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Management of vulnerable adult patients seeking to leave hospital: Understanding and using relevant legislation

A clinical case of a patient suffering from medical illness, mental disorder, and self-neglect highlights which legislation doctors should follow when balancing the need to preserve patient autonomy and protect vulnerable patients by keeping them in hospital.

ABSTRACT: British Columbia has three pieces of legislation that are relevant to the protection and treatment of vulnerable adults who require hospitalization but decline to stay voluntarily: the Health Care (Consent) and Care Facility (Admission) Act (HCCCFAA), Mental Health Act (MHA), and Adult Guardianship Act (AGA). Patients may require hospitalization for multiple reasons, in which case more than one piece of legislation may be used simultaneously. However, physicians are often uncertain about when and how to exercise the appropriate legislation, what the legislation actually permits, and what documentation is required. To our knowledge, there currently are no publications regarding how these three acts intersect as related to the hospitalization of vulnerable individuals. Compounding this problem are gaps in the legislation that can predispose health care providers to inappropriately use the Mental Health Act, which is being increasingly scrutinized following a report by the BC Office of the Ombudsperson.

The HCCCFAA is applicable when hospitalization is required for treatment of medical illness. Adult patients who are capable of making a decision about receiving health care can either consent to or refuse treatment. Management of patients who are incapable of making a decision regarding their medical treatment may be treated in an emergency, including ongoing hospitalization, if a substitute decision-maker is not available to provide consent. In nonemergency settings, consent from a temporary substitute decision-maker must be obtained.

The MHA applies to cases where a person with mental illness would pose significant risks if their mental health disorders were left untreated. The MHA authorizes involuntary psychiatric treatment only. Currently, certified patients, even those who are capable of making their own treatment decisions, cannot refuse psychiatric treatment proposed by the treating physician.

The AGA applies to patients 19 years or older who appear to be experiencing abuse, neglect, or self-neglect and are suspected of not being able to seek support and assistance. The AGA allows for involuntary short-term hospitalization while an investigation and safety planning are being conducted. If risk of abuse, neglect, or self-neglect as well as the inability to seek support and assistance is proven, a support and assistance plan can be put in place following discharge from hospital to help mitigate risk.

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In the general hospital setting, patients often wish to leave hospital before doctors and other health care providers feel it is safe to discharge them. There can be multiple reasons for this, such as the patient requiring ongoing treatment of a medical illness or psychiatric treatment of a mental disorder, or they are at risk of abuse, neglect, or self-neglect due to their social circumstances. Balancing the often competing interests of protecting vulnerable patients and preserving patient autonomy can leave physicians unsure of the most appropriate course of action. To identify which piece of legislation is most relevant, it can be helpful to start with the question: Why does the patient require ongoing hospitalization **[see the Figure]**? Patients may require hospitalization for multiple reasons, in which case more than one piece of legislation may be used simultaneously.

A clinical case

Ms Safe* is a 55-year-old single female who lives alone and is a T6 paraplegic from a motor vehicle accident. She has chronic ischial wounds

**Ms Safe is a fictional composite patient.*

that have necessitated previous hospital admissions for 6 weeks of IV antibiotic treatment. She now requires daily wound care from home health nursing staff and regular offloading to avoid a recurrence of osteomyelitis. However, she is often not compliant with offloading, and she removes the wound dressings.

Ms Safe is brought to hospital by ambulance after her wound care nurse calls 911, saying that "the wound is down to the bone." The ambulance report indicates that Ms Safe has refused to come to hospital for several weeks. An infectious disease specialist confirms she requires another 6 weeks of IV antibiotics for treatment of osteomyelitis. Ms Safe tells the hospitalist she wants to leave hospital, so the hospitalist asks a psychiatrist for a second opinion regarding her capacity.

Both the treating hospitalist and consulting psychiatrist find Ms Safe incapable of consenting to ongoing hospitalization and IV antibiotics because she says she will "be fine" without further medical treatment. Ms Safe is held in hospital and treated for her medical illness under the Health Care (Consent) and Care Facility (Admission) Act (HCCCFAA), given her incapacity, emergent nature of needing treatment, and lack of available temporary substitute decision-maker. Eventually, temporary substitute decision-maker consent is obtained from the Public Guardian and Trustee.

