

# Developing a capacity test for compulsion in mental health law

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Concepts of mental capacity are taking on an increased importance in the mental health law of the United Kingdom. For England and Wales, the proposal to introduce a threshold requirement of 'impaired decision-making' into the criteria for detention under sections 2 and 3 of the Mental Health Act 1983 was the first amendment to be voted upon in the House of Lords' reading of the Mental Health Bill. Despite its emphatic (and whipped) resistance to this amendment, Government lost the vote by a wide margin<sup>3</sup>, although it seems possible, at the time of writing<sup>4</sup>, that the Government will seek to overturn their defeat in the Commons<sup>5</sup>.

It is therefore timely to re-examine the role of such capacity tests in mental health legislation dealing with detention and treatment. This paper describes as yet unresolved definitional questions that must be encountered when concepts of mental capacity operate as a threshold for coercive psychiatric detention and/or treatment.

## Mental capacity tests in the Mental Health Act 1983 and other legislation

In the House of Lords debate, the Minister stated that the proposal to introduce a test of impaired decision-making was "one of the core amendments that will undermine the broad intent of the Bill"<sup>6</sup>. Indeed, the clear implication of the Government's resistance to this amendment was that the introduction of any sort of capacity-based criteria for detention would undermine the purpose of the Mental Health Act 1983 itself. The 1983 Act was described as "based upon need and risk" where "it is the needs of patients and the risk that their disorder poses to themselves and to others, not their decision-making ability, that must determine whether compulsion should be used"<sup>7</sup>. This is undoubtedly a correct description of the practical test in the current law, but it is arguably an inexact account of the intention of legislators.

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3 The amendment introducing an impaired decision-making test was accepted by 225 votes to 119. All but one of the 119 peers who voted against the opposition amendment were from the Government benches. Three Labour members (Lords Bragg and Winston, and Baroness Wilkins) defied their whip to vote alongside 222 other

peers from all benches who supported the amendment. 25 Labour peers abstained from voting.

4 16 March 2007

5 Rosie Winterton, Minister of State for Health Services: Local Government Association conference, Mental Health Bill, 1 March 2007. Downloaded on 2 March 2007 from [www.dh.gov.uk](http://www.dh.gov.uk)

6 Lords Hansard, 10 Jan 2007, Column 243 (Lord Hunt of Kings Heath)

7 *ibid.*, column 243-4.

It is true that the nineteenth century codifications of rules relating to the civil compulsion of mentally disordered people in England and Wales, from which the current law has evolved, were founded upon the paternalistic assumption that authorities could recognise a ‘proper person to be taken charge of and detained under care and treatment’<sup>8</sup> without specific terms being established by statute. However, legal developments in the twentieth century have addressed the question of criteria for such recognition and, for certain circumstances, recognised that an absence of mental capacity to provide consent to intervention could be the threshold for coercive intervention: for example, the Mental Treatment Act 1930 allowed that temporary treatment procedures available under that Act could only be invoked to detain a patient ‘for the time being incapable of expressing himself as willing or unwilling to receive such treatment’<sup>9</sup>.

The framework of current law relating to the detention of psychiatric patients in England and Wales was established with the enactment of the Mental Health Act 1959, itself based upon the recommendations of the Royal Commission led by Lord Percy between 1954-7. The Percy Commission concluded that

*the use of compulsory powers on grounds of a patient’s mental disorder is justifiable when [inter alia] ..., if the patient himself is unwilling to receive the form of care which is considered necessary, there is at least a strong likelihood that his unwillingness is due to a lack of appreciation of his own condition deriving from the mental disorder itself.*<sup>10</sup>

Thus the Percy Commission envisaged mental incapacity (which interestingly, for the time, it defined in terms of “lack of appreciation”) as the basis upon which psychiatric compulsion could be justified. Rather than proposing that such a principle should be expressly stated in the law, the Percy Commission sought to establish a general legal framework that would translate it into practice<sup>11</sup>.

It could be argued that the legal framework over the last half century has disappointed the Percy Commission’s expectation, although we should be careful of measuring that expectation against current concepts of mental incapacity and finding it wanting. The Percy Commission sought to enact its criterion of ‘lack of appreciation’ through a restriction of long-term treatment to the mentally ill or ‘severely subnormal’<sup>12</sup>, thus apparently assuming that broad classifications such as ‘mental illness’ could be used as a status-test of mental capacity. This is clearly incompatible with current models of incapacity.

