* (clearly stated within the code of practice paragraph 1.22) the definition of treatment under the Act is *treatment for mental disorder* and within this seemingly innocuous gap lies the nub of many calls to the Commission to determine what is and what isn't permissible and helps to explain the reason why it can be difficult to determine the correct authority that best protects the rights of the patient whilst ensuring that the right treatment is provided and further, why in some cases we may suggest that a Part 6 order is necessary (particularly when the 'treatment' is not urgent). These observations will be made available to the Scottish Mental Health Law Review as further evidence for the need for definitions under AWI, MHA and ASP legislation to work seamlessly together.

[20] Curtice, M & James, L. (2016) Faith, Ethics and Section 63 of the Mental Health Act BJPsych Bulletin 40(2) 77-81

[21] GT, Re [2020] EWCOP 28I: Court of Protection best interests and the use of s63 Mental Health Act 1983 accessed on 11 January 2022 at https://www.capsticks.com/insights/gt-re-2020-ewcop-28i-court-of-protection-best-interests-and-the-use-of-s63-mental-health-act-1983

We find the following questions helpful in determining whether treatment for a physical issue that is a manifestation of a mental disorder fits within the remit of treatment for mental disorder within the 2003 Act.[22]

- (If the patient is not detained): do they meet the criteria for detention? We suggest that very considerable caution should be exercised before detaining a patient for purposes of treating a physical manifestation of a mental disorder under the MHA but if there is clear evidence of objecting/resisting treatment, there are more safeguards available to the patient.
- Does the proposed treatment clearly fall within the definition of medical treatment under the Act (section 329): is the treatment for mental disorder or in consequence of the patient having a mental disorder? Is the physical disorder directly causing the mental disorder (this would be authorised- see below*).
- Is there a clear connection between the mental disorder and the treatment you are giving? What is that connection?
- Will the treatment of the physical issue amount to treatment of the mental disorder? If so, how?
- Have you checked if the patient has made an advance planning document? If so, what does it cover?

* The Code of Practice provides examples of treating chest infection causing delirium under the Act, starvation induced depression, hypothyroidism induced depression as treatments that could be authorised under the Act. It states that self-harm (including overdose) as a result of mental disorder may also be treated under the Act. On the code of practice's clear direction that the Act can be used to enforce treatment in overdose as a result of mental disorder, it is worthwhile to consider this in the context of the tragic 2009 case of Kerri Woolterton. She was a young woman with who self-harmed through the ingestion of antifreeze and was assessed as retaining capacity to refuse treatment (dialysis) for the physical consequences- she subsequently died. She also had an advance directive to refuse treatment. David et al (2010)[23] have reflected- with no criticism intended towards the doctors involved in the case- on the confusion that can arise from two sets of legislation- one predicated on capacity and the other on mental disorder and the gap between these[24].

A key distinction that we make above and restate here is to consider if there is resistance/objection- where this is present in the treatment of mental disorder or sequelae, the MHA might be preferentially used. Where this is absent for the person lacking capacity, the AWI might be preferred. As noted above, this is a complex area and we are happy to provide guidance and advice.

[22] We have reworked and adapted these questions in the Scottish context from Keene AR & Burnell H. Section 63 Mental Health Act 1983 and the overdosing patient. Clinical Risk. 2014;20(5):111-113.
[23] David AS, Hotopf M, Moran P et al. Mentally disordered or lacking capacity? Lessons for managing serious deliberate self-harm. BMJ, 2010; 341:c4489.
[24] To some extent Scottish mental health law that requires the presence of significantly impaired decision making (a construct distinct from but closely related to capacity) reduces but does not eliminate the gap that David et al, draw attention to.

## 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.

> *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 for the liver disease can be given under a section 47 certificate of incapacity.*

> *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.*

## Adult Support and Protection (Scotland) Act 2007

Where an adult is indicated as an adult at risk of harm as defined in the Adult Support and Protection (Scotland) Act 2007 ('ASP')[25], the local authority may initiate adult support and protection procedures. Following initial inquiries and a subsequent ASP investigation, in which it is found in all the circumstances, to require legal proceedings to safeguard the adult, the local authority can apply to the Sheriff Court to seek an appropriate ASP order.[26]

A medical examination[27] of an adult at risk may be required as part of an investigation into their circumstances. The adult has the right to refuse to consent to that examination. However, if they refuse consent and are incapable of making that decision, and the doctor considers that medical examination or treatment is necessary, the doctor can act/make decisions in accordance with the rest of this guidance.