Several days later, Ms Safe complains that nurses are putting a chip under her skin that is being used to track her, which is why she removes her dressings. A chart review reveals that Ms Safe was trialed on risperidone during her most recent hospitalization for osteomyelitis but that she did not take the antipsychotic following discharge. Ms Safe is currently refusing oral antipsychotics.

Ms Safe is certified under the Mental Health Act (MHA) and treated with oral risperidone for 1 month before she is switched to a depot intramuscular formulation of risperidone, given her history of noncompliance. She is released on extended leave to ensure compliance with psychiatric treatment in the community. Ms Safe's psychosis remits with risperidone treatment, and she no longer removes her bandages. However, she is still noncompliant with offloading and has another recurrence of osteomyelitis that requires readmission to hospital 1 month after discharge. Readmission is again prompted by wound care nurses calling 911.

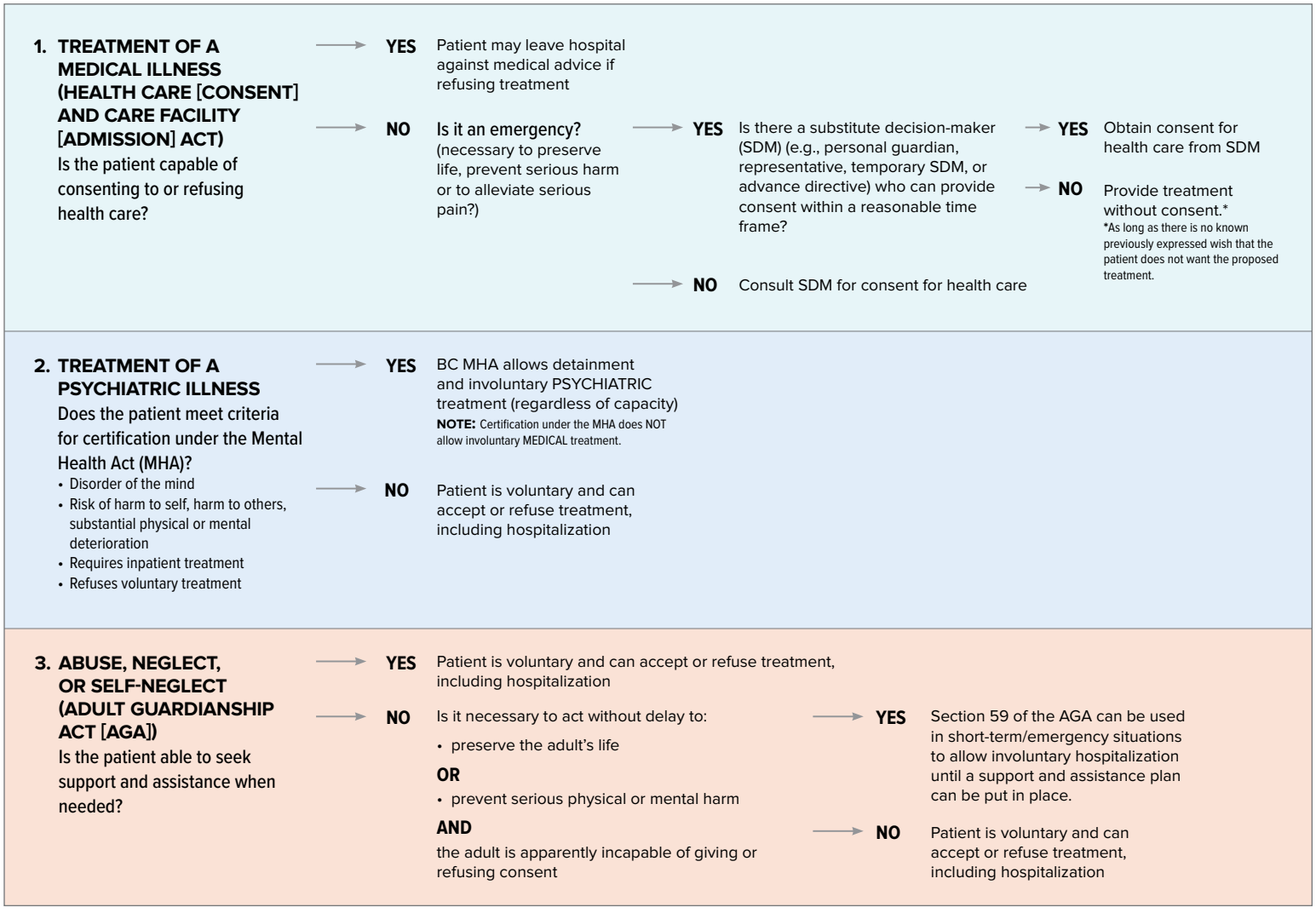

FIGURE. Reasons for hospitalization.

After further investigation by a social worker, it is determined that Ms Safe meets criteria for Section 59 of the Adult Guardianship Act (AGA) because of self-neglect, and she is held in hospital for 1 week after her IV antibiotic treatment has been completed to allow a support and assistance plan (SAP) to be put in place. The SAP includes home care nursing support four times a day to encourage offloading, regular wound care, and help with personal hygiene. Home health nursing staff and community social workers monitor Ms Safe's compliance with the SAP. Ms Safe has not presented to hospital for 6 months since the time of her last discharge, which is significantly longer than the interval between her last three visits to hospital.

Health Care (Consent) and Care Facility (Admission) Act

When does the HCCCFAA apply?

The HCCCFAA applies to all health care for adults 19 years and older. "Health care" is defined as "anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other purpose related to health."[1] Hospitalization for the purposes of providing health care is part of the health care treatment plan and can either be consented to or refused by patients who are capable of making this decision. In the case of Ms Safe, the HCCCFAA was the first applicable legislation because the initial indication for hospitalization was medical treatment.

All patients who are capable of providing consent for health care must do so before treatment can be delivered, unless it is an emergency.[2] Capacity to consent is specific to the treatment being proposed and must be assessed by the physician who is proposing treatment. However, as the Canadian Medical Protective Association advises, any physician who is uncertain whether a patient has the capacity necessary to provide consent in a nonemergency situation may wish to obtain a second opinion from a colleague.[3] Often psychiatrists are called upon to provide a second opinion.

