

Clinical Reviews

A review of the clinical and legal issues surrounding refusal of treatment following overdose

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Key Learning Points

- The Mental Capacity Act may authorise treatment for patients over 16 who refuse treatment following an overdose and lack the capacity to do so.
- The Mental Health Act should only be considered if the person additionally requires assessment and treatment of a mental disorder in hospital. The MHA can authorise medical treatment for physical conditions as long as it is ancillary to the treatment for mental disorder.
- Emergency treatment should not be unduly delayed to allow recovery of capacity or more detailed assessment of capacity if this would lead to serious harm

Abstract

This article reviews the clinical and legal issues involved in dealing with patients who refuse medical treatment following an overdose. We first describe a real case that has been made anonymous, before discussing a general approach to management.

We then review the relevant legislation, including the Mental Capacity Act (2005), the Mental Health Act (1983) and legal issues surrounding the treatment of young people. We discuss how this legislation may be applied in practice and then conclude with the outcome of the case, sources of further information and some key learning points.

Keywords

Refusing treatment, capacity, overdose, mental health act.

Case history

A 17 year-old girl presented to hospital alone claiming to have taken an overdose of 28 tablets (14g) of paracetamol. Following initial assessment, she was found to require treatment with N-acetyl cysteine (based on the normal risk treatment nomogram) and was admitted to the Acute Medical Unit (AMU). However, she refused medical treatment, and on further evaluation she appeared truculent, distressed and refused to cooperate with the assessment. Her parents were not contactable and her boyfriend said he was her next of kin.

This was her second paracetamol overdose that week (the first did not require medical treatment) and she had no other known past medical or psychiatric history.

Assessment

A comprehensive assessment covering the issues outlined in Box 1 is required. The importance of

- Reasons for refusing treatment
- Basic risk assessment for further self harm and other risks (for example child protection, domestic violence)
- Capacity to refuse medical treatment
- Is there any mental illness? Check mental state examination and past psychiatric history
- Brief review of reasons for overdose, social circumstances and stressors
- Gain collateral information with consent

Box 1. Areas to cover in the assessment.

investing time in gaining rapport and engaging the patient cannot be overstated in these situations. It is all too easy to jump into thinking about the legalities, rather than approach the situation firstly as a doctor with a patient. Her reasons for refusing treatment could be easily rectified, for example needing to arrange childcare, a needle phobia or a lack of understanding of the seriousness of the situation. It is also important to clarify the time scale for assessment early on – assessing someone who presents more than 8 hours after a paracetamol overdose is more urgent than assessing someone who presents immediately after the event.

The National Institute for Health and Clinical Excellence (NICE) guideline for self harm¹ stipulates that all patients admitted following self harm should receive a needs-based and risk-based assessment. This is often less urgent than the acute medical treatment of a significant overdose and can usually be performed by mental health colleagues once the medical treatment is complete. However, a basic risk assessment on admission should always be performed to identify whether patients are at high risk of absconding or further serious self harm, pending a more detailed mental health evaluation.

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Assessment of Mental Capacity

The Mental Capacity Act (2005)² (MCA) together with its Code of Practice³ sets out the legal framework and best practice for assessment of capacity, determination of best interests and actions which may be lawful in relation to those who lack capacity. The patient should be assessed to determine whether she has the mental capacity to refuse consent to medical treatment (see Box 2).

For all assessments of mental capacity, it is important to consider the environment and circumstances of the assessment and do everything reasonable in order to maximise the patient's capacity. For example, does the patient need an interpreter, pain relief or treatment for substance withdrawal symptoms? A clear explanation of the nature of the assessment, together with support in a calm, quiet and private environment is required.

If the decision regarding medical treatment is not urgent, other attempts could be made to maximise capacity, for example by allowing time to sober up or contacting relatives (with consent) or other professionals who may know the patient.

For the purposes of the MCA, one decision maker should be identified from the clinical team, usually the senior doctor caring for the patient. However, this person may need to seek advice and second opinions from a number of other colleagues (e.g. senior psychiatrists).

In this scenario, the factors that could be affecting the patient's mental capacity include:

- Severe anxiety or heightened emotional state resulting in an inability to concentrate and take in information

- Intoxication or withdrawal
- Severe depression
- Psychosis, believing that staff are trying to poison rather than help her

The *threshold* for determining capacity is dependent upon how serious the decision is. A greater degree of mental capacity is required to refuse potentially life-saving treatment than to refuse something less critical (e.g. measurement of her vital signs). In order to refuse life saving treatment, it must be clear that the patient has full and complete capacity to make this decision.³

In an emergency situation, it may not be practical or appropriate to delay treatment whilst trying to help patients make their own decision or consult with others. In such cases, and where delay is likely to lead to harm, treatment may proceed if it is felt to be in the patient's best interests.³

If this patient is found to lack capacity, then her best interests should be assessed (see Box 2). Best interests are not only medical, but in this case are likely to be straightforward as the treatment proposed is potentially lifesaving.

