ECT and the law

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Outline

• Assault
• Mental health law in E&W
  • MHA
  • ECT in general hospital
  • MCA
  • DOLS
• Scotland, NI, ROI (briefly)
• Negligence
Assault

• Touching without authority could be assault

• Authority can come from:
  • Valid consent
  • MHA
  • LPA or court-appointed deputy
  • Court declaration (not strictly authority, but a declaration that Rx is lawful)
  • Best interests decision in a person lacking capacity
England and Wales
MHA s58A(3) – adults with capacity who consent

• ECT may be given to a detained patient in three circumstances:
  • P is 18 or over,
  • P has consented, and
  • RC or SOAD has certified that P is capable of understanding the nature, purpose and likely effects and has consented to it
MHA s58A (4) – minors

- P is under 18,
- P has consented,
- SOAD has certified that P is capable of consenting, and has consented, and
- ECT is appropriate.
MHA s58A (5) – person lacks capacity

- RC or SOAD has certified that:
  - P is not capable of understanding nature, purpose and likely effects
  - ECT is appropriate
  - ECT would not conflict with valid and applicable advance decision
  - ECT would not conflict with a decision of a donee of LPA or court-appointed deputy

- ss(7) says that above does not confer authority to give ECT to P who lacks capacity (implying that giving ECT would be a best interests decision under MCA)
MHA 1983 s60

• P may withdraw consent at any time if he has capacity at that time (even if he lacked it at the beginning of the course of treatment)
MHA s62 Urgent treatment

• s58A does not apply to treatment
  • which is immediately necessary to save P’s life; or
  • which (not being irreversible or hazardous) is immediately necessary to prevent serious deterioration
ECT in general hospital under MHA

• Which is the detaining authority – general or psych trust?
ECT if P on s17 leave from psych hospital to general hospital

Key legal issues:

• (1) Can you impose ECT (or other treatment) to a patient who is on leave? YES (N.B. not if they are on CTO – must recall to treat)

• (2) Does s17 give authority to deprive of liberty? Uncertain. S17(7) allows P to be ‘kept in custody...for the purpose of giving effect to a condition...by a person authorised in that behalf by the condition’, so it may be lawful if you have made ECT a specific condition of leave and have specifically authorised the general hospital to keep them in custody.

  • If s17(7) does not in fact authorise DOL, then you cannnot use the usual MCA DOLS procedures because P is ineligible while on leave if the purpose is treatment of mental disorder.
Detained by psych hospital, on leave to gen hosp

• Will have to be on s17 leave to general hospital specifically for ECT
• Can make accepting medication and ECT a condition of leave, provided that P understands this
• Can give ECT under s58A if P lacks capacity, but consider if ECT engages DOLS. But if on s17 leave, ineligible for DOLS (MCA Schedule 1A(4)(2)).
• Cannot give ECT under s58A if P under CTO unless P consents and SOAD certifies
• Must have an AC from the detaining hospital, though can delegate day to day care to a psychiatrist at the general hospital (if they have one)
• AC at detaining hospital continues to be responsible for renewals of detention and certificates under part IV (treatment)
• Need to clarify who is RC out of hours
• If P lacks capacity, MCA instead of MHA? Must consider DOLS, cannot use if P objects
Detained by general hospital

• Hospital must be registered as a psychiatric hospital
• General hospital managers have to be capable of receiving applications for admission, ensuring that P’s rights are protected, ensuring there is a process for appeals to managers and tribunal, managing renewals, leave, etc.
• Needs RC at the hospital
• If P lacks capacity, consider if DOLS applies
England and Wales

Mental Capacity Act (2005)
MCA principles

• Presume capacity
• Must provide all possible assistance to make a decision
• Must not treat as unable to decide because of unwise decision
• Best interests (must consider P’s past and present wishes, P’s beliefs and values, views of carers and others – MCA s4)
• Least restrictive (GA is very restrictive)
Test of incapacity

(1) impairment of, or disturbance in functioning of, mind or brain which results in