What does the HCCCFAA permit?

If a patient is capable of refusing treatment, including ongoing hospitalization, they may leave hospital against medical advice. However, if the patient is incapable of refusing treatment, further management hinges on whether the treatment is considered an emergency. Emergencies are defined as anything that is "necessary to preserve life, prevent serious harm or to alleviate serious pain,"[1] and requires clinical judgment by the treating physician. In the event of an emergency where the patient has not previously expressed wishes declining consent for a related intervention, the physician may provide emergency health care treatment, including ongoing hospitalization, if a substitute decision-maker is not available to provide consent. In the case of Ms Safe, she was incapable of providing consent and wanted to leave the emergency room immediately. Given her risk of serious harm without treatment, she was kept in hospital under the emergency provisions of the HCCCFAA until a suitable and available substitute decision-maker could be located.

Capacity to consent is specific to the treatment being proposed and must be assessed by the physician who is proposing treatment.

In the absence of an advance directive, substitute decision-makers are selected according to a hierarchy outlined in the HCCCFAA. The highest ranking substitute decision-maker is the personal guardian (committee of the person), who is appointed by a judge under the Patients Property Act. The next highest ranking substitute decision-maker is a representative, who is appointed under the Representation Agreement Act. Health care providers should ask to see the court order appointing the committee, or the representation agreement, before obtaining substitute consent, particularly because there are different scopes of a representative's authority.[2] However, in most cases, patients who are incapable of providing consent for nonemergency treatment require consent from a temporary substitute decision-maker, as outlined in the hierarchy of the HCCCFAA.[1] The temporary substitute decision-maker is often not the same as the next of kin or contact person listed on the hospital chart. For individuals who do not have a suitable temporary substitute decision-maker, the office of the Public Guardian and Trustee can be reached during regular business hours to obtain substitute consent for nonemergency health care. Hospital social workers are often called upon to help identify a temporary substitute decision-maker because they are familiar with the selection hierarchy and the requirements of the decision-maker.

