ADRTs and section 63 of the MHA

Advance Decisions to Refuse Treatment (ADRTs) allow for the refusal of particular treatment to persist through an individual's loss of capacity to give or refuse consent.

Advance Decisions to Refuse Treatment should only be considered where the patient does not have the contemporaneous capacity to consent to or refuse treatment.

Valid and applicable Advance Decisions to Refuse Treatment (ADRTs) can be 'overridden' if they are refusing treatment for mental disorder and the individual is detained under a relevant section of the Mental Health Act (meaning their treatment is governed by Part 4 of that Act).

This raises several interesting questions about the scope of 'treatment for mental disorder' and how far this extends, and therefore in what circumstances people with mental disorder may be able to refuse treatment.

Advance Decisions to Refuse Treatment

Section 24 of the MCA provides for ADRTs. This puts into legislation the previous common law position around advance directives.

One of the features of advance decisions is that "the burden of proof is on those who seek to establish the existence and continuing validity and applicability…..If there is doubt that doubt falls to be resolved in favour of the preservation of life" (HE v A Hospital NHS Trust [2003] EWHC 1017).

It is difficult to see how sufficient information on which to base a decision could have been provided without the involvement of a healthcare professional (although this argument may be deteriorating due to the availability of information on the internet)

"Where there is any doubt [as to the validity and applicability], a clinician can safely treat someone and receive protection from liability" St Comm. A, para. 225. Section 26 of the MCA spells this out:

(2) A person does not incur liability for carrying out or continuing the treatment, unless, at the time, he is satisfied that an advance decision exists which is valid and applicable to the treatment.

(3) A person does not incur liability for the consequences of withholding or withdrawing a treatment from P if, at the time, he reasonably believes that an advance decision exists which is valid and applicable to the treatment.

"Treatment should not be delayed while attempts are made to establish whether an advance decision has been made if the delay would prejudice the patient's health" (Jones MCA Manual 1-217)

Validity and Applicability

An advance decision is not valid if P:

- Has withdrawn the decision whilst he still had capacity (can be done orally)
- Made an LPA since making the ADRT and the LPA has decision-making authority for the particular treatment
- Has acted in a way clearly inconsistent with the ADRT (e.g. made because of faith but faith now abandoned)

An advance decision is not applicable if

- P has capacity to consent to or refuse the proposed treatment
- The proposed treatment is not that stipulated in the ADRT
- Any circumstances specified in the ADRT are absent
- There are reasonable grounds for believing that circumstances exist which P did not anticipate when making the ADRT which may have affected their decision (e.g. development of new treatments without previous side effects, existence of dependents)

For life-sustaining treatment the ADRT must be in writing, witnessed and signed by the patient (or another person in his presence and under his direction) and the witness.

In order to determine validity and applicability a clinician may need to examine:

- Any doubts about the patient's capacity at the time of making the ADRT
- The information that the patient received about the treatment and the consequences of their decision
- The circumstances surrounding the making of the ADRT
- The possible effect of undue influence
- Whether the ADRT is applicable to the proposed treatment and was intended to apply in the circumstances that have arisen

Where an ADRT is **not** found to be valid and applicable treatment can be given in a patient's best interests under the Mental Capacity Act (as they will lack capacity to consent to or refuse treatment or the ADRT would not have been examined in the first place).

A valid and applicable ADRT has the same effect as someone with capacity refusing treatment.

The Court of Protection has no power to override a valid and applicable ADRT

Overriding an ADRT using the MHA

Section 28 of the MCA has the effect that an otherwise valid and applicable ADRT can be overridden by the provisions of ss58 and 63 of the MHA for patients whose treatment for mental disorder is governed by part 4 of the MHA (detained under a section authorising treatment) (just as an individual's capacitous refusal can be overridden).

Section 58 is concerned with the administration of medication. Medication is identified by its chemical composition and not its method of administration, such that liquid food is not a medication. Only medication that is prescribed as treatment for mental disorder or to relieve the symptoms of mental disorder comes within the scope of this section (or medicines that are ancillary to the core treatment e.g. antiparkinsonian alongside anti-psychotic). Medicines do not fall within the scope of this section merely because they have an effect on mental state. An ADRT refusing medication can therefore be overridden if the patient is detained under a relevant section of the MHA and the medication is given for the treatment of mental disorder.

