

# Mental health law: compulsory treatment in a general medical setting

**Compulsory treatment of severe mental disorder can seem complicated even to psychiatrists. This article attempts to explain the current legal framework as it applies in common clinical situations in a general medical context.**

The majority of patients are treated for their mental disorders in the same way as they are for their general medical disorders; valid and informed consent is given voluntarily and after detailed discussion with their doctor. Some patients do not give such consent to being treated, either because of an incapacity to give valid consent, lack of insight into their disorder or a wide range of other reasons which may amount to simple refusal of treatment.

Mental disorder is unlike any other form of medical disorder in that an adult patient, whose capacity to consent or refuse treatment is not in doubt, can be lawfully treated for their mental disorder both without their consent and in spite of their refusal.

To consider an extreme example, a patient with oesophageal varices who faces imminent death without a blood transfusion can, if his/her capacity is not in doubt, refuse such treatment. However, a patient with a severe depression who insists on leaving hospital to go home and kill him/herself can be kept in hospital and treated for his/her mental illness even if he/she objectively has capacity and seems to have made a definite decision to refuse such treatment. The outcome of not treating these patients is the same (imminent certain death) but the response of the treating doctors and the legal position are in stark contrast.

Treatment of patients with mental disorder without their consent has to be regulated and performed within a specific legal framework. This article describes the current legal framework in England and Wales. Legal principles in other jurisdictions (including Scotland and Northern Ireland) are likely to be broadly similar but details will vary widely and specific local consultation is strongly advised.

## The common law

Whether a deed is lawful or not can be determined in two ways. The first is by 'statute'; the deed is considered in the light of particular acts of Parliament which refer to it and clearly define the deed itself and the circumstances under which it is or is not lawful.

The second is by 'common law'; no specific act of Parliament is involved. The deed is considered in the light of long-established legal principles (e.g. habeas corpus) and previous court rulings which provide legal precedents relating to similar deeds in similar circumstances.

There are two principles of the common law that are highly relevant to this article.

## Doctrine of necessity

The House of Lords has summarized this as follows:

**'under the common law doctrine of necessity a doctor can lawfully [treat] adult patients who are incapable, for one reason or another, of consenting to his doing so, providing that the...treatment concerned is in the best interests of such patients...either to save their lives or ensure improvement or prevent deterioration in their physical or mental health. [F v West Berkshire Health Authority, 1989]'**

This doctrine most obviously covers patients who are unconscious or delirious but extends to any patient who lacks capacity to give or withhold consent (*Figure 1*).

The judgment continued by saying that:

**'in many cases...it will not only be lawful for doctors [to treat] adult patients disabled from giving their consent; it will be their common law duty to do so.'**

Particularly relevant to this article, the judgment also went on to elaborate that if a patient were to become severely mentally disturbed, a doctor could provide emergency treatment in the absence of the patient's consent if:

1. The patient's behaviour precludes rational communication with him/her
2. A reasonable person would conclude that such action would be in the patient's best interests (*Figure 2*).

### Figure 1. Common law: lack of capacity as a result of physical illness.

A 79-year-old male inpatient on the stroke unit develops an acute confusional state secondary to a urinary tract infection. He is confused and disorientated, believes the nurses are trying to kill him and is trying to leave hospital. Nursing staff are reluctant to prevent him leaving, saying this would be illegal as he is not 'sectioned'.

This patient can be lawfully detained and treated under the common law doctrine of necessity. He lacks the mental capacity to consent or refuse treatment and so can be treated without consent according to his 'best interests'. This can include stopping him leaving hospital and administering antibiotics and sedative medication by any appropriate route, using physical restraint if necessary. Use of the Mental Health Act is not necessary or appropriate unless his mental incapacity becomes chronic, when further advice should be sought.

**Dr Steven Linford** is Specialist Registrar in General Adult Psychiatry, Barts and the Royal London Specialist Registrar Training Scheme, East London and The City Mental Health Trust, Homerton Hospital, London E9 6SR

## Proportionality

This dictates that one's response to a particular situation should be appropriate to the circumstances and not irrationally severe or excessive (e.g. in the case in *Figure 2* an intramuscular injection would be lawful under common law but a session of electroconvulsive therapy would not).

## The Mental Health Act 1983 Section 5(2)

Inpatients being treated in hospital for medical problems do sometimes decide, for various reasons, to cease treatment and leave hospital against medical advice. As discussed above this is their absolute right in law. However, the treating medical team may feel that such a patient is suffering from a significant mental disorder and that to allow him/her to leave hospital would result in risks to that patient or to others.

The 'responsible medical officer' or RMO (i.e. the consultant in charge of the patient's care) or their 'nominated deputy' (i.e. a junior doctor working for the RMO) can complete a report under section 5(2) of the Mental Health Act (MHA) 1983 which provides authority to detain such a patient in hospital for up to 72 hours (*Figure 3*).