Patients should be verbally notified by the physician about the finding of incapacity to make a treatment decision, but currently there is no formal process for patients in BC to appeal that finding.

What does the HCCCFAA not include?

The HCCCFAA does not include involuntary psychiatric treatment for patients admitted to hospital under the MHA. It also does not address treatment or other control measures of reportable communicable diseases, regardless of patient capacity, in accordance with the Public Health Act: Health Act Communicable Disease Regulation.[4]

What is required for HCCCFAA documentation?

No specific form is required for use of the HCCCFAA. If a physician deems a patient incapable of making a medical treatment decision, they must document their opinion, along with brief reasons, in the patient's chart. In the case of Ms Safe, she was documented as incapable because she failed to appreciate the foreseeable consequences of declining treatment—she said she would "be fine," despite a substantial risk of worsening infection, sepsis, and death without treatment. Physicians must also document who has provided consent for treatment in nonemergency situations—either the patient, or a substitute decision-maker for incapable patients. While not required under the HCCCFAA, it is common practice to document this on a health authority consent form, especially for major health care treatment such as surgery, dialysis, or use of blood products.

Mental Health Act

When does the MHA apply?

The MHA, as outlined in Section 22, applies to patients who meet all four of the following criteria:[5]

- Is suffering from a disorder of the mind that seriously impairs the person's ability to react appropriately to their environment or to associate with others.
- Requires psychiatric treatment in or through a designated facility.
- Requires care, supervision, and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of self or others.
- Is unsuitable to be a voluntary patient.

The MHA is meant to allow involuntary psychiatric treatment of persons with mental illness who would pose significant risks if their mental health disorder was left untreated.[6] In the case of Ms Safe, she met the criteria because she had a psychotic disorder, required treatment in a hospital, was at risk of physical deterioration because she was interfering with her wound care, and was not cooperative with voluntary psychiatric treatment.

What does the MHA permit?

The MHA allows for involuntary psychiatric treatment, defined as "safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment."[5] Examples of psychiatric treatment include use of antidepressants, antipsychotics, and mood stabilizers, while an example of an associated procedure is the monitoring of complete blood counts for patients receiving clozapine. Currently, certified patients, even those who are capable of making their own treatment decisions, cannot refuse psychiatric treatment proposed by the treating physician.

The MHA also allows for the extension of the terms of certification upon discharge under extended leave for patients who have poor insight or a history of treatment noncompliance. Extended leave stipulates that if patients do not comply with psychiatric treatment in the community, they can be recalled to hospital for further assessment and treatment. Extended leave enforcement is typically monitored by a community psychiatrist, together with case managers.

Patients must be notified of their rights under the MHA, which include provision of a second opinion regarding treatment and assessment by a review panel regarding the appropriateness of ongoing involuntary hospitalization. Review panel meetings must occur within 14 days of the request for first certification, and the panel is composed of a lawyer, psychiatrist, and member of the general public.[7]

The MHA authorizes involuntary psychiatric treatment only—treatment of medical illness is addressed under the HCCCFAA.

What does the MHA not include?

The MHA authorizes involuntary psychiatric treatment only—treatment of medical illness is addressed under the HCCCFAA. In the case of Ms Safe, certification under the MHA permits involuntary antipsychotic administration but does not address consent for her IV antibiotics, which is covered by the HCCCFAA. The importance of this distinction is highlighted in recommendation 5 of the BC Ombudsperson Special Report No. 42, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act*.[8]

What is required for MHA documentation?