The Government is therefore correct to conclude that the current *working assumptions* that underpin compulsory detention and treatment under the current mental health law in England and Wales are based upon criteria of best interests (‘necessary for the health or safety of the patient’) and dangerousness (‘for the protection of other persons’), and that there is no requirement that a person must be mentally incapacitated in any sense to be detained for assessment or treatment under the 1983 Act. Indeed, modern assumptions about the relationship between mental disorder and mental capacity are exemplified by the Code of Practice assumption that all detainees under the 1983 Act are presumed generally to

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8 *An Act for the Regulation of the Care and Treatment of Lunatics*, 8 and 9 Vict. (1845) c.100 ss.45,48; *Lunacy Act 1890*, 53 Vict. c.5, forms 8, 12. See Bartlett, P (1996) ‘Sense and Nonsense: Sensation, Delusion and the Limitation of Sanity in Nineteenth-Century Law’ in L Bentley and L Flynn (eds) *Law and the Senses*, London: Pluto, n.21 for a fuller listing. This phrase is discussed in Percy Commission (1957) *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957*, Cmnd. 169, para 231.

9 *Under the Mental Treatment Act 1930. The Percy Commission (1957) op cit. n.2, para 232 found that reluctance of some doctors to declare patients incapable of such expression, or lack of clarity over the meaning of this term, had limited the use of this alternative to certification under Lunacy Act powers.*

10 Percy Commission (1957) *op cit*, para 317

11 Hoggett, B (1996) *Mental Health Law*, fourth edition, London; Sweet & Maxwell, p. 40.

12 Hoggett 1996 *op cit. n.4, p.41.*

retain capacity unless and until declared otherwise<sup>13</sup>. But it would be disingenuous to argue from this that the notion of a capacity-based threshold for detention or other coercion was not considered, or was rejected, by those who laid the foundations of the current Mental Health Act<sup>14</sup>.

Notwithstanding the attitudes of past legislators, over the lifetime of the 1983 Act there have been increasing calls for revisions to encompass a criterion of mental incapacity, either alone or in combination with other criteria, as the basis for civil detention and/or compulsory treatment<sup>15</sup>. The Government's own expert advisory committee on mental health reform was in favour of a form of incapacity test as one criterion amongst others for psychiatric compulsion<sup>16</sup>. The years since that committee's report have seen the introduction of a Mental Capacity Act to codify common law treatment of incapacitated patients who fall without the scope of Mental Health Act powers. Campaigners also point to other jurisdictions that have developed capacity-based legislation relating to psychiatric coercion. Mental incapacity is one criterion for civil commitment under the American Psychiatric Association's model statute<sup>17</sup> and, variously defined, is consequently a common but not exclusive criterion for compulsory intervention in the United States<sup>18</sup>. Ontario law has for some time established that no patient with capacity may be treated without informed consent, whether for somatic or psychiatric purposes, although the thresholds for compulsory admission to psychiatric hospital are based upon criteria of dangerousness<sup>19</sup>. The Government has reserved its right not to comply with the Council of Europe recommendation to member states that competent refusals of psychiatric treatment should be generally respected<sup>20</sup>.

### “Impaired decision making” as a capacity test

The amendment passed by the House of Lords in January does not establish a test of mental incapacity as a threshold for detention under sections 2 or 3, but rather imposes a “lower test”<sup>21</sup> of impaired decision-making alongside the existing criteria for detention under section 2 or 3 of the 1983 Act. The clear model for this is the Mental Health (Care and Treatment) (Scotland) Act 2003. This establishes a prospective

