ROYAL COLLEGE of PHYSICIANS of EDINBURGH

Evening Medical Update: Poisoning
Tuesday 25 June 2019

Street drugs: what's new and what to know? – Professor Simon Thomas

What does drug poisoning commonly masquerade as?
There is a very wide differential diagnosis and it is not possible to do this justice with a short answer. Many drug-induced syndrome have multiple non-toxic causes such as unconsciousness, seizures, agitation, fever, multi-organ failure, pulmonary oedema etc.

Did your slide say use naloxone repeatedly in cardiac arrest? I didn't think this was in the RESUS guideline.
I did not have a slide on cardiac arrest. I did say that repeated naloxone may be needed in severe opioid poisoning.

Can overdose of traditional cannabis alone make you unwell enough that you need to visit the emergency department?
Yes. Cannabis toxicity causes ED presentation, especially after high doses of potent preparations. Vomiting is common, for example. Seizures, unconsciousness, hallucinations etc. may also occur. Ingestion by children carries substantial hazard.

Are there any rapid diagnostics in use or in the pipeline for poisoning? Would it be useful in mixed OD?
At the moment drug screening is of limited value. A positive test does not mean that the detected drug is the problem. A negative rest may occur because the drug is not detected effectively by the screen used. There are also false positives under some circumstances. NPS generally not detected by current screens. Best to treat the features the patient presents with.

What is interaction between opioids and pregabalin or gabapentin? These medications became controlled drugs recently.
All of these are sedating. It is likely that, as with other sedatives, gabapentinoid co-use may increase risk of opioid overdose (i.e. increased risk of unconsciousness and death)

Are all the drugs legal and any things needs to be done for their prevention?
All psychoactive drugs that are not already controlled by the Misuse of Drugs Act are controlled by the Psychoactive Substances Act (unless specifically exempted, such as medicines, alcohol etc.)

Why is misuse so high in Scotland?
There is a link between drug misuse and social deprivation. There is also local culture that may influence what drugs are used and how. There is a high use of potentially toxic drugs (heroin, benzodiazepines) and these carry a high risk of drug-related death.

Do you think cigarettes and alcohol should be classified as controlled drugs?
That is a wider societal question and my opinion is no more valid than that of any else. But I doubt it will happen. No one is doubting the adverse health effects of these uncontrolled substances.

What are the figures in developing countries?
Drug misuse occurs all over the globe, but patterns vary by country. Some countries have easily accessible data, but many others do not. NPS use may be less prevalent in some developing countries, but there is limited information available.

International weapons: a clear and present danger – Professor Michael Eddleston

What are the key measures for triage in a chemical attack?
Standard ABC but with care regarding not self-contaminating. Most patients will arrive already decontaminated. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/712888/Chemical_biological_radiological_and_nuclear_incidents_clinical_management_and_health_protection.pdf

All the symptoms are so similar and confusing. How can we differentiate them in an emergency situation? Any flow chart?
Read this document for discussion of the different types and a flow diagram:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/712888/Chemical_biological_radiological_and_nuclear_incidents_clinical_management_and_health_protection.pdf

While dealing with which poisonings should doctors be more careful? I know it is the case in o.p. poisoning.
Yes, be careful! However, most patients will arrive at hospital already decontaminated from the scene. Otherwise they should be decontaminated on arrive at ED. This document provides useful information:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/712888/Chemical_biological_radiological_and_nuclear_incidents_clinical_management_and_health_protection.pdf

Is my poisoned patient detainable? – Dr Roger Smyth

How does the Montgomery ruling affect our ability to assess capacity in the poisoned patient?
The Montgomery ruling (Montgomery v Lanarkshire Health Board [2015] UKSC 11) was concerned with level of information about treatment and treatment risks required to be given to a capable patient in the process of obtaining valid consent for a proposed intervention in order to avoid a potential negligence claim. It made no change to the assessment of capacity.

Given patient is overdosed how reliable could the patient be competent and therefore to be treated in best interest?
In a patient of 16 years of age or over there is a *presumption of capacity*. A patient cannot be found to be incapable by reason of any individual diagnosis or condition. In Scotland capacity for any individual decision is assessed in line with the test set out in s1(6) of the AWIA. Following an overdose a patient might potentially be found to lack capacity by reason of a mental disorder which precipitated the overdose (e.g. major depressive episode, psychotic illness), or by reason of organic cognitive impairment secondary to the effects of poisoning or co-morbid drug intoxication.