Certification under the MHA requires completion of a Form 4: Medical Certificate (Involuntary Admission). The first Form 4 detains an individual for 48 hours; a second Form 4 extends the certification to 1 month. Each Form 4 must be completed by different physicians with an independent licence, but the forms do not need to be completed by a psychiatrist.[7] Extensions of certification require completion of a Form 6: Medical Report on Examination of Involuntary Patient (Renewal Certificate), which lasts 1 month, then 3 months, then 6 months for each subsequent renewal. A Form 5: Consent for Treatment (Involuntary Patient) must also be signed by the physician who proposes psychiatric treatment prior to treatment commencing. Several other forms require completion for involuntary admission of a patient, including Forms 13, 15, and 16, which are typically completed by psychiatric nurses on psychiatric inpatient units. Copies of all applicable MHA forms are provided in Appendix 16 of the *Guide to the Mental Health Act, 2005 edition*.[7]

Adult Guardianship Act

When does the AGA apply?

The AGA applies to all patients 19 years or older when a report is received or it appears that an adult is experiencing abuse, neglect, or self-neglect and is suspected of not being able to seek support and assistance or is determined as not being able to do so. The inability to seek support and assistance can be due to an illness, disease, injury, or other condition that affects the person's ability to make decisions about the abuse, neglect, or self-neglect.[9] AGA assessments and investigations are conducted by designated responders. It should be clarified who fulfills the role of designated responder in your local setting, but it is most commonly hospital social workers. Physicians play a key role in communicating with designated responders regarding these concerns so that AGA investigations can occur.

Section 59 of the AGA, which authorizes the provision of emergency assistance, is much like the MHA equivalent of certification. For patients who are apparently unable to seek support and assistance when needed, to invoke Section 59 all three criteria must be satisfied:

- The adult is apparently abused, neglected, or self-neglected.
- There is risk to life, or physical/mental harm, or property damage or loss.
- The adult is apparently incapable of providing or refusing consent.

Ms Safe was not seeking support and assistance when needed, since the wound care nurses had to call 911 in order for her to go to hospital for appropriate care. Ms Safe met all three criteria because she appeared to be

self-neglecting, as evidenced by the fact that she was not complying with offloading, which led to repeated recurrences of osteomyelitis. She was also at risk of serious physical harm and was incapable of providing consent for treatment.

What does the AGA permit?

Designated responders investigate allegations of abuse, neglect, or self-neglect. If criteria for Section 59 are met, this allows:

- Involuntary hospitalization on a short-term basis while investigation and safety planning are underway.
- If risk of abuse, neglect, or self-neglect as well as the inability to seek support and assistance are proven, a support and assistance plan can be developed and put in place following discharge from hospital to help mitigate the applicable risks.

A support and assistance plan specifies any services required by the patient, including "health care, accommodation, social, legal, or financial services."[9] Vulnerable adults are not compelled to accept the plan unless a court order is obtained, which is costly and thus obtained infrequently.[6] However, in clinical practice, collaboration with the adult and other associated parties can often result in implementation of a support and assistance plan.

Designated responders must advise patients of their right to obtain legal counsel, but there is no formal review panel similar to the MHA review panel process. Patients can go to court to challenge their involuntary status under Section 59 of the AGA.

For Ms Safe, her hospital stay was extended briefly under Section 59 of the AGA before she was released with a support and assistance plan. A court order was not obtained to compel her to accept the terms, but she was largely cooperative. In future, if Ms Safe does not comply with the terms of the support and assistance plan and is self-neglecting again, she could be brought back to hospital under Section 59 of the AGA, ideally before her condition has deteriorated so significantly that she requires another 6-week course of antibiotics.

What does the AGA not include?

Perhaps in contrast to the MHA, the AGA requires that the least intrusive, most effective measures be taken to mitigate risk. This typically requires some attempts at managing patients in the community with maximal supports before placing them in long-term care facilities. Section 59.2 states that the designated agency (i.e., health authority) may "provide the adult with emergency health care;" however, in our clinical practice, the HCCCFAA is still used for this purpose.

Section 59 of the AGA, which authorizes the provision of emergency assistance, is much like the MHA equivalent of certification.

What is required for AGA documentation?