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- 13 Department of Health (1999a) *Mental Health Act Code of Practice*, London: Stationery Office, p.66.
- 14 *Traces of a concern with capacity thresholds are more apparent in the 1983 Act's provisions regarding treatment than with its criteria for detention. The 1983 Act requires patients' capacity status to be assessed and recorded in relation to certain treatments (including ECT and, in some circumstances, psychotropic medication), but does not preclude the imposition of such treatments where a capacitated patient refuses consent. The only determinative capacity-based threshold in the current law relates to treatments falling under s.57 of the 1983 Act (such as neurosurgery for mental disorder), which are explicitly removed from the Act's general coercive framework, and may only be given with capacitated and informed consent from the patient as well as a favourable multi-disciplinary clinical opinion.*
- 15 see for example, Szukler, G & Holloway F (1998) 'Mental health legislation is now a harmful anachronism', *Psychiatric Bulletin* 22, 662-5; Campbell T. and Heginbotham C, (1999) *Mental Illness: Prejudice, Discrimination and the Law*, Aldershot: Dartmouth, p.217ff; Gunn, M (2000) 'Reform of the Mental Health Act 1983: the Relevance of Capacity to Make Decisions', *JMHL* 3; 39-43; Zigmund, T & Holland, A J (2000) 'Unethical Mental Health Law; History Repeats Itself' *JMHL* 3;49-57
- 16 Department of Health (1999b) *Report of the Expert Committee: Review of the Mental Health Act 1983*. London, p.88ff.
- 17 Raymont, V, Bingley W, Buchanan, A, David A S, Hayward P, Wessely, S, and Hotopf M (2004) 'Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study' *The Lancet* Vol 364 October 16, 2004.
- 18 Wilbur, K H and Zarit, S H (1999) 'To decide or not to decide for others: competency, choice and consequences' *Ageing and Mental Health* 3(4):277-280.
- 19 Bartlett, P (2003) 'The Test of Compulsion in Mental Health Law: Capacity, Therapeutic benefit and Dangerousness as Possible Criteria'. *Medical Law Review* 11, 326-52
- 20 Council of Europe (2004) *Recommendation (2004)10 of the committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder. Adopted by the Committee of Ministers on the 22 September 2004.*
- 21 *Lords Hansard*, 10 Jan 2007, Column 246 (Lord Hunt of Kings Heath)

patient's inability to make a safe decision about care and treatment as one of five criteria for a compulsory treatment order, and requires that capacitated refusal of consent to ECT should be respected except in 'emergency' situations<sup>22</sup>.

The concept of 'significantly impaired decision-making' is not defined in the Scottish Act, although it is discussed in the Code of Practice to that Act<sup>23</sup>. The only specific distinction made between "significantly impaired decision-making ability" and "incapacity" in that Code is a statement that the former must always be consequent to mental disorder, whereas incapacity (as defined by the Adults with Incapacity (Scotland) Act 2000) may also be caused by physical disability. Aside from this distinction, the Scottish Code suggests that each concept relies upon similar factors: the extent to which the person's mental disorder might adversely affect his or her ability to believe, understand and retain information concerning care and treatment, make decisions based on that information, and communicate those decisions to others. The Code warns against determining a person to have an impairment of decision-making ability by reason *only* of a lack or deficiency in a faculty of communication, and against conflating disagreement with professional opinion with an impaired ability to decide upon treatment.

As such, the phrase 'significantly impaired decision-making' would appear to be wider than, and therefore inclusive of, any form of mental incapacity discussed in this paper. The potential breadth of its application may undermine its use as a meaningful threshold for coercion. Whilst studies of the Scottish Act's practical implementation are not yet available, Chiswick<sup>24</sup> has questioned whether the decision-making test in that Act adds anything to the other four criteria for compulsory treatment. The other criteria are: (1) presence of mental disorder; (2) availability of medical treatment likely to treat the disorder or alleviate symptoms; (3) significant risk to the patient's health or safety, or to the safety of others, without such treatment; and (4) necessity of making a compulsory order<sup>25</sup>. Such a critique must be similarly applicable to the changes proposed by the amendment to the 1983 Act.

## **The indeterminacy of mental incapacity as a test in law**

Although it would appear that mental incapacity is a narrower concept than impaired decision-making, it is itself broadly and loosely defined in many clinical and even legal contexts.

The inconsistencies in the statutory language of capacity tests are in part a result of the way in which the law has been created in a piecemeal fashion over time, as well as the different contexts in which the tests are applied. The capacity test in the Mental Health Act 1983 (section 58) speaks of the patient being "capable of understanding the nature, purpose and likely effects of" the treatment, whereas that of the Mental Capacity Act 2005 (section 3) describes a person as incapacitated to make a decision if s/he is unable "(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means)". In part, the Capacity Act test is simply a reflection of case-law over the interpretation of the 1983 Act's test. As this case law is reflected

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22 We have previously expressed concern that the essentially indeterminate thresholds for incapacity are liable to distortion where clinicians are required to find incapacity if they are to override patients' resistance to ECT treatment: see MHAC evidence to the Joint Committee on the Draft Mental Health Bill, Session 2004-05, HL Paper 79-II, HC 95-II, Ev 33-4 (paras 6.9 – 6.12).