Is there an England equivalent of the adults with incapacity act?
Yes - the Mental Capacity Act 2005. This applies to England and Wales. See:
https://www.legislation.gov.uk/ukpga/2005/9/contents

How residual capacity can be encouraged?
This is probably the least well-known and least considered of the five principles of the AWIA. It is less relevant in the emergency situation but becomes much more relevant in longer term planning for those with incapacity - for example a care placement directed by a Welfare Guardianship. Residual capacity could be encouraged for example by: 1) taking care only to request welfare or financial powers for those areas where incapacity clearly exists and encourage the adult to continue to exercise decision-making over other areas; 2) in designing care placements and supervision arrangements aim to maximise the opportunities for personal choice and independent decision making, 3) facilitating any opportunities for functional improvement (e.g. via re-learning or rehabilitation if possible).

Isn't the necessity principle putting Drs in trouble as we are breaking a law for patient's benefit? Are there cases where a doctor was punished for using this principle?
No, use of the common law necessity principle is in no sense "breaking the law", it is instead using well-established common law principles, rather than a statute law framework, to provide legitimate justification for an intervention. Its continued use in emergency situations is encouraged by the AWIA Code of Practice for Part V in para2.3: "Common law allows medical treatment to be given in an emergency to patients who cannot consent. This remains the case and there is no need to go through the steps in Part 5 of the Act in order to give treatment for the preservation of the life of the adult or the prevention of serious deterioration in the adult's medical condition. What is appropriate in a particular situation is a matter basically for clinical judgement, against the background of the principles and requirements of the Act", and in para 3.3: "Treatment in emergencies is specifically exempted from the scope of the Act. There is already a common-law authority for a practitioner to treat a patient for the preservation of the life of the adult or the prevention of serious deterioration in his or her medical condition. There should be no question, therefore, of consultation putting a patient's life at risk. What is meant by "reasonable and practicable" will vary from situation to situation. It will normally be reasonable and practicable to consult relatives, proxies or carers, where these people are present or easily contactable."

Do you commonly have patients under MHA and AWI?
I frequently use the Mental Health Act in my practice to authorise civil detention. In my practice the MHA is more frequently used in individuals with delirium, dementia, and other organic mental disorders, but is occasionally used in poisoned individuals. The AWI cannot be used to authorise civil detention and no patients will be "detained under the AWI".

How would you approach a patient with poisoning who absconds from ED before a doctor can make a capacity assessment? Are you obliged to involved police?
If a patient has been seen by a fully registered medical practitioner, and assessed as meeting the MHA criteria for an Emergency Detention Certificate (EDC) they can be detained in their absence on the basis of this assessment and returned to hospital under this authority (see s.36(12) for time-limits on this usage). If they have not been seen by a

fully registered medical practitioner then this legal authority cannot be used. There is no automatic obligation to involve the Police but they might be asked to become involved, for example if the patient was felt to be at risk. Police can detain an individual (in a public place) they believe to be suffering from a mental disorder under s.297 of the MHA and bring them to a 'place of safety' (e.g. a local ED) for assessment by a doctor. Alternatively, a GP could be asked to review the patient's mental state and level of medical risk.

Can you explain the effect of mental health on capacity?
This is a somewhat broad question. Again, in a patient of 16 years of age or over there is a *presumption of capacity*. A patient cannot be found to be incapable by reason of any individual diagnosis or condition. The test of incapacity in Scotland is set out in the AWIA s1(6). This defines incapacity as being unable to act on, make, understand, retain memory of, of communicate a decision as a result of mental disorder. The final one of the five deficits - inability to communicate - can be as a result of a purely physical disorder, all the rest must be due to mental disorder. In Scotland 'mental disorder' is defined in the MHA as 1) mental illness, 2) personality disorder, 3) mental handicap.

