Advances in Psychiatric Treatment (1998), vol. 4, pp. 243–249

Medico-legal aspects of liaison psychiatry

Eleanor Feldman

This article considers the use of the Mental Health Act 1983 (MHA) and application of common law principles with respect to patients with behavioural disturbances in NHS general hospitals in England and Wales. Legal issues do not apply across national boundaries; in the UK there are two other Mental Health Acts currently in force: Scotland's (1984) and Northern Ireland's (1986).

The Mental Health Act 1983 in the general hospital

General psychiatrists are familiar with applying the MHA to individuals suffering from psychiatric illnesses which it is generally agreed fall within its remit, that is, disorders such as schizophrenia and affective psychoses, and where the main issues concern assessment and/or treatment of that mental disorder. Familiarity and confidence derives from years of established custom and practice, tribunals, use of the MHA by staff who have been appropriately trained and who are familiar with its workings, and the monitoring and advice of the MHA Commission.

However, within liaison psychiatry, there is less experience and agreement regarding the use of the MHA in situations which can quite commonly arise in general hospital in-patients. A broader range of diagnostic categories may need to be considered, for example, delirium, or neurotic conditions compromising medical care. Physicians and surgeons seek advice about the treatment of life-threatening physical illness in non-consenting mentally disordered patients. There is less experience to draw upon in a young and small sub-speciality: feedback is not received from tribunals in general hospitals; the psychiatrist advises medical and nursing staff from other specialities who are unfamiliar with the principles and practice of the MHA; the MHA Commission does not routinely visit general hospitals. The consultant psychiatrist covering a general hospital must expect to be challenged by situations beyond their everyday experience of the MHA. Clarification of a few basic principles and discussion of some typical case examples may assist.

The remit of the Act

The MHA allows for the legal detention and treatment of adults with mental illness, mental impairment and psychopathic disorder where admission and/or treatment are considered necessary in the interest of their health and safety, or for the protection of others, and where they are unable or unwilling to consent to such admission and/or treatment. In legal terms, it is an 'enabling Act', which means it does not have to be used in all instances where it might be applicable, but its use does provide certain legal safeguards for patients and for staff. While any mental disorder can fall within the Act's remit, in practice there are common circumstances where restraint and treatment are applied without recourse to the Act, and where it may be preferable to do so. In these situations, the actions performed can only be defended within the scope of the common law. The most relevant common law principles are discussed later.

Definition of mental disorder

In Section 1 of the MHA, mental disorder is defined broadly. Section 1(2) states:

> "'Mental disorder' means mental illness, arrested or incomplete development of mind, psychopathic

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https://doi.org/10.1192/apt.4.4.243 Published online by Cambridge University Press

disorder and any other disorder or disability of mind and 'mentally disordered' shall be construed accordingly".

This may include temporary states of mental disturbance such as delirium and intoxication, as well as more prolonged conditions such as dementia and brain damage. The very broad definition of mental disorder allows clinicians a wide degree of discretion in deciding whether or not to use the powers of the Act, although in general psychiatric practice the Act has come to be used in a quite narrow range of conditions.

Intoxication v. dependence on alcohol or drugs

It should be noted that someone who is intoxicated with alcohol or drugs and who is judged to have the capacity to refuse essential intervention may in certain circumstances legitimately be subject to the MHA, although there must be grounds for intervention other than alcohol or drug addiction alone. Section 1(3) states that the Act cannot be applied to persons by:

"reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs".

Treatment for physical illness

The MHA does not apply to the detention and treatment of patients for physical illness, for which they must give informed consent, or be treated under common law. However, what is the position where the physical illness itself results in disability of mind through disordered brain function? Although not appropriate for the treatment of physical disorder *per se*, the MHA may apply where physical disorder contributes to mental disorder or is otherwise inextricably linked with the mental disorder (re: K. B., 1993), for example, feeding in anorexia nervosa or the use of thyroxine in mental disorder caused by hypothyroidism. It does not apply in situations where the treatment of the physical illness will not impact upon the mental disturbance; this area falls within the scope of the common law (re: C (Adult: Refusal of Treatment), 1994).

Use of the medical holding orders

Section 5(2), the emergency medical holding order for those who are already voluntary in-patients, is not applicable in an accident and emergency department, which is regarded as an out-patient setting. Where accident and emergency departments have wards, these are in-patient areas. Patients cannot be conveyed to another hospital on Section 5(2), but will need to be on a hospital admission or treatment order. Admission and treatment orders are enforceable in any NHS hospitals, not just psychiatric hospitals, so long as the appropriate administrative formalities are observed. Where different NHS hospital trusts operate on the same site, it is advisable for the respective trust managers formally to agree to act on each others' behalf with respect to the MHA.