The report is provided on a statutory form and must state the reasons for making the decision to detain the

**Figure 2. Common law: lack of capacity as a result of mental illness.**

A 35-year-old woman is brought to accident and emergency by her family and is diagnosed with a manic episode. She becomes increasingly elated and behaviourally disturbed, taking off her clothes and making sexual advances towards male staff. When offered medication she refuses, becomes agitated and hostile, and starts throwing things around the department.

This patient can be lawfully detained and treated under the common law doctrine of necessity. She is clearly mentally disordered and posing a risk both to herself and to other people. Her behaviour precludes rational communication with her and any reasonable person would agree the situation necessitates intervention. Treatment is therefore lawful even against her expressed wishes and there is arguably a duty under the common law to provide such treatment. This can include stopping her leaving hospital and giving sedative medication, under physical restraint if necessary.

This patient needs to be assessed under the Mental Health Act to consider detention under section 2 or 3 for ongoing treatment but emergency treatment under the common law should not be withheld while this is arranged.

**Figure 3. Section 5(2) of the Mental Health Act 1983: a voluntary inpatient wishes to leave hospital.**

A 45-year-old man has been admitted to a general medical ward for observation following a serious overdose of paracetamol and amitriptyline. He has been severely depressed for months, this is his second overdose in a week and he regrets surviving. The day after admission he wishes to go home, saying he is wasting everyone's time and wants to be left alone. He is not confused or agitated.

This patient is an inpatient with a mental disorder (depression) and would be at high risk of further self harm if allowed home. He can lawfully be detained in hospital under section 5(2) for up to 72 hours to allow a full Mental Health Act assessment to consider further detention under section 2 or 3.

Section 5(2) can only be applied by the medical consultant (responsible medical officer) or a junior doctor working under him/her (nominated deputy). The duty psychiatrist cannot apply section 5(2) on this patient.

patient and why voluntary treatment is no longer appropriate. The 72-hour period of detention allows for a full and formal MHA assessment to occur to decide whether the patient is detained for a longer period of assessment or treatment under section 2 or 3 of the MHA (see below).

Section 5(2) provides authority to detain a patient, but not to treat them. A person detained under section 5(2) may of course consent to treatment but if they do not, they can only lawfully be treated if an emergency develops as described above which warrants their treatment under the common law doctrine of necessity.

A patient detained under section 5(2) cannot lawfully be transferred to another hospital, unless such transfer is urgently necessary to treat an immediately severe or life-threatening medical condition. Transfer from a general to a psychiatric hospital must therefore await the outcome of the full MHA assessment.

## Section 2 and section 3

Section 2 allows a patient with apparent mental disorder to be detained in hospital for up to 28 days for an assessment to clarify the existence and nature of that mental disorder. Treatment can also be administered under section 2 either as part of the assessment or following on from it.

Section 3 allows for a patient with a pre-existing and already defined mental disorder to be detained in hospital for up to 6 months to receive treatment for that mental disorder. Section 3 can be applied following on from an assessment under section 2 or, in a patient where the history and diagnosis are already well known, may be the initial section applied.

In order to detain a patient under section 2 or section 3, the patient must be assessed by three professionals: two doctors and an approved social worker. The two doctors must not work for the same hospital and therefore be independent of each other. At least one must be approved under section 12 of the MHA as being experienced in mental health (essentially either a psychiatrist who has attained Membership of the Royal College of Psychiatrists or a specially trained GP).

Usually one of the two doctors is the local psychiatric consultant or SpR and the other is the patient's GP or medical or surgical consultant. The social worker must also be approved, i.e. have undergone specific postgraduate training in mental health law. Ideally all three professionals would jointly assess the patient but this is not vital.

A patient subject to section 2 or section 3 can be lawfully detained in hospital for the duration of that section. The detaining hospital can be a general or psychiatric hospital and the patient can be transferred between hospitals if necessary.

Both section 2 and section 3 give equal legal authority to treat a patient for their mental disorder (under section 2, treatment and the response to it are considered part of the assessment of the mental disorder).

This treatment can be lawfully given without the patient's consent or even against his/her express wishes; it

can be lawfully given even if the patient is fully alert and orientated, is calm, presents no immediate risk of any kind and appears to have capacity to consent or refuse this treatment.

Thus section 2 and section 3 give an almost unique power to the treating medical team to forcibly treat patients for mental disorder in situations even when the common law doctrine of necessity does not necessarily apply.

Treatment under section 2 or section 3 can only be given for the purposes of treating mental disorder. Treatment for physical illness per se is not covered by the MHA and remains subject to the same rules of informed consent as for any other patient. Only if the mental disorder is caused or clearly exacerbated by a physical disorder can treatment of physical disorders be lawfully imposed under the MHA (in such cases treatment of the physical disorder is treatment of the mental disorder) (*Figures 4 and 5*).