Practicalities of Treatment

If treatment is to be administered in her best interests, the practicalities of this must be addressed. Treatment must be administered using the least restrictive option and may include restraint if this is necessary and proportionate.³ It is important to ensure that security and ward staff have received appropriate training on the MCA in order to enlist their support.

The Act applies to everyone over the age of 16 in England and Wales and is based on 5 key principles:

1. All adults are presumed to have capacity until proven otherwise. A person cannot be presumed to lack capacity simply because of their age, appearance or a previous mental health diagnosis.
2. Patients should be supported in making their own decisions as far as possible, and opportunities taken to maximise capacity (eg using simple language, visual aids or other means)
3. Patients must be allowed to make what may be seen as unwise or irrational decisions
4. If a person lacks capacity, any action must be taken in their best interests
5. Any action must be the least restrictive possible on an individual's basic rights and freedoms

Capacity Assessment: for a person to lack capacity there must be an impairment of, or a disturbance in the functioning of, the mind or brain.

Assessment of capacity is decision specific. A person does not 'have' or 'not have' capacity in general. Whether a person lacks capacity to make a particular decision must be decided 'on the balance of probabilities'. The assessment should cover whether the person is able to:

- Understand the information relevant to the decision (including the reasonably foreseeable consequences of deciding one way or the other or failing to make a decision)
- Retain that information
- Use or weigh that information in a decision making process, and
- Communicate the decision (whether verbally, using sign language or any other means).

Best Interests:

If a person lacks the mental capacity to make a decision, a 'best interests assessment' should be made, taking into account the following:

- If capacity is likely to be regained and the decision is not urgent, consider delaying the treatment until capacity returns
- Every effort should be made to include the individual in the decision making process
- Consider the patient's past and present wishes and feelings, beliefs and values when deciding on best interests
- Involve relatives, carers and other professionals in the process

Box 2. The Mental Capacity Act (2005).²

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Criteria for Detention Under the MHA

- A mental disorder is present
- The mental disorder is of a nature or degree which requires detention in hospital
- The mental disorder results in risks to self, others or deterioration of health
- Detention under the MHA is the least restrictive alternative

The sections most likely to be encountered in the AMU are:

Section 5(2): 'The doctors holding power': allows the detention of an inpatient for up to 72 hours if the registered medical practitioner (the Consultant in charge of the treatment) or their nominated deputy (any doctor appointed by that consultant, usually the medical registrar) feels they need assessment under another section. It does not apply to patients in the Emergency Department and does not include provisions for treatment.

Section 2: Allows admission for assessment for up to 28 days and may include treatment. Applications can be made by the nearest relative or, more usually, an approved mental health practitioner and must be supported by two medical recommendations, one of whom must be 'approved' under section 12 of the MHA.

Box 3. Mental Health Act 1983 (MHA).⁴

If a full assessment has been conducted and it is still unclear whether or not she has capacity to refuse medical treatment, the next stage would be to get opinions from senior medical and psychiatric colleagues. In very complex cases, the on call site manager can contact the Trust solicitor in order to obtain an urgent legal judgement, even if this is in the middle of the night. Medical defence organisations are also able to provide guidance.

If you conclude that she does have capacity and are considering allowing her to leave hospital to suffer the consequences of the overdose, it is strongly recommended that you do not make this decision on your own. Ideally more than one senior colleague should concur with and document the decision.

What about using the Mental Health Act 1983 (MHA)?

Many doctors and AMU staff think that the MHA is necessary to treat patients like this, however this is not the case.

A mental health assessment will be part of the initial assessment. This includes clarifying recent psychological symptoms, enquiring about past psychiatric history, personal history and social circumstances. As part of this, a mental state examination should be performed. The results of the mental health assessment may determine whether the patient has a mental disorder, as defined by the MHA, which fulfils the criteria for detention (see Box 3). This assessment requires a referral to psychiatric colleagues.