The options available to the local authority following an investigation include an application to the sheriff court for a 'removal order' under the ASP (this is different to a removal order under the 2003 Act, discussed above). If granted, the removal order would permit the adult to be moved to any place to protect them from harm, such as a residential facility. If the adult is capable of refusing consent to the granting of a removal order, and does so, the order cannot be executed. However, if the local authority evidence to the Sheriff that the adult has been subject to 'undue pressure' to refuse consent to the order, the order can proceed. In the event the adult is deemed not to have capacity to consent to the removal order, the requirement to prove undue pressure does not apply and the sheriff will require evidence of the adult's lack of capacity.

If the adult is incapable of making a decision about medical treatment and the Sheriff grants the removal order, the adult can be removed to a specified place within 72 hours of the order being made. The removal order expires seven days after the person has been removed (or such a period as specified by the Sheriff). Once the adult has been removed to a place of safety, the adult may require medical treatment which may then be authorised under section 47 of the 2000 Act.

This situation of removal under an ASP removal order and then treatment under part 5 of the 2000 Act may be appropriate in some circumstances where an adult is at risk of harm and does not require admission to hospital for treatment.

[25] Adult Support and Protection (Scotland) Act 2007 s.3 (unable to safeguard own wellbeing, rights, property/other interests; are at risk of harm; and the adult is affected by disability, mental disorder, mental infirmity, etc.).
[26] ASP s.11 Assessment Order; s.14 Removal Order; s.19 Banning Order
[27] ASP s.9 Medical Examinations

## A principle-based approach to determining whether an intervention needs to proceed and the appropriate legal authority for this

Having considered the above legal frameworks, in considering decisions in individual cases, we suggest the following process:

### The clinician must consider that the proposed treatment or intervention is of benefit to the person

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.

> *Case example. Mrs A was a woman with dementia admitted to a general hospital ward. She had not been formally diagnosed but dementia is apparent 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 a particularly 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.*

It is important to consider 'benefit' in the widest meaning of the term, in weighing up the advantages and the risks and harms of an intervention. As Baroness Hale said at the Supreme Court:

> *The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be*[28].

## Does the person lack capacity to consent to the treatment or intervention being proposed? Can they be supported to make a decision or make their wishes known about treatment?

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.

The Code of Practice for part five of the 2000 Act contains some helpful guidance on assessing capacity with regards to a specific treatment taking points from the BMA guidance on this and our guidance on Consent to Treatment (section 1.11).[29] It states that to demonstrate capacity to consent to treatment individuals should be able to:

- Understand in simple language what the treatment is, its purpose and nature and why it is being proposed;
- Understand its principle benefits, risks and alternatives;
- Understand in broad terms what will be the consequences of not receiving the proposed treatment; and
- Retain the information long enough to use it and weigh it in the balance in order to arrive at a decision.

[28] Aintree University Hospital NHS Trust v James [2013] UKSC 67
[29] Code of practice for practitioners authorised to carry out medical treatment or research under part 5 of the Adults with Incapacity (Scotland) Act 2000 https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/

In order for the person to be able to do this, the clinician must present information about the treatment in a way that the person can understand.

In determining what information should be shared with patients to obtain or determine their capacity to consent to a treatment, in keeping with the *Montgomery V Lanarkshire*[30] case, the GMC advises that doctors must try to find out what matters to the patient. This helps to ensure that they share person-centred and relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action[31].

Clinicians should make all reasonable attempts to support people to make decisions about their care and treatment.

Good communication is essential and the involvement of speech and language therapist might assist people with communication difficulty.

"Easy-read" or pictorial descriptions of treatment may be useful.

The clinician must also remember that capacity can fluctuate.