Documentation of a Section 59 or an AGA investigation is completed by the designated responder; therefore, the exact format may differ by health authority. When a patient is being held in hospital under Section 59 of the AGA, a form called Adult Guardianship Act Certificate of Emergency Assistance is used by most designated agencies and, like the Form 4 for the MHA, should be located centrally in the patient's chart.

Recently, a Supreme Court of British Columbia case investigated the protracted involuntary detention of a vulnerable adult in hospital under Section 59(2)(e) of the AGA.[10] This case highlighted that Section 59 is meant to be used as an "emergency measure" and that any detained patients should be notified of their reasons for detainment and have the ability to contact a lawyer. In most health authorities in BC, it is considered best practice to ensure the vulnerable adult is reassessed every 5 days to determine that they still meet criteria for detainment under Section 59.

Discussion

Challenges to appropriate use of existing legislation

While legislation is clear that the HCCCFAA should be used for incapable adults who require hospitalization for medical treatment, inappropriate use of the MHA for this purpose does occur and is likely multifactorial. Our experience in educating health care providers on this topic has indicated that there is a general lack of knowledge and comfort among physicians regarding use of the emergency provisions under the HCCCFAA for treatment of incapable patients requiring medical treatment. Also, the HCCCFAA does not have a universally recognized equivalent of the MHA Form 4 that documents a patient's incapacity and that either a substitute decision-maker has consented or emergency conditions are satisfied. The absence of a universally recognized form can create anxiety and uncertainty about whether detainment and treatment of an incapable patient is lawful, especially among non-physician health care providers. However, health authorities may have appropriate forms that can be used for this purpose. We propose that having a universally recognized form in BC to document incapacity and appoint a substitute decision-maker may also be beneficial.

Another barrier to using the HCCCFAA appropriately is uncertainty regarding levels of observation of incapable patients who pose a flight risk from open units. Should these patients be treated the same as those certified under the MHA? Strictly speaking, police do not have jurisdiction under the HCCCFAA to bring eloped patients back to hospital, as they do under Section 28 of the MHA. Hospital staff have also expressed concern that security will not assist in the detainment of patients who are not certified under the MHA. At our institution, security staff are instructed to follow clinical direction from health care providers and are not to rely on certification status alone to determine which patients should be detained. Suggestions for improvement include developing institutional policies for managing incapable patients who require medical treatment, including guidance on levels of observation and ensuring that patient capacity to consent to treatment is reassessed regularly given that patient capacity can fluctuate.[11]

Challenges to using the AGA in practice include physicians' lack of awareness of the legislation. Since AGA investigations are completed by designated responders who are typically not physicians, clear and collaborative

communication between physicians and designated responders is required to ensure all relevant information regarding risk is adequately communicated. In our experience, communication is best conducted directly in face-to-face meetings or by phone to ensure important details or nuances are not missed. Additionally, there is limited ability to apply for a court order to force compliance with support and assistance plans by uncooperative individuals or in cases of extreme risk that require quite intrusive measures to prevent imminent harm. With the results of a recent Supreme Court challenge,[10] there is increased scrutiny regarding the appropriate use of Section 59, which may make some designated responders less inclined to invoke emergency measures. Finally, police are largely unfamiliar with the AGA and may be reluctant to bring eloped AGA patients back to hospital, despite legislation stating that designated responders are authorized to use any reasonable force to return patients to a safe place.

Despite the challenges discussed above, having increased knowledge of applicable legislation **[see the Figure]** can help physicians and health care providers ask pertinent questions to determine if the HCCCFAA, MHA, or AGA can be enacted to keep vulnerable patients in hospital. The HCCCFAA should be used when patients require hospitalization for medical treatment and the MHA when involuntary psychiatric treatment is required, and patients meet criteria for certification. While enactment of the AGA is outside the scope of most physicians, knowing that it exists, when it is applicable, and the importance of collaborating with designated responders can ensure risks with regard to abuse, neglect, or self-neglect are best mitigated by Section 59, either during hospitalization or with a support and assistance plan following discharge. ■

There is a general lack of knowledge and comfort among physicians regarding use of the emergency provisions under the HCCCFAA for treatment of incapable patients requiring medical treatment.

Competing interests

None declared.

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