Any consultant in charge of a patient's care may be the responsible medical officer (RMO) with respect to the MHA; therefore, according to the law, consultant physicians and surgeons may detain their own in-patients using Section 5(2). In general hospitals, the initials RMO apply to the resident medical officer who is a senior house officer; it is therefore very important to be clear that, where the term RMO is applied in respect of the Mental Health Act, it always refers to the consultant with medical responsibility for the case. The MHA allows for the nomination of a deputy by any RMO and this deputy must be a registered medical practitioner (not a pre-registration house officer; see Box 1). Under the MHA, consultant physicians and surgeons may nominate their own juniors, who are senior house officer grade or above, to act as their deputy. Whether or not this is a good practice is another matter. The *Code of Practice* on the use of the MHA (Department of Health & Welsh Office, 1993; new revision due to be published autumn 1998) has advised that only consultant psychiatrists should nominate a deputy, and that where an RMO of another speciality wishes to detain their own patient, they should make immediate contact with a psychiatrist. Problems can arise if junior physicians are left to invoke the powers of Section 5(2) because they and their seniors are often unclear about the precise nature and scope of the powers and the powers may not be administered correctly. Most seriously, arrangements may not be made for the patient to be assessed by an approved psychiatrist with a view to an admission order or termination of the holding order. An audit carried out in Leeds demonstrated various such failings in the use of Section 5(2) when it was left to physicians to invoke the power (Buller *et al*, 1996).

Use of the place of safety order and the role of the police

Section 136 empowers the police to detain and take to a place of safety an individual who falls within its remit. It is not an emergency admission order. Its purpose is to enable the police to take a patient

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somewhere where they can safely be assessed by two doctors and an approved social worker, with a view to detention under the MHA. There is no official documentation for Section 136.

Police may legitimately escort patients to hospital who request their help, or those who require hospital treatment but are incapable of consenting. However, they should not bring patients against their will to a hospital unless under Section 136 of the MHA and where, by local agreement, the hospital is the designated place of safety. In many districts, hospitals are not the designated place of safety, but the police cells are. A recent report (Royal College of Psychiatrists, 1997) has commented on the inadvisability of making a hospital a place of safety. Accident and emergency departments, far from being safe places for severely mentally disturbed individuals, are often ill-equipped to deal with the kind of very disturbed people that the police bring in, and hospital staff and other ill patients in the vicinity may be placed at risk.

Managerial arrangements for the MHA

Papers relating to MHA detention and treatment orders must be dealt with appropriately by those acting on behalf of hospital management, usually the medical records department, otherwise the orders are not legally in force. Senior managers of general hospitals need to make arrangements for the receipt and holding of section papers and ensure that rights are read to patients. The links with relevant officers in the psychiatric hospitals need to be made clear. If the general hospital is in a different trust to the psychiatric hospital, there either needs to be a designated person within the general hospital who is properly trained in the administration of the MHA, or a written agreement whereby clinical staff of the general hospital will have access to the relevant MHA officer in the psychiatric trust.

At a practical level, clinical and administrative staff on medical and surgical wards will not be aware of what to do with MHA papers, and will often think it sufficient to file them in the notes. Therefore, psychiatrists involved with advising on MHA orders will need to make sure that the relevant staff in the medical records department are informed and have agreed to take appropriate action. As this is an important legal issue, it is advisable to record this discussion in the medical notes (see Box 2).

Box 1. Be extra careful

Pre-registration house officers are not qualified to assess capacity to refuse medical intervention nor to act as a nominated deputy with respect to Section 5(2).

A Section is not in force until the papers have been received on behalf of the hospital managers and the form certifying this has been completed. Filing the recommendations and application in the notes is not sufficient.

General hospitals outside the NHS are not recognised for the purposes of the MHA.

Box 2. To demonstrate capacity to consent or refuse medical treatment individuals should be able to:

Understand in simple language what the medical treatment is, its purpose and nature and why it is being proposed.

Understand its principal benefits, risks and alternatives.

Understand in broad terms the consequences of not receiving the proposed treatment.

Retain the information for long enough to make an effective decision.

Make a free choice (i.e. free from pressure).