Providing sufficient time is an important consideration- there has recently been a renewed focus on this in line with the UK government's response to the independent inquiry into issues raised by the former surgeon, Ian Paterson and the acceptance in principle of the recommendation that patients should have sufficient time to consider options before making a decision about treatment and care and that regulatory bodies are aware of this.

## If the person lacks capacity does the person have an advance plan or statement that covers the situation? What are their wishes and feelings? Does the person have a welfare proxy?

Advance decisions to refuse treatment (ADRTS) are legally binding instruments under the Mental Capacity Act (2005) in England and Wales made by a mentally competent adult that refuses specific treatment interventions in the event that the adult loses capacity to so in the future. They do not have any formal status under the 2000 Act in Scotland and there is no equivalent section in the 2000 Act.

However, if a clinician was aware of/presented with a competent advance planning document refusing an intervention, the expectation would be that this would be regarded and respected. The principles of the AWI Act include the duty to take into account the past and present wishes of the adult. Therefore, the Commission believes that a competently made advance decision to refuse treatment would be taken into account and provide a degree of weight in the clinician's decision making process even if it does not have the nature of a legally binding document.

[30] Chan S W, Tulloch E, Cooper E S, Smith A, Wojcik W, Norman J E et al. Montgomery and informed consent: where are we now? *BMJ* 2017; 357 :j2224 https://www.bmj.com/content/357/bmj.j2224

[31] GMC guidance on Decision making and consent (2020) accessed 11 January 2022 Decision making and consent - GMC (gmc-uk.org)

As well as the legal implications that may follow, if the reason for refusal is understood, e.g. because of previous unpleasant experiences, it might be possible to negotiate alternative ways of providing a treatment that is deemed to be of benefit.

Advance Statements have a different meaning and are documents indicating what a person *would or would not* want for *treatment of mental disorder* if they lack capacity at the relevant time. They do not have a bearing on unrelated physical disorders. The Commission has published guidance on the use, prevalence and overrides of advance statements. Please see our website for relevant details.

### Welfare Proxies

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.

A person who has capacity can appoint a welfare attorney with the authority to consent to treatment at a time when the person lacks capacity.

The attorney may give, or refuse, consent[32]. If the attorney refuses consent, and the practitioner feels that the treatment is necessary, if the dispute cannot be resolved, this would trigger the dispute resolution process in which the practitioner can ask for the Commission to appoint an independent doctor to determine whether the treatment should be given, a view that would be conclusive, unless either party decides to go to court. Please see Appendix 5 for details of this process.

It is essential that general practitioners, hospital wards and care homes have a record of this information to avoid delay and ensure timely contact with any welfare proxy. This should include contact details for the welfare proxy, and a copy of the welfare power of attorney document, welfare guardianship order or intervention order.

## Is force/restraint necessary? If it is necessary- what is the lawful basis for its proportionate use?

Refusal and resistance may be based on a lack of understanding. Even where the person lacks capacity, well-presented information can sometimes overcome resistance to a necessary procedure. It is particularly important to involve others that know the person well, e.g. relatives and carers. Explanation, support and reassurance by someone the person trusts can sometimes to overcome resistance. If a person has a specific fear of hospitals or specific procedures, and there is time, there should be consideration of psychological interventions to reduce any fear of the procedure.

[32] We note that the SG guidance uses the term 'withhold consent' rather than 'refuse' although the BMA guidance uses the term refuse. In practice, proxies *can and do* 'refuse' consent. See commentary for a perspective on this and consideration of any asymmetry in process in Ward, A (2020) Can Welfare Powers of Attorney in Scotland refuse medical treatment on the granter's behalf? - Journal of Medical Ethics blog (bmj.com) Accessed 11 January 2022

*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 and may make force/restraint seem necessary, 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 – the physical disorder is not a consequence or cause of the mental illness - it is important to offer the best possible mental health treatment – to improve his mental health and to reduce the impact the mental illness may have on his decision making process.*

## The lawful use of force

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. It would be inappropriate to use large amounts of force for relatively small likely benefit. Clinicians must consider the difference between the best possible treatment using significant force and any consequences that might have, and a perhaps less effective treatment where the need for force is much lower and what consequences that might have. These are not straightforward decisions.

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.

