10 December 2024

Shared Insights

Complex medical treatment decisions for patients with mental disorder

Panel of speakers

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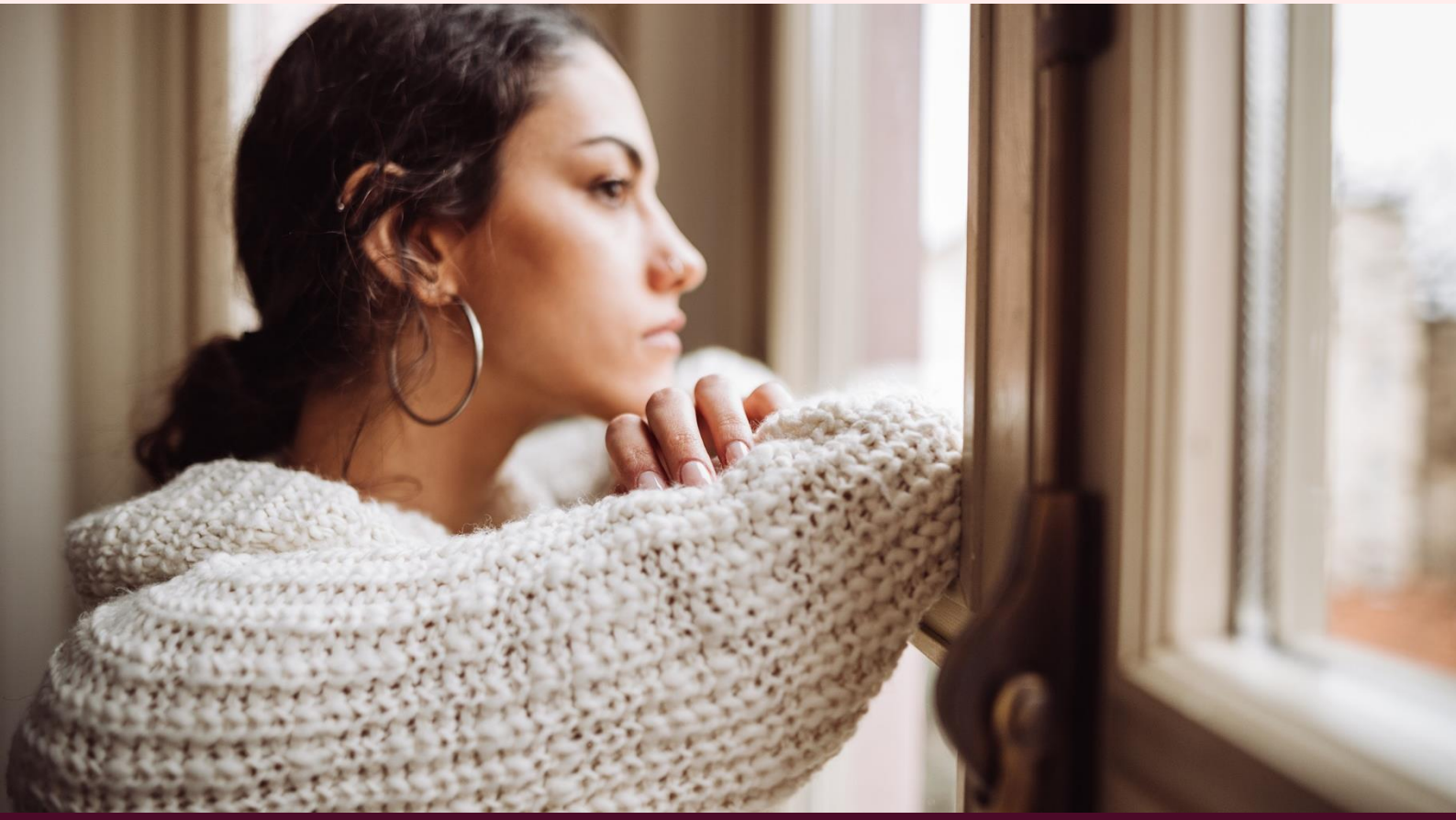
NHS
Nottinghamshire Healthcare
NHS Foundation Trust



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Introduction

During this Shared Insights session, we discussed complex medical treatment decisions for patients with a mental disorder.

We reviewed the various legal frameworks available, the conditions under which patients can make their own treatment decisions, how to assess capacity for treatment decisions and when treatment may fall under the Mental Health Act. We also looked at several complex real-life medical treatment cases and discussed areas such as restraint and mental health obstetric patients.