Clarifying the common law for use in the general hospital

Common law

The common law refers to the corpus of rights, duties, obligations and liabilities recognised by the courts over the years. It comprises principles identified by judges which have evolved to meet the needs of particular cases or particular developments in society. This judge-made law is distinguished from statute law which comprises Acts of Parliament. Once common law principles have been identified, their application should follow. Lord Donaldson, a former Master of the Rolls, succinctly referred to the common law as "common sense under a wig".

Applying common law

Common law principles may assist where there are no statutory protections or mechanisms in play. In

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England and Wales, the MHA is the relevant codifying statute, and where its provisions apply there is no need to consider the common law. On issues where the statute law is silent, the lawfulness of any act or omission is tested by the application of the common law.

Common law principles applicable to mentally disturbed individuals

Assumption of capacity in adults

The starting point is the recognition in common law that every adult (aged 18 years or over) has the right and capacity to decide whether or not he/she will accept medical treatment, even if a refusal may risk permanent damage to his/her physical or mental health, or even lead to premature death. The reasons for the refusal are irrelevant.

Capacity is a legal concept and concerns an individual's ability to understand what is being proposed and the consequences of either refusing or accepting the advice given (see Box 2). A patient under a Section of the MHA has the same rights as any other person with respect to decisions not covered by the powers of the Act. General psychiatrists are rarely involved in decisions regarding capacity as the MHA does not require any explicit test of capacity to determine eligibility for its application. Capacity becomes a key issue when there is refusal of treatment for a physical illness.

In law, pre-registration house officers are not qualified to assess a patient's capacity but all registered medical practitioners are. (British Medical Association & Law Society, 1995). Where mental disorder is present or likely, psychiatric involvement is necessary for a proper assessment of capacity.

Capacity in minors

People under the age of majority do not have the same rights at law as adults. Stated briefly: parents or guardians must agree with decisions to consent up to the age of 16 years, while those over 16 may be able to consent without their parent's or guardian's involvement. Where there is a refusal, those under 18 can have their wishes overridden by parents, guardians or the High Court (British Medical Association & Law Society, 1995).

Necessity

The courts recognise a common law principle of 'necessity' to cover situations where action is needed to assist another person without his or her consent. Although such a situation will usually be some form of emergency, the power to intervene is not created by that emergency, but derived from the principle of necessity. In *The Times* (31 May 1998), Lord Griffiths, when dealing with the common law power to restrain a violent person with mental disorder, said that the power was:

> "confined to imposing temporary restraint on a lunatic who has run amok and is a manifest danger either to himself or to others – a state of affairs as obvious to a layman as to a doctor. Such a common law power is confined to the short period necessary before the lunatic can be handed over to the proper authority".

In practice, there is often a period of time when patients who are about to be made subject to the MHA will have to be restrained before the formalities of the Act can be completed. It also quite common for such patients to require some sedation prior to the completion of formalities. Such actions will be defensible if carried out as a necessity using the minimal intervention required.

Actions performed out of necessity should not continue for an unreasonable length of time, but progress should be made either to a situation of consent or to the use of powers under the MHA. It is not possible precisely to define what is a reasonable or unreasonable length of time as this would vary with the particular circumstances of each case.

Duty of care

Common law imposes a duty of care on all professional staff to all persons within a hospital. By assuming the responsibility of a particular clinical staff appointment, and claiming professional expertise, an individual undertakes to provide proper care to those needing it. Staff may be negligent by omission.

As well as individual staff, hospitals also have duties, for example to provide back-up staff who are properly trained to assist with aggressive uncooperative patients in a casualty department, and the hospital must ensure that such staff are authorised to act if necessary. Many hospitals experience problems with fulfilling this duty because they fail to train security staff in this role, and commonly such staff are disinclined to assist in necessary restraint as they believe that they will be exposed to the risk of litigation for assault. This is a key area for improved staff training and the involvement of the hospital's risk management advisers.

Bolam test

Where clinical decisions are being made, an individual clinician's competence will be judged against what is considered reasonable and proper by a body of responsible doctors at that time, as ascertained in court from expert testimony (Bolam

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v. Friern Hospital Management Committee, 1957). Bolam was a psychiatric patient who was given unmodified electroconvulsive therapy at a time when that was normal practice; he developed fractures and claimed that his consultant had been negligent in not warning him of this complication. As it was not normal practice at that time to warn patients of such a complication, and medical opinion was still divided as to whether electroconvulsive therapy should be given modified or unmodified, the defense was that a responsible body of medical opinion at that time would have acted in the same way as Bolam's consultant.