Mental health nurses are legally allowed to detain an individual for 6 hours under section 5.4. Would a RGN be allowed to do this?
No. In England and Wales the 'Nurses' Holding Power' is contained in s.5(4) of the Mental Health Act 1983 which grants the power to detain to: "a nurse of the prescribed class". The 'prescribed class' is a nurse on the Mental Health or Learning Disability register (RMN or RMLD) (see 'Reference guide to the Mental Health Act 1983, para.8.80). In Scotland the equivalent 'Nurses' Holding Power' is contained in s.299 of the Mental Health (Care and Treatment) (Scotland) Act 2003 which allows a "nurse of the prescribed class" to detain a patient for a non-renewable three hour period. Here the 'prescribed class; is defined in the Mental Health (Class of Nurse) (Scotland) Regulations 2005 is also an RMN or RMLD.

28 year old female, 8 weeks far in pregnancy with staggered overdose of paracetamol and ibuprofen over 4 days' time. What should be the threshold for mental health referral?
All such cases should be referred for mental health assessment and I would suggest there should be no 'threshold'. There are potentially three reasons for mental health assessment in the case stated: 1) emergency assessment of mental state to guide decisions regarding use of MHA, AWIA, and common law powers, and urgent psychiatric management, 2) psychosocial assessment after self-harm, 3) mental health assessment of mental disorder in pregnancy. Mental health advice in (1) should be requested by the emergency treating physician in case of doubt or where it would aid patient management. (2) And (3) occurring together or separately should always prompt mental health referral.

Do patients have capacity as long as they agree with us? (Sorry tongue in cheek)
No, patients have capacity by right once they reach their 16th birthday and are presumed to retain it as long as they live. There will almost certainly be more scrutiny of the capacity of patients who refuse our interventions. However, this may very well be appropriate. We must remember that a capable patient can refuse even life-saving treatment.

Could you apply the principles to your case - patients like Emma are seen commonly on the medical take and take a lot of time and cause much anxiety. Emma's case is a very common scenario, how do we apply what you have told us to such a case? Can you apply your presentation to Emma from your case? What happens to the patient in scenario?
There is no one answer to that can be applied in these situations – all such patients must be assessed individually using the principles and tests I set out in the talk. The Mental Welfare Commission Guidance documents: "Right to treat", "the Mental Health Act in General Hospitals", and "the Adults with Incapacity Act in General Hospitals" are available at www.mwcscot.org.uk and provide much helpful information for decision making in these cases.

I tried to highlight the most important factors in decision making in the talk. The first issue is that she is requesting to leave. There should be an effort to persuade her to stay and inform her of the benefits of treatment and the risks of not receiving treatment. Any concerns she has should be listened to and addressed. Should she continue to insist on leaving then we will require to consider detention under the MHA. The doctor should consider whether the criteria for MHA detention are met. Assuming they are, she should be reviewed with a Mental Health Officer (MHO) if time allows, and detained under EDC with their agreement. The EDC gives authority to detain her in hospital, to prevent her from leaving, and to return her if she does leave.

The next consideration is treatment. Some detained patients will accept treatment and are felt to have capacity to do so. If they refuse treatment, but are felt to lack capacity to refuse, then we need to consider the appropriate legal authority to treat. As I stated in the talk, the legal authority for treatment in this situation is not completely clear both because these questions tend to arise in clinically fraught, time-pressured, and rapidly-changing situations, and because the legal situation often requires us to use three different legal frameworks (CL, AWIA, MHA). If the Scottish Government's current consultation in this area decides to opt for the proposed 'fusion law' then it may become easier and clearer, but considering the situation now:

The AWIA clearly allows us to make treatment decisions for incapable patients, usually with the authorisation of the s.47 form. The AWIA however specifically excludes "use of force or detention" unless "immediately necessary and only for so long as is necessary", and excludes placing a patient in hospital against their will (s.47)7)). Therefore only the MHA gives us statutory provisions allowing use of force or deprivation of liberty, unless these are justified under common law.

The Mental Welfare Commission's guidance in this area is "Right to treat". The case of Mr X in appendix 1 is close to our situation. The MWC state: "In this case, it can be argued that force or detention is immediately necessary and therefore lawful under the Act. However, the meaning of "immediately necessary and only for as long as is necessary" has not been tested in court. If Mr X repeated wishes or attempts to leave, and if the grounds are met, detention under the 2003 Act should be considered. According to the code of practice for the 2003 Act, Mr X could be given treatment for the physical damage caused by self-harm under the terms of the 2003 Act.