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 legal options are:

1. The common-law principle of necessity in emergency situations (to convey the person to hospital and/or provide immediate treatment).
2. The use of reasonable, immediate 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 there is no time to obtain authorisation under an intervention order or welfare guardianship under 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.
3. 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.*
4. 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. In our view, a welfare attorney cannot authorise the use of force[33]. There is a duty on local authorities to apply for a part six order under the 2000 Act if no other application is being made.
5. 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 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.*

*Case example: 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.

[33] Our 2020 guidance on common concerns with powers of welfare attorney provides more details on our views here https://www.Commissionscot.org.uk/sites/default/files/2020-07/CommonConcerns_PowersOfAttorney_July2020.pdf (accessed 11 January 2022)

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 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. Our publications on "Rights, Risks and Limits to Freedom[34]" and "Covert Medication[35]" 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.*

We do not suggest that there is any hierarchy here in determining benefit prior to establishing incapacity and taking heed of the adult's wishes and feelings or sounding out the views of those important and exercising residual capacity. To promote benefit assessment as a principle ahead of the others would push benefit close to a 'best interests' test determined by the clinician and away from CRPD models. The act does not envisage these as a hierarchical set of principles.

[34] Mental Welfare Commission good practice guide "Rights, risks and limits to freedom" https://www.Commissionscot.org.uk/sites/default/files/2021-03/RightsRisksAndLimitsToFreedom_March2021.pdf

[35] Mental Welfare Commission good practice guide "Covert Medication" https://www.Commissionscot.org.uk/sites/default/files/2019-06/covert_medication.pdf

# 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 recent actions appear to show that he is at least ambivalent. Given this information, there is enough to suggest that, at least temporarily, his capacity to refuse or consent to treatment 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 S47 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 i.e., the liver failure 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 e.g. a private area out of sight of other patients and passers-by is highly desirable.

## Mr Y

Mr Y has bipolar disorder and 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 because of beliefs that he can heal himself without the need for 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. In this case it appears that in the context of a manic episode his decisions about his need for insulin are affected. 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.

**2. 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.

**3. Force must be lawful and proportionate**

Immediate treatment using the necessity principle would only 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 primarily to treat his diabetes. 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.