Law applied to clinical situations

The advice given below is not intended to be prescriptive, but to show how the principles discussed may be applied in practice. In law, as in medicine, there is always a place for considered judgment according to the particular circumstances of each case.

Acute organic brain syndrome

A 54-year-old male on a high-dependency unit was recovering from a cardiac arrest which required prolonged resuscitation. As he emerged from several days of coma, he became acutely distressed, disorientated and paranoid. He required heparin for his prosthetic heart valves, and antiarrythmic drugs, but refused to have either and walked about, dressed and demanding to leave. He tried to push past the doctor and the nursing staff. The only way to help him was to restrain and sedate him against his will, keeping him on the high-dependency medical unit.

This man's refusal is not based on any real understanding of his circumstances and, in delirium, he had no grasp of his risk; it was very clearly in his best interests to detain and sedate him so that he could receive life-saving treatments. He lacked the capacity to give meaningful consent or refusal, there was a clear duty of care and a situation of urgent necessity.

The MHA could be applied for detention and sedation to treat the delirium (a form of mental illness), but delirium is not a situation in which the MHA is commonly used. Such patients are more often detained and treated without recourse to the MHA in view of the evident lack of capacity to give meaningful consent or refusal, the transient nature of the disturbance, and the (so far) undisputed need for intervention. However, if strong measures are required, such as the use of psychiatric nursing staff to pin the man to his bed while he is forcibly injected with haloperidol, or if the situation persisted over a prolonged period, it may be advisable to use the MHA.

Treatments other than sedation in this case are not authorised by the MHA, but are justifiably given in a legal sense when the patient lacks the capacity to make a meaningful refusal. The same legal decision could also apply to the use of sedation.

Patient refusing medical intervention after deliberate self-harm

A 30-year-old male was brought to an accident and emergency department following an overdose of 70 paracetamol taken four hours prior to arrival at hospital. No history was available and the patient refused to say anything about himself other than he wanted to be left alone to die. He refused to give blood to test for paracetamol level and refused any medical intervention. A decision had to be made whether medical treatment could be given without his consent.

This illustrates a fairly common scenario. The patient presented the medical staff with the dilemma of whether they should assume he had full capacity to refuse medical treatment, in which case they might leave him to suffer the consequences of liver failure and possibly death, or whether they should act out of urgent necessity and as part of their duty of care to treat someone in whom capacity may reasonably be in doubt and where the patient could be mentally ill. A psychiatrist would not be in a position to assess the patient for mental disorder before the harmful effects of paracetamol become irreversible, and a psychiatric opinion would also be needed to assist in a proper evaluation of capacity. My own position on such cases is to take it that there is reasonable doubt with respect to such patient's capacity to make a fully informed and reasoned choice and proceed with whatever action is necessary to save their life under the common law. The MHA will not assist with respect to treatment for the poisoning. Is it better for a clinician to have a living patient who may sue for assault for saving their life that they no longer want, or to have a dead patient with grieving relatives who may sue for negligence? There are currently no precedents either way.

Intoxicated patient refusing to cooperate with assessment following deliberate self-harm

A young adult male was brought to the accident and emergency department by paramedics who found him lying in a doorway with a suicide note

https://doi.org/10.1192/apt.4.4.243 Published online by Cambridge University Press

and an empty bottle of paracetamol. He was intoxicated with alcohol, belligerent, refused to talk to any staff and tried to leave. No other information was available and a decision had to be made as to whether or not to let him go.

This case typifies a common clinical problem faced by accident and emergency staff and psychiatrists covering accident and emergency departments. If there is sufficient concern to warrant detaining this patient for further assessment of a possible underlying mental disorder, then use of the MHA is certainly justified. The fact that the patient is intoxicated is not an obstacle to use of the MHA, as the Act is not being used to detain or treat the person because of alcohol misuse or dependence alone, but because of the concern that they may have an underlying mental disorder.

Anorexia nervosa patient in extremis *and refusing food*

A 19-year-old female weighing only four stone was admitted to an acute medical unit. She consented to a saline drip, but not to any dextrose or parenteral feeding. She was close to death from starvation.