All patients detained under section 2 or section 3 have a right to appeal to both an independent mental health review tribunal (in essence a peripatetic court) and to the hospital managers. Both these bodies have the power to discharge a patient from detention under the MHA but not to otherwise change their clinical management.

Patients detained in general hospitals will in essence be under the joint care of the treating consultant physician or surgeon and the local consultant psychiatrist. The consultant psychiatrist becomes the RMO under the MHA and also has the power to discharge a detained patient; in addition he/she has the power to grant a detained patient temporary leave from the hospital under section 17 of the MHA.

## Conclusions

The legal situation is likely to be subject to dramatic changes in the next few years as the government attempts to introduce both a mental capacity act and a new mental health act. Proposals currently before Parliament include a community treatment order, to allow compulsory treatment outside of hospital, and wholesale reform of the tribunal system. The principles underlying any new legislation, however, are likely to be broadly similar.

This article does not attempt to cover every possible circumstance in which compulsory treatment of mental disorder may be necessary in a general hospital setting (there are 149 sections of the MHA, some of which are rarely relevant even in psychiatric practice). However, some of the most common clinical scenarios and the current legal situations are described above.

Every acute trust should have ready access to both clinical and legal advice from the local mental health trust, ideally via a dedicated psychiatric liaison team or from the mental health act administration office or the consultant psychiatrist on call. **BJHM**

*Conflict of interest: none.*

*F v West Berkshire Health Authority* (1989) All ER 545 (House of Lords Judgment)

### Further reading

British Medical Association (2004) *Assessment of Mental Capacity*. 2nd edn. BMJ Books, London  
 Jones R (2002) *Mental Health Act Manual*. 8th edn. Sweet & Maxwell, London  
 Leung W-C (2001) The new mental health act: a guide for clinicians. *Hosp Med* 62(6): 347–50  
 Zigmund T (2003) Reform of the mental health act: its direction and impact. *Hosp Med* 64(5): 260–1

**Figure 4. Organic cause for mental disorder: enforcing medical treatment under the Mental Health Act 1983.**

A 36-year-old woman with established systemic lupus erythematosus (SLE) is admitted to a general hospital under the care of a consultant rheumatologist. She has cerebral lupus which causes her to become manic; she is agitated, labile and argumentative in mood and has grandiose delusional beliefs. She begins refusing all investigations and medication and her mental state continues to deteriorate.

This patient has a mental disorder that requires treatment which she is refusing. The clear organic basis for the mental disorder does not affect the legal position. She is assessed under the Mental Health Act and detained under section 3. In this case, treatment for her SLE (a physical disorder) is de facto treatment for her mania (mental disorder) and so can be given compulsorily under section 3, including such medications as steroids and immunosuppressants.

**Figure 5. Mental illness and capacity: when the Mental Health Act 1983 cannot be used.**

A 50-year-old man is detained in the local psychiatric hospital under section 3 for compulsory treatment of paranoid schizophrenia; he has delusions that foreign spies are monitoring him and inserting thoughts into his head.

During this admission he develops severe angina pectoris and is transferred to the local general hospital for investigation. Angiography reveals severe three-vessel coronary artery disease needing semi-urgent coronary artery bypass. He refuses to consent to this, despite the dire prognosis without surgery. The cardiologists wonder whether they can proceed with surgery, as he continues to be detained under section 3 and therefore 'clearly lacks capacity'.

This patient has both a mental disorder and a physical disorder, both of which need treatment. The Mental Health Act allows compulsory treatment of his mental disorder. The act only allows compulsory treatment of physical disorder if the physical disorder is causing or clearly exacerbating the mental disorder. This is not the case here and so his Mental Health Act status is irrelevant.

A detailed assessment of this patient's mental capacity is needed. If he has capacity, then he can refuse treatment for his physical disorder and surgery cannot proceed. If he lacks capacity (when all the facts are explained to him in terms he is able to understand) then the surgeons must decide whether to proceed with surgery under the common law doctrine of necessity according to his best interests. This is the same whether or not his schizophrenia is the cause of his incapacity.

## KEY POINTS

- Patients with mental disorders sometimes need to be compulsorily treated within a general medical setting.
- Patients who lack capacity can usually be treated under the common law doctrine of necessity.
- The Mental Health Act 1983 provides the only statutory framework for longer-term treatment of mental disorder.
- Treatment for physical illness can only be given compulsorily under the Mental Health Act if this is de facto treatment for secondary mental disorder.
- The law is constantly evolving; up-to-date advice is always required. Future mental capacity and mental health acts are likely to make big changes to this area.