The MHA includes provisions for treatment of 'mental disorder, or one or more of its symptoms or manifestations'.⁴ The MHA Code of Practice states that this only includes physical health problems if treatment is

Medical Protection Society (MPS): 0845 605 4000 or email querydoc@mps.org.uk

Medical Defence Union (MDU): 0800 716 646 or email advisory@the-mdu.com

Trust Solicitor – can be contacted via the on call manager 24 hours a day

British Medical Association Mental Capacity Tool Kit: http://www.bma.org.uk/images/MentalCapacityToolKit%20July2008_tcm41-175571.pdf

British Medical Association Medical Ethics Department: 020 7383 6286 or www.bma.org.uk/ethics

Box 4. Points of Contact.

'part of, or ancillary to, treatment for mental disorder (e.g. treating wounds which are self-inflicted as a result of mental disorder).'⁵ Thus, medical treatment for an overdose can occur under the MHA providing this treatment is part of a wider treatment programme for a mental disorder which meets the criteria for detention under the MHA. Caution is advised before using the MHA in this manner and legal advice may be necessary in such cases.

Mental Capacity Act or Mental Health Act?

The MHA states that the 'least restrictive alternative' should be used when planning treatment. The Code of Practice expands on this by stating that "if the Mental Capacity Act (2005) can be used safely and effectively to assess or treat a patient, it is likely to be difficult to demonstrate that the criteria for detaining the patient under the Mental Health Act are met."⁵

The first option would therefore be to assess and treat this patient using the Mental Capacity Act. Should she be found to have capacity to refuse medical treatment for her overdose, treatment could subsequently be given under the provisions of the Mental Health Act if she has an underlying mental disorder which meets the criteria for detention. Practically, this second option would be difficult to implement in the timescale before irreversible liver damage occurs.

Treatment for this patient cannot be undertaken under the powers of a section 5(2) as treatment decisions whilst on a 5(2) are governed by the patient's capacitous consent or the MCA.⁵

Can parents give consent on her behalf?

The legal provisions relating to children under the age of 16 are outside the scope of this review. However the relevant legislation regarding the treatment of 16 and 17 year olds, referred to as 'young people', is outlined below.

The MCA applies to everyone aged 16 years and above (unless it includes a deprivation of liberty, which only applies to those aged 18 years and above).² Although parents of young people can give consent on their behalf if they lack capacity⁷ (providing the decision is in the 'zone

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of parental control' – *i.e.* the kind of decision that would normally come under the remit of parents⁸), it is usually not necessary for a parent to consent as the decision can be made by a clinician using the MCA and in the young person's best interests. Indeed, it may be unhelpful for a parent to consent on a young person's behalf if problematic issues of control exist at home. It is still good practice to involve the family in the decision making process, if the young person agrees.

For non-urgent treatment, if a young person has capacity, a person with parental responsibility cannot consent on their behalf, and cannot overrule a capacitous refusal of treatment.³ However, for emergency treatment of a young person who has capacity and is refusing potentially life-saving treatment, 'it is likely that the young person's decision could be overruled and the clinician could act without anyone else's consent if the refusal would in all likelihood lead to their death or to severe permanent injury'.³

The MHA has no lower age limit and should be applied as for adults but it is important to consider whether or not this is the 'least restrictive alternative'.

What actually happened...

This patient presented four hours post-overdose, giving enough time for an assessment of her mental capacity.

The AMU Consultant felt that she did not have capacity to refuse treatment. The patient was unable to weigh up the information given to her due to anxiety and emotional over-arousal which did not change over the time of assessment despite measures by the medical and nursing staff to provide reassurance and explain the

situation to her. She was not found to have any evidence of mental illness and thus the MHA was not considered at any point.

Second opinions were sought from consultant colleagues, a medical defence organisation and a liaison psychiatry consultant. The patient's boyfriend was informed that he was not her legal next of kin, but his input was sought regarding her social circumstances and best interests.

As the patient was actively refusing treatment, it was decided that the only safe option would be to administer treatment under sedation with lorazepam, which would initially require restraint. It was felt that this was in proportion to the circumstances and the least restrictive option.

The plan was clearly explained to all the AMU staff, (including medical, nursing and security colleagues) to ensure that they were satisfied with the legal position before implementing a difficult management plan. A side room was identified to maximise the patient's dignity. Boluses of intramuscular and then intravenous lorazepam were used to sedate the patient enough to allow intravenous n-acetylcysteine treatment for 24 hours. (The definition of sedation means the patient can still maintain verbal contact). She was monitored closely with continuous electrocardiogram, oxygen saturations, regular measurement of vital signs and 1:1 nursing. No medical complications occurred and she was seen the following day by the hospital self harm team who arranged support outside of psychiatric services. To our knowledge she has not presented with any further self harm.

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