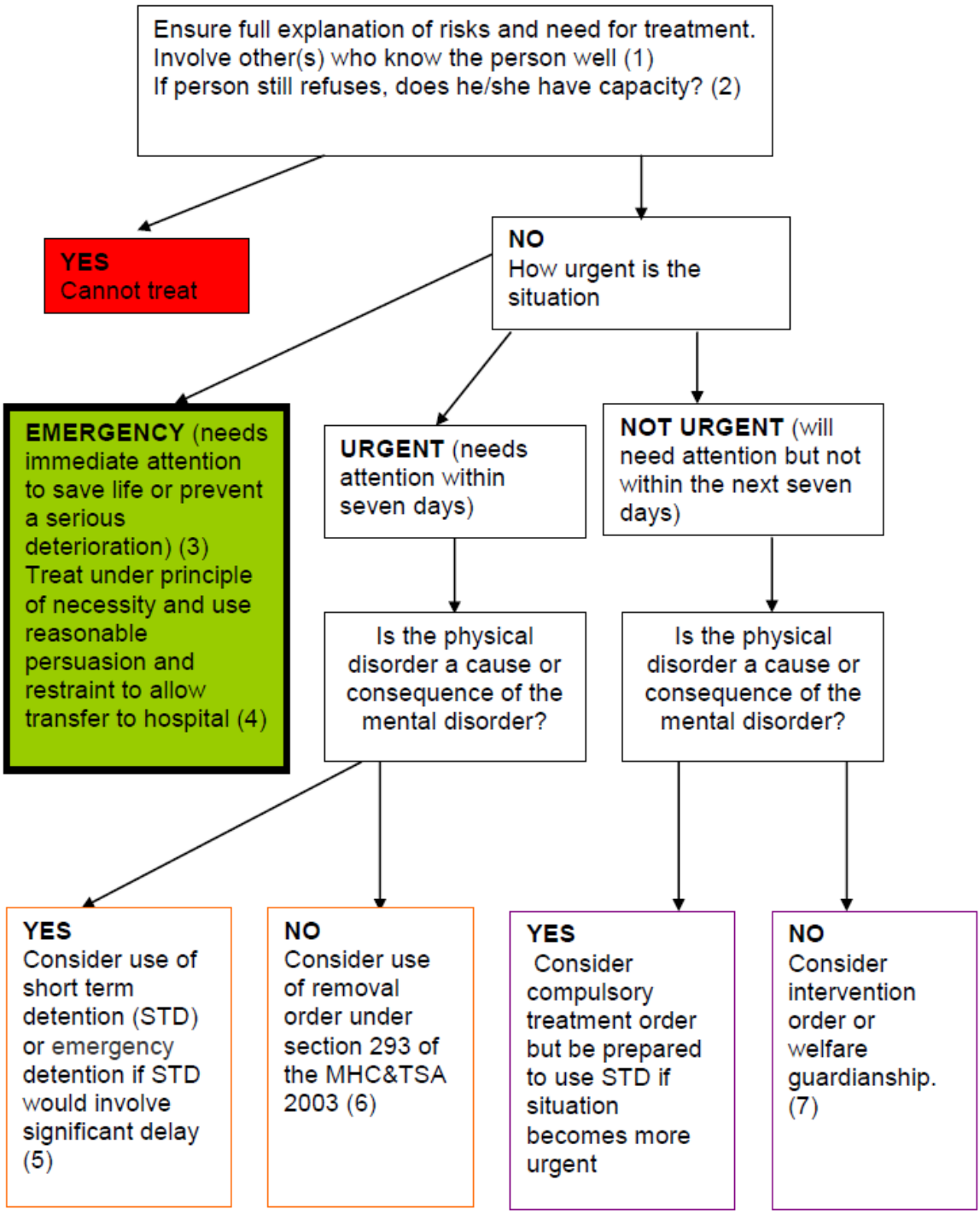
| Step in process | Issues to consider |
|---|---|
| Does the person lack capacity? | • Assess in accordance with the definition of incapacity in the Adults with Incapacity (Scotland) Act 2000.<br>• There is a presumption in favour of capacity, but this can be challenged if there is evidence to the contrary.<br>• Use communication aids and help from speech and language therapy to help people understand information.<br>• Capacity can fluctuate. Wherever possible, choose a time and place that is most comfortable and give the person time and support to make decisions.<br>• People with capacity cannot be forced to have treatment that they have competently refused, even if serious deterioration or death will result. |
| Is the treatment necessary? | • Be clear that the likelihood of benefit in the widest sense for the person outweighs the likelihood of harm.<br>• Apply the principles of the 2000 Act. Take the person's past and present wishes into account and consult relevant others where appropriate.<br>• Take special notice of any advance directive or advance statement or any advance plans.<br>• Consider the views of any person with the legal authority to consent or refuse consent on the person's behalf and proceed accordingly |
| Is force necessary? | • Give an appropriate explanation tailored to the needs and requirements of the person<br>• involve the support of those who know the person best to reduce need for force.<br>• Work to "desensitise" fear of hospital and medical procedures if this is an issue<br>• If mental illness is causing incapacity and refusal of treatment, maximise the benefit of treatment for mental illness, if possible.<br>• Consider whether anxiolytic medication might be appropriate to reduce or eliminate the need for force and ensure that there is a legal basis for this and that any medication for this purpose follows established guidelines |
| Is the force required proportionate to the purpose of the intervention? | • Force is only appropriate if the overall likely benefit justifies it.<br>• 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.<br>• 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. (NB since the first edition of this guidance we have seen force to provide medical treatment authorised within the powers of a welfare guardianship order. An application for a welfare guardianship with such powers could be considered. Or, if a welfare guardian has already been appointed, an application for variation of the powers.) 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 if the physical disorder is a direct cause or consequence of the mental disorder. |

# Appendix 4: Removal to hospital (see also notes on next page)

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



## Notes

1. This is explored in the Mental Welfare Commission's good practice guidance on consent to treatment http://www.Commissionscot.org.uk/sites/default/files/2019-06/consent_to_treatment_2018.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 https://www.legislation.gov.uk/asp/2003/13/section/293