The MHA is frequently used in relation to patients with anorexia who are close to death to authorise feeding as part of the psychiatric, as well as part of the physical, treatment of these patients. Experts in eating disorders regard re-feeding as an essential first step in the psychiatric treatment, as starvation itself produces distorted thinking. There are legal precedents to support this view, notably re: K. B., 1993. The MHA Commission have issued a guidance note on this particular topic which discusses the legal issues in more detail (Mental Health Act Commission, 1997).

It is worth noting that a patient who needs to be in a general hospital for their psychiatric treatment, as may be the case in this patient, can be admitted under Section 3 or Section 2 direct to the general hospital, but only providing it is an NHS hospital. Non-NHS general hospitals are not recognised under Section 145 of the MHA (see Box 1).

Patient with anorexia nervosa and diabetes, refusing insulin

A similar patient to the case above also had insulin-dependent diabetes; she agreed to feeding, but refused insulin, since she knew that she would not gain weight without it. She would have died if her wishes had been followed, so the hospital staff had to feed her and give her insulin to prevent her death.

I would take the view that there is no difference between this case and the preceding situation. Insulin is as essential for healthy weight gain as is food; hence, its administration would also form part of the psychiatric treatment plan under Section 3 of the MHA. There is currently no legal precedent on this precise point.

Patient with schizophrenia refusing surgery, but accepting other medical care

A 59-year-old male with chronic schizophrenia was a long-stay patient under Section 3. He developed a gangrenous foot and the surgeon's advice was to proceed with amputation. The patient refused surgery on the grounds that he did not want an amputation, but he agreed to antibiotics and all other forms of treatment. The surgeon asked whether the operation could be carried out as part of treatment under Section 3 and he impressed his conviction that the patient was likely to die without the amputation.

The MHA does not apply unless the treatment of the physical disorder would improve the patient's mental disorder. A precedent on this (re: C (Adult: Refusal of Treatment), 1994) found that a patient with schizophrenia could not have his gangrenous leg amputated under the terms of the MHA treatment order, as surgery would not improve his mental condition. The operation might have proceeded under the common law had the patient been found by the court to lack capacity, but he was judged to have the capacity to refuse. The patient also took out an injunction against the hospital to ensure that they did not proceed to amputate his leg in the event that he became delirious or unconscious. The patient's infection successfully resolved without surgery.

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Multiple choice questions

1. With respect to Section 3 of the MHA:
   a naso-gastric feeding in anorexia nervosa may be given without the patient's consent
   b the responsible medical officer should be involved in assessment of capacity to refuse surgical treatment for a life-threatening condition
   c the common law assumption of capacity is automatically overruled with respect to decisions on life-saving medical treatments
   d next of kin may decide on the patient's behalf that they should have a life-saving treatment for a physical illness
   e a patient can be admitted from the community to a general NHS hospital against their will under a Section 3; it does not have to be to a psychiatric hospital.

2. Under the common law:
   a adults may ignore their doctor's advice, even if this means they will die
   b a delirious patient may be detained and sedated against their stated wish
   c a suicidal person may be detained in an accident and emergency department prior to psychiatric assessment
   d a doctor's duty of care to a patient after attempted suicide may involve giving resuscitative treatment against the patient's stated wish
   e a doctor would automatically be guilty of assault and battery for saving the life of a patient after a suicide attempt where the patient stated they did not wish to be resuscitated.

3. Under section 5(2) of the MHA:
   a patients in an accident and emergency department who have made a suicide attempt may be held against their will pending psychiatric assessment
   b patients already admitted to a medical ward who have made a suicide attempt may be held against their will pending psychiatric assessment
   c the medical junior house officer may sign the paper for a patient on a medical ward
   d the consultant physician may sign the paper for a patient under their care
   e a consultant psychiatrist cannot be RMO for a patient on a medical ward.

4. The following fall within the remit of the MHA 1983:
   a head injuries
   b alcohol dependence
   c drug-induced abnormal mental states
   d dementias
   e some endocrine disorders.

5. Patients intoxicated with alcohol who have attempted suicide:
   a may never legally be subject to detention under the MHA
   b may be held responsible in law for their actions when drunk
   c may temporarily lack capacity to make an informed choice about medical treatment
   d may never legally be detained under common law in an accident and emergency department
   e may never legally be placed under Section 2 and transferred to a psychiatric ward.

MCQ answers:

1	2	3	4	5
a T	a T	a F	a T	a F
b T	b T	b T	b F	b T
c F	c T	c F	c T	c T
d F	d T	d T	d T	d F
e T	e F	e F	e T	e F

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