(2) inability to:
   • understand relevant information, and/or
   • retain it, and/or
   • use or weigh it, and/or
   • communicate decision
‘The flack jacket’ (ss 5 and 6)

• D is not liable for an act of care or treatment if he takes:
  • reasonable steps to establish that P lacks capacity
  • reasonable belief in P’s best interests
• Does not override advance decisions
• Does not protect against negligence
Restraint

• Restraint permitted if
  • Necessary to prevent harm to P
  • Proportionate response to likelihood and seriousness of the harm

• Restraint is use or threat of force where P resists, or restriction of liberty, whether or not P resists
Advance decisions to refuse treatment

- MCA ss 24-26
- Can make an AD to refuse ECT
- Must be valid and applicable
- Can be withdrawn
- Can be overridden by an LPA-HW created later which covers the Rx
- Can be overridden if new circumstances have arisen which P did not anticipate (reasonable grounds for belief)
- Need not be written (unless to refuse life-sustaining treatment, in which case must be signed and witnessed)
- Be very careful if AD conflicts with your view of best interests
DOLS

• P is deprived of liberty if he is under continuous care and supervision, and is not free to leave (Cheshire West)

• DOL requires authorization from local authority

• 6 criteria must be met:
  • Age
  • Mental health
  • Mental capacity
  • Best interest
  • Eligibility
  • No refusals
Eligibility for DOLS in relation to ECT

- Determined by Schedule 1A of MCA (complex!)
- Ineligible if detained under MHA
- Ineligible if on CTO or guardianship (Sch 1A (4)(2)*)
- Ineligible if on s17 leave (Sch 1A (4)(2)*)
- Ineligible if donee of LPA or deputy objects
- Ineligible if P is ‘within scope’ of MHA but objects to all or part of the treatment

*if what is proposed is medical treatment for mental disorder in hospital
What is an objection wrt DOLS?

• In determining whether P objects to being a mental health patient or to some or all of the mental health treatment -
• ‘Regard must be had to all the circumstances including:
  • P’s behaviour
  • P’s wishes and feelings
  • P’s views, beliefs and values
  • but regard is to be had for circumstances from the past only so far as is still appropriate to have regard to them’
Does giving ECT amount to a DOL?

• Fact specific
• Acid test: is P subject to continuous supervision and control?
• Lack of objection is not relevant to whether or not it is a DOL
• Not relevant that ECT may be in P’s best interests
• Currently there appears to be a large number of people in general hospitals who meet this test but whose DOL has not in fact been authorized
• If P objects and lacks capacity DOL cannot be authorized, so consider MHA
• Lack of case law, so uncertain
ECT under MCA

Provided that:

- P lacks capacity and does not object, and
- There is no objection (under LPA or deputyship), and
- If there is a DOL (as there probably is for a P in hospital) then this has been authorised by the Supervisory Body in the usual way, then
- ECT under MCA would appear to be lawful (though this is complex and could be changed by new case law).
- If P is having outpatient ECT, then arguably there may still be a DOL requiring authorization during the few hours when ECT is being given
- The legal position under MHA is much more clear-cut, though some might consider it more restrictive (others consider it less restrictive as patients' rights are arguably better protected).
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* Not clear if it is lawful to detain P in one hospital while on s17 leave from another. S17(7) suggests that, if authorised, it may be.

** ECT under MCA might be lawful, but if there is a DOL, cannot authorize it if P on s17 leave, so will not be lawful.
ECT law – a ‘simple’ summary

• If P has capacity and objects, ECT is not permitted
• If P has capacity, consents and is not detained, just need usual consent procedure
• If P lacks capacity, the law on ECT is mind-bogglingly complex, even for judges. New cases may change the interpretation of the law.
• The MHA is probably the clearest and legally most secure route to lawful ECT where P lacks capacity
• If P is at a general hospital, lacks capacity and needs ECT, detain under MHA to general hospital if practicable
Scotland
Scotland

• Two acts:
  • Adults with Incapacity Act (Scotland) 2000
  • Mental Health (Care and treatment) (Scotland) Act 2003