Section 63 is concerned with medical treatment (in alternative forms to medication) for mental disorder given under the direction of an approved clinician. It states that consent is not required for medical treatment in these situations. As with section 58, the scope extends to treatment for symptoms or consequences of the mental disorder or treatment ancillary to the core treatment as well as treatment of the mental disorder. This would therefore cover: blood tests for patients taking clozapine, seclusion, therapies etc. An ADRT refusing medical treatment can therefore be overridden if the patient is detained under a relevant section of the MHA and the treatment is for mental disorder.

ECT can be given despite a valid and applicable ADRT refusing it only in the circumstances of an emergency, as per MHA s58A(5) &(9) and s62 (1)(a)&(b) – i.e. immediately necessary to save life or immediately necessary to prevent a serious deterioration of his condition.

These provisions therefore make the situation synonymous between detained patients who lack capacity and have ADRTs and detained patients with capacity who are refusing treatment.

ADRTs which can legally be overridden should still be considered to express patient wishes and feelings, which should be considered as part of the guiding principles of the MHA (MHA Code of Practice para. 17.8).

ADRTs and Suicide attempts

Several questions have been raised about the possibility of making an ADRT prior to a suicide attempt to prevent healthcare professionals from trying to save life.

Validity & Applicability of the ADRT

One of the first confirmations that is required when establishing if an ADRT is valid and applicable is whether the individual had mental capacity to make the advance decision at the time they made it.

The first principle of the Mental Capacity Act is that everyone aged 16 or over should be assumed to have capacity and therefore it should be assumed that the individual had capacity to make the ADRT unless there are reasonable grounds to think otherwise, which may make the ADRT inapplicable.

Simply because someone has a mental disorder does not mean they lack capacity, although this will obviously be an important consideration.

Simply because someone wishes to commit suicide does not mean they lack capacity.

However, in Re T (Adult : Refusal of Treatment) [1992] 4 All ER 649 it was suggested that a high level of capacity would be required to make such a decision.

The same criteria should be applied to determining the validity and applicability of an ADRT refusing treatment following a suicide attempt as set out above for all ADRTs.

If the ADRT's validity and applicability is not disputed then the ADRT must be respected (unless it can be overridden using the MHA – although see 'things to consider' below). Re W (Adult: Refusal of Medical Treatment) [2002] EWHC 901 stated that a valid advance decision to the effect that he/she is not to be resuscitated if found in an unconscious state after attempting suicide was to be respected.

Use of the Metal Health Act

However, as highlighted above, where a patient is detained under a relevant section of the Mental Health Act the ADRT could be overridden if it relates to medication or treatment covered by sections 58 or 63.

In B v Croydon Health Authority [1995] All ER 683 the Court of Appeal found that feeding by nasogastric tube was treatment within the scope of s63 where it was treatment aimed at a symptom of the disorder which was a refusal to eat in order to inflict self harm. This was further applied to an individual with anorexia in Re KB [1997] 2 FLR 180.

In R v Collins and Ashworth Hospital Authority [2000] MHLR 17, hunger strike was found to be a symptom of the patient's personality disorder and therefore force feeding came within section 63.

Treatment under section 63 "also includes medical and surgical treatment for the physical consequences of self-poisoning or self-injury if the self-poisoning or self-injury can be categorised as either the consequence or symptom of the patient's mental disorder" (Jones MHA Manual 1-731).

The key things here will be:

- That the patient is detained under a relevant section of the MHA
- That it can be shown that the suicide attempt was a consequence or symptom of their mental disorder

Things to consider:

- If a patient is not detained prior to the suicide attempt then would it be lawful to detain them simply to use section 63 to save their life following a suicide attempt (how thorough could the assessment be, especially if the patient was already unconscious)?
- In any case, if the ADRT is found to be valid and applicable then the patient is deemed to have had capacity to make the decision to refuse treatment. Therefore, it would be hard to see how the suicide attempt could be a symptom of their mental disorder, meaning sections 58 and 63 would not be applicable anyway, even if you were able to detain them.
- If the suicide attempt can be directly linked to a mental disorder then it should be considered whether the patient could have had the capacity to make the ADRT in the time period during which they were suffering from the mental disorder.
- If a patient is detained prior to a suicide attempt then it should be clear whether the suicide attempt is a symptom or consequence of their mental disorder and therefore whether the proposed treatment is within the scope of section 63.
- If a patient is detained prior to a suicide attempt then section 63 would authorise treatment aimed at preventing or diminishing symptoms or consequences of the mental disorder.

If in doubt seek advice from your line manger in the first instance.

360 Assurance can provide training on all aspects of the Mental Capacity Act and the Mental Health Act. For more information please contact elaine.dower@nhs.net.