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How we can help

Browne Jacobson is proud to offer a team of specialist healthcare lawyers providing legal services to NHS bodies, local authorities, commissioners and independent sector providers of mental health services.

Our team has a wealth of experience in consent to treatment, mental health law and mental capacity law, making us well-equipped to provide expert advice on a broad range of legal issues. This includes:

- Consent to treatment for both adults and children, including when a patient refuses to consent.
- Assessing an individual's capacity to make treatment decisions and best interests decision making.
- Detention and treatment of patients detained under both the civil and criminal sections of the Mental Health Act.
- The interaction between the Mental Health and Mental Capacity Acts.
- Advice and representation in health and welfare cases before the Court of Protection, including serious medical treatment and end-of-life cases.
- Training for health and social care staff on consent to treatment, the Mental Capacity Act and the Mental Health Act.
- Mental health related inquests.

The team works closely with clients to provide advice and representation tailored to their specific needs, particularly in complex treatment cases for patients with mental health disorders.

"Browne Jacobson is one of the leading firms in this area in terms of medical treatment. They are excellent lawyers with brilliant knowledge of the law."

Chambers & Partners Review 2025 [Band 1]

An overview of the legal frameworks

Rebecca Fitzpatrick –
Partner, Browne Jacobson

When dealing with a complex medical treatment case, it is important to start by stripping it back to basic principles. First, determine if the person can make their own treatment decisions by considering the framework of **consent**. Valid consent must be:

- Voluntary and ongoing,
- Based on sufficient knowledge of the treatment's purpose, effects, likelihood of success, alternatives, and consequences of no treatment,
- Given by someone with the capacity to make decisions about treatment.

Capacity

The law presumes that those aged 16 and above possess the capacity to make their own decisions. Where there is any doubt, a capacity assessment must be conducted.

The Mental Capacity Act (MCA) provides the legal framework for assessing capacity. Section 3 of the MCA outlines the following test:

1. Does the person (P) have the functional ability to make the decision about treatment?
   a) Does P understand the information relevant to the decision?
   b) Can P retain the information long enough to make a decision?
   c) Can P use and weigh the information to come to a decision? (Mental disorders may interfere with this ability.)
   d) Can P communicate their decision?
2. Is there an impairment or disturbance in the functioning of the mind or brain?
3. Is there a causal nexus between the impairment or disturbance and the functional ability to make the decision?

If an individual is not detained under the Mental Health Act (MHA), or if they are detained but require treatment for a physical health disorder, the MCA can serve as the framework for treatment. The MCA applies to all forms of treatment, not solely mental health treatment.

Treatment under the MHA

Treating someone without their consent is normally a criminal offence (assault). However, Part 4 of the MHA allows treatment of a detained individual's mental disorder *without* consent – subject to certain procedural safeguards. Clinicians should always seek consent where practicable but can proceed without it if necessary. Note that Part 4 does not apply to patients held under short-term detention powers such as s.4, s.5, s.35, s.135 or s.136; for these cases, standard consent principles or the MCA should be followed in the usual way.

The provisions under Part 4 MHA allow treatment to be given without consent, largely section 63 (treatment under the direction of the Approved Clinician not requiring consent) and section 62 (urgent treatment).

Medical treatment for mental disorder that falls within Part 4 MHA is defined as treatment including "*nursing, psychological intervention and specialist mental health, rehabilitation and care…. the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations*" (see s.145). This can include interventions that are not strictly medical. This is a broad definition and case law has established that if there is a close link between the person's mental disorder and the reason why they require or are refusing treatment, then this is likely to be covered by the MHA. For instance, the force-feeding of a patient who has a diagnosis of anorexia or borderline personality disorder is permitted under section 63 MHA where there is evidence of a link between the refusal/inability to eat and the patient's mental disorder (see *Re KB [1997]*).

In *A Healthcare, B NHS Trust v CC* [2020] EWHC 574 (Fam) the court ruled that a s.3 MHA patient with psychotic depression and a mixed personality disorder who was refusing treatment and had fluctuating capacity could be given dialysis treatment without his consent under s.63 MHA as his refusal to consent was a "clear" manifestation of his mental disorder. In *Nottinghamshire HC v RC* [2014] EWCOP 1317, the court held that a blood transfusion for a patient who had engaged in significant self-harming came within s.63 MHA. Where physical healthcare treatment is provided under the MHA framework, it will be important to document how the physical issue, or the patient's decision to refuse the treatment for the physical disorder, is due to a manifestation or symptom of their mental disorder. For example, treatment for the physical effects of self-harming or P refusing to eat or refusing treatments due to mental disorder/as an act of self-harm.