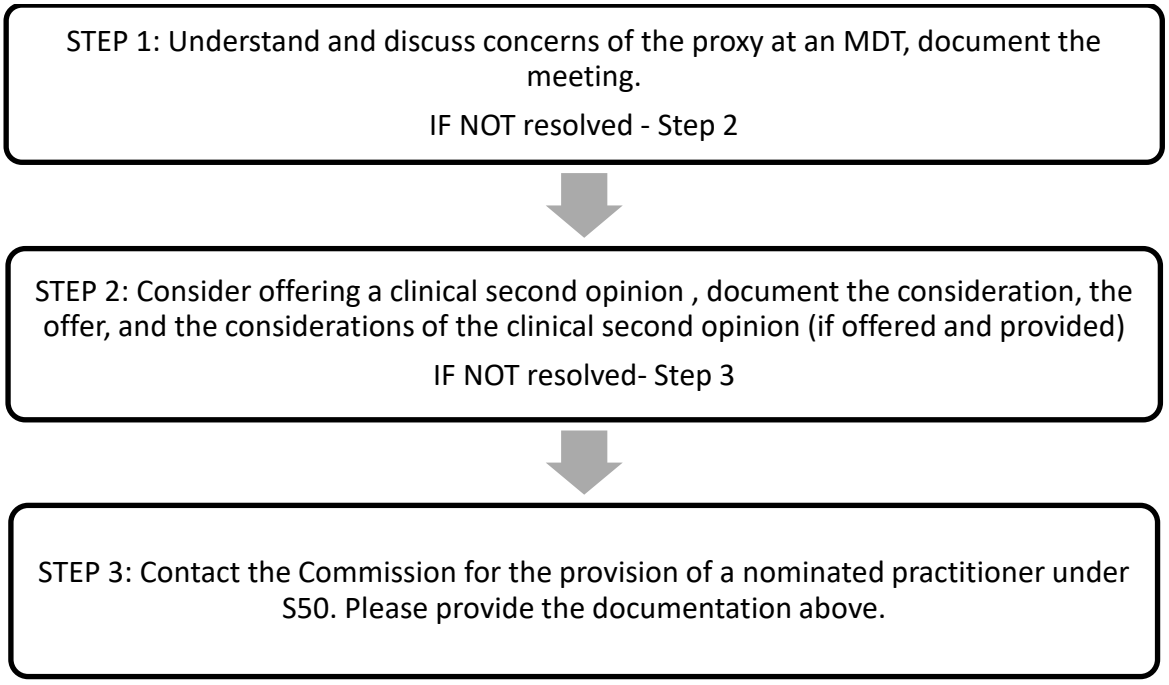
7. Presently, the Adults with Incapacity Act and associated codes of practice are unclear on the correct procedure to follow for non-urgent physical health interventions that the adult with incapacity actively resists. The best advice is to apply for welfare guardianship – the Sheriff may take the view that, on the basis of this application, an intervention order will suffice.

# Appendix 5: Dispute resolution where the welfare proxy refuses treatment that the person's clinician considers necessary and of benefit [36]

In some instances a welfare proxy with the power to make a decision about the proposed treatment may disagree with it and withhold their consent. In these circumstances, the treatment cannot be given (unless it is required for the preservation of the life of the adult or the prevention of serious deterioration in their medical condition – there is always common law authority to give such treatment). If the practitioner responsible for the proposed treatment cannot reach agreement with the welfare proxy about whether or not to give it, the 2000 Act contains arrangements to resolve such disputes under section 50.[37]

The practitioner should contact the Mental Welfare Commission. We will identify a nominated practitioner to give an opinion on the proposed medical treatment, independent from the practitioner who issued the original s47 certificate. If the nominated practitioner determines that the treatment should be given, it can then be given, unless the welfare proxy appeals to the Court of Session

Flowchart on steps if there is a disagreement between the proxy and the treating team regarding treatment proposed by the clinician:




[36] Reproduced from our guidance TreatmentUnderSection47oftheAdultsWithIncapacityAct_April2021.pdf (Commissionscot.org.uk)
[37] Section 50 of the 2000 Act: https://www.legislation.gov.uk/asp/2000/4/section/50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