• ECT cannot be given to a competent patient who refuses
Adults with Incapacity Act (Scotland) 2000

• s47 gives general authority to treat but excludes ECT
• s48 requires designated second opinion practitioner to complete a prescribed form
• Proxy decision-makers (eg welfare attorneys or guardians) cannot consent to ECT
Mental Health (Care and treatment) (Scotland) Act 2003

• 10 principles

• Patients detained by a short term detention certificate (STDC) may be given ECT only if:
  • they can and do consent (form T2), or
  • if they are incapable of consenting, treatment is authorised by DMP as being in best interests (form T3)

• If P objects or resists, ECT can be given only if:
  • P lacks capacity
  • ECT is necessary to save life, prevent serious deterioration, or alleviate serious suffering
Advance statements (Scotland)

• P can specify what type of treatment he would or would not like to receive
• Clinician must have regard to AS, but does not have to follow it
• If overridden, reasons just be given in writing and copied to patient, named person, welfare attorney, guardian, and Mental Welfare Commission
N. Ireland
Northern Ireland

• Mental Health (Northern Ireland) Order 1986
• ECT may be given to P if he consents, or, if detained, where second opinion has been obtained
• Emergency treatment can be given
• Mental Capacity Act (Northern Ireland) 2016 became law on 09/05/2016, but is not yet implemented. Currently, no legislation about mental capacity in force
Ireland
Ireland

• Irish Mental Health Act 2001
• Code of Practice (2009), Rules (2010) specify what information must be given to P, cognitive and physical assessments, conditions for administration of ECT, staffing levels in ECT suite
• Majority (90% in 2012) of ECT is given with valid informed consent
• Recent amendment: ECT can not be given to detained patient if has capacity and refuses.
Negligence
What is negligence?

1. Duty of care to P
2. Breach of duty
3. Harm to P results from breach of duty
1957 ECT case

• P given unmodified ECT, voluntary patient, sustained acetabular fractures. P sued, alleging hospital negligently failed to give muscle relaxant, failed to provide manual restraint, and failed to warn him of the risks.

• What is the name of the patient?
• Did he win the case?
What is the name of the patient?

- Mr Bolam!
- P lost the case because, where a doctor had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment, he was not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique.
Negligence since Bolam – informed consent

• Major change in law on informed consent: Montgomery v Lanarkshire Health Board [2015] UKSC 11
• Pregnant diabetic P not warned of risk of shoulder dystocia
• Consultant thought that if he told P of the risk, she would opt for Caesarean, which he thought was not in her best interests
• Supreme Court said a doctor is under a duty to tell P of any material risk and of any reasonable alternative treatment. A risk is material if a reasonable person in P’s situation would be likely to attach significance to the risk.
• Very limited ‘therapeutic exception’ if disclosure would be seriously detrimental to P’s health.
Negligence since Bolam – role of the court

- Court is entitled to consider whether or not a view expressed by doctors, even if reputable and experienced, is capable of withstanding logical analysis.
- Court may find negligence, even if Bolam test is satisfied
Key points

• Must not give ECT to a competent P who refuses
• ECT while on s17 leave to general hospital is legally problematic, partly because powers to detain in gen hosp under s17 are limited, and partly because, if giving ECT results in DOL, then cannot authorize DOL while on s17 leave in hospital for treatment. Probably legally best to detain P to the general hospital if possible. Uncertain area, get advice.
• Not clear if ECT amounts to DOL. If it does, need to consider requesting DOLS authorization for ECT under MCA if P lacks capacity and does not object.
• If P lacks capacity and objects, probably cannot give ECT to a patient under MCA (since ECT may involve a DOL, which cannot be authorized for treatment of mental disorder). You avoid this complex issue by using MHA.
• If P lacks capacity, does not object and is on s17 leave, probably cannot give ECT as DOLS cannot be authorized.
• Consider effect of an advance decision to refuse ECT carefully. Binding in E&W if valid and applicable. Strongly persuasive, but not binding, in Scotland.