However there are limits to treatment under Part 4 MHA – it will not allow treatment for physical disorders that are entirely unconnected with the person's mental disorder and nor is it appropriate to detain someone under the MHA where the primary purpose of detention is to treat the physical illness rather than the mental disorder

Restraint

Restraint, including chemical restraint, can be used under the MCA but clinicians need to clearly demonstrate that the restraint is in the person's best interests, necessary to protect them from harm and proportionate. If restraint is required to protect others, the MCA is not available. Common law powers may be used but only for a short duration.

Practicality and safety are important factors when considering the use of force to deliver treatment. For instance, providing dialysis to a mentally incapacitated individual by force would likely require significant sedation or anaesthesia, which presents significant risks for the patient. Each case will need to be assessed individually, and in some instances, NHS Trusts have determined that it is not feasible to provide regular dialysis treatment under restraint and have therefore not presented it as an option for the court to choose from.

In obstetric cases, if it is anticipated that the mother may lose capacity during birth, a detailed birth plan should be prepared to address this situation. If necessary, an application can be made to court for anticipatory declarations, allowing the court to make orders regarding the patient's best interests should capacity be lost during birth. The case of *NHS Trust & Others v FG (Rev 1)* [2014] EWCOP 30 provides guidance for clinicians caring for a pregnant woman who lacks or may lack capacity to make decisions about her obstetric care resulting from a psychiatric illness. NHS Trusts are expected to follow this guidance.

In the event of an unanticipated loss of capacity during labour with insufficient time to apply to court, clinicians can rely on sections 4B, 5, and 6 of the MCA, as well as certain common law powers, to take necessary actions deemed to be in the patient's best interests.

The Mental Health Units (Use of Force) Act 2018 governs the use of force in mental health units, including physical, mechanical, or chemical restraint and isolation.

Key takeaways

- Start by stripping cases back to basics:
  - Can the person consent to medical treatment?
  - Do they have the capacity to consent? If in doubt, apply the MCA test. If they lack capacity, the MCA can potentially be used to treat.
  - Is the person detained under the MHA and is there a close connection between their mental disorder and the reason they need or are refusing treatment? If so, the MHA can be used to treat.
- If a refusal to treatment might lead to death or serious consequences, seek legal advice at an early stage. Also seek advice in cases of uncertainty.

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A review of a forensic psychiatry case

Dr Gillian Bennett – Consultant Forensic Psychiatrist,
Nottingham Healthcare NHS Foundation Trust

Dr Bennett discussed a complex treatment case that she was involved with. As a Consultant Forensic Psychiatrist at Nottingham Healthcare NHS Foundation Trust, Dr Bennett provides mental healthcare services to prisoners.

Case study

This case involved a 32-year-old patient (R) who was serving a life sentence for murder and had moved to a prison in Nottinghamshire in August 2020. His notes evidenced some intermittent psychotic symptoms since July 2018, but he also was using "spice" (synthetic cannabis) and Subutex (opioid medication). From 2021 onwards there was no objective evidence of psychosis, but R was intermittently mute and was refusing to eat.

R was referred to and accepted by a medium secure unit (MSU) in September 2022 and was placed on their waiting list. The working diagnosis was a psychotic disorder driving food refusal.

In January 2023, R's BMI had dropped to 14. He had four admissions to an acute hospital but all the investigations returned normal results. There was no urgency for artificial feeding at this time.

R's fifth admission to the acute hospital in February 2023 was precipitated by hypoglycaemia – it could have resulted in his death in prison had it not been identified in time. R came under the care of a gastroenterologist on admission to hospital. He was accepting of intravenous (IV) fluids but would not accept a nasogastric (NG) feeding tube.

Had R been detained under the MHA, he could have been treated under s.63, given that there was a link between his mental disorder and his refusal to eat. However, R was not detained and could not be admitted to the MSU as he was not medically well enough.

Theoretically, R could have been detained under the MHA at the acute hospital, but not all acute hospitals permit this and the Ministry of Justice (MoJ) would have needed to issue a warrant for it. There were also questions over who would serve as the Responsible Clinician if R was detained in an acute hospital and how the security aspects would be managed, as prison officers would leave, leading to gaps in the security arrangements. Therefore, this option was not feasible.

The remaining option was to apply to the Court of Protection (CoP) for an order permitting NG feeding and oral antipsychotics, including the use of restraint, at the acute hospital. This was on the basis that R lacked the capacity to make treatment decisions for himself. The application was duly made and two hearings were held in February 2023. The court initially agreed to the provision of nutrition, hydration and antipsychotics, delivered via the NG tube, for a week. Restraint could also be used to reinsert the tube if it became dislodged. After one week, R's body weight was still very low but the risk of refeeding syndrome was no longer as high, and he was therefore well enough to be transferred to the MSU.

In terms of CoP process, it took a lot of time and effort to prepare the case and senior personnel, including the Deputy Director for Forensic Services, needed to be involved. Several meetings, including best interests meetings with R's family, were held and several witness statements were prepared. Dr Bennett also gave evidence in court. Two court hearings were required before R could be transferred to the MSU.

Key takeaways

The case illustrates that if your preferred option of treating under the MHA is not available, then there might be an option to treat under the MCA if the patient lacks capacity to make decisions about their treatment.

Case law examples

Ed Pollard – Partner
Browne Jacobson

Ed gave an overview of some cases involving treatment and restraint under the MCA.

Dialysis cases

Ed was involved in a case where the individual required dialysis but lacked the capacity to make decisions about the treatment. The Trust was very clear from the outset that restraining the patient to administer dialysis would be practically difficult and potentially dangerous. When making the application to court to determine what was in the patient's best interests, the Trust made it clear that restraining the patient to deliver dialysis was not an option available for the Court to consider.

Therefore, in complex medical treatment cases, if there is a clinical option that clinicians are not willing to provide, it is important to clearly communicate this to the court.

The case of *Manchester University NHS Foundation Trust v WV* [2022] EWCOP 9 illustrates that a Trust's initial stance on the risks or potential harm of a particular treatment can evolve during the course of judicial proceedings as evidence is scrutinised. This case involved a 17-year-old male with learning disabilities, autism, and ADHD who needed a kidney transplant. Initially, the clinicians deemed the procedure and subsequent treatment unfeasible due to the anticipated harm to the patient.

However, after reflecting upon the evidence given at the hearing, the Trust adopted a neutral position and agreed that it should be for the court to decide what would serve WV's best interests. The court ultimately decided that the transplant should proceed.

Eating disorder cases

Eating disorder cases frequently arise in the Court of Protection. Treatment for eating disorders can be provided under section 63 MHA; however, if a person is not detained, the MCA applies. The treatment approach will depend on whether the individual has capacity, which can often be a complex issue.

For patients lacking capacity, the level of restraint necessary to facilitate feeding might influence the assessment of whether treatment aligns with the individual's best interests.

Capacity may vary across different domains

There can be instances where an individual is considered to possess capacity in all areas except the one being evaluated by the court. Ed was involved in the case of *Re Patricia* [2023] EWCOP 42, which concerned a young woman with anorexia nervosa who was dangerously close to death. Although there was consensus that Patricia had the capacity to litigate and provide instructions to her own lawyers, there was disagreement regarding her capacity to make decisions about medical treatment for her anorexia. The Judge, underscoring the rarity of such cases by comparing them to 'a snow leopard', ultimately determined that despite having capacity in many areas, Patricia lacked the necessary capacity to make medical treatment decisions regarding her anorexia.

Mental health obstetric cases

For obstetric cases, if there is a chance the woman may lose capacity during pregnancy or labour, a detailed birth plan should be created with the patient. Disputes about the patient's best interests may need court resolution. If capacity is lost unexpectedly during labour, clinicians can act in the patient's best interests. The focus is on the mother's best interests, not the unborn child's, as the baby is not a legal entity until it takes a breath. However, the mother's best interests include having a healthy baby.

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Resources

- Guidance for clinicians caring for a pregnant woman who lacks or may lack capacity to make decisions about her obstetric care resulting from a psychiatric illness is contained at the end of the judgment for the case of *NHS Trust & Others v FG* (Rev 1) [2014] EWCOP 30.
- Notes from our previous Shared Insights session on the Mental Health Units (Use of Force) Act 2018, which governs the use of force in mental health units (including physical, mechanical, or chemical restraint and isolation) can be found here.
- The judgment from the first case discussed by Dr Bennett can be found here.
- The judgment from the *Manchester University NHS Foundation Trust v WV* [2022] EWCOP 9 case can be found here.
- The judgment from Ed's case of *Re Patricia* [2023] EWCOP 42 can be found here.
- We have previously written an article on an obstetric case involving an MHA/MCA crossover. In the case of *Rotherham, Doncaster and South Humber NHS Foundation Trust v NR and another* [2024] EWCOP 17, the Court of Protection considered whether a 35 year old pregnant woman, NR, who was detained under the MHA, had the capacity decide whether to have a termination and whether such a procedure was in her best interests.
- All of our mental health and mental capacity related articles can be found here on our website.

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