23 Scottish Executive (2005) *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice, volume 2 - civil compulsory powers* (parts 5, 6, 7 and 20), Edinburgh, paras 22-7.

24 Chiswick, D (2005) 'Test of capacity has little practical benefit' *BMJ* 2005;331: 1469-70

25 *Mental Health (Care and Treatment) (Scotland) Act 2003, s.57(3)*

in the Mental Health Act Code of Practice, the practical implementation of the two capacity tests is likely to be roughly the same, or at least it would be so insofar as that Code is actually followed by practitioners. The Mental Health Act Commission still encounters a variety of understandings of the 1983 Act's use of mental capacity<sup>26</sup>. From April 2007, either statutory framework could be used to impose treatment for mental disorder in England and Wales<sup>27</sup>.

The leading case on the 1983 Act's definition of capacity (and the definition used in common law) is usually taken as *Re C (Adult: Refusal of Medical Treatment)*<sup>28</sup>, in which Justice Thorpe formulated a test that went beyond cognition when considering the proposed amputation of a Broadmoor patient's gangrenous leg. Justice Thorpe stated that "the question ...whether...C's capacity is so reduced by his chronic mental illness that he does not sufficiently understand the nature, purpose and effects of the proffered amputation" depended on "first, comprehending and retaining treatment information, second, believing it and, third, weighing it in the balance to arrive at choice". The patient was deemed to have capacity to refuse the amputation, notwithstanding his delusional belief that he was an internationally renowned doctor able, with God's help, to treat himself. The court was impressed by the fact that Mr C appeared to accept that he might die without the amputation, but had decided (as do many older people) that, if so, he would rather die with two feet than one<sup>29</sup>. In *B v Croydon District Health Authority*<sup>30</sup>, a case concerning the proposed force-feeding of a personality-disordered patient, Justice Thorpe initially found that the patient had mental capacity, but the Court of Appeal found otherwise in 1995 on the grounds that the patient's self-starvation was not a "true choice", in that "she did not appreciate the extent to which she was hazarding her life, was crying out inside for help but unable to break out of the routine of punishing herself". In a later case, *Re MB (medical treatment)*<sup>31</sup>, the Court of Appeal ruled as incapable a patient who had the cognitive ability to comprehend and retain information about a proposed treatment, but whose needle-phobia made her "unable to use the information and weigh it in the balance".

In January 2006, the then Master of the Rolls (Lord Phillips) stated that section 58 of the Mental Health Act "seems to lay down the relevant test of capacity when it speaks of the patient being 'capable of understanding the nature, purpose and likely effects of' the treatment", but continued:

*Arguably these words do not go far enough to define capacity. In R (Wilkinson) v Broadmoor Hospital Authority ... Hale LJ suggested that the test of capacity laid down by this court in relation to treatment for a physical disorder in In re MB (Medical Treatment) [1997] ... was suitable for assessing capacity for the purpose of section 58(3)(b) of the Mental Health Act. That test includes the requirement that the patient is able to use the information "as to the likely consequences of having or not having the treatment" and "weigh it in the balance as part of the process of arriving at the decision".*

*Whatever the precise test of the capacity to consent to treatment, we think that it is plain that a patient will lack that capacity if he is not able to appreciate the likely effects of having or not having the*

26 Mental Health Act Commission (2006) *In Place of Fear? Eleventh Biennial Report of the Mental Health Act Commission 2003-05*. London, Stationery Office, p.240; Kinton, M (2006) 'Seminal Issues in Mental Health Law by Jill Peay' (review article) *JMHL* 14:102-6, p.105.

27 *The Mental Capacity Act 2005 comes into force in England and Wales on the 1 April 2007*.

28 *Re C (Adult: Refusal of Medical Treatment) [1994] 1 W.L.R. 290; 1 All E.R. 819*.

29 *Subsequently (after Mr C had won his case and had*

*survived the gangrene with both legs intact) his solicitor realised that he was incapable of making a will because of his delusional ideas about death itself, although these delusions were unknown to the solicitor and the court at the time of Justice Thorpe's decision. See Scott-Moncrieff, L (2004) 'Capacity, Choice & Compulsion' *JMHL* 11;142-153*

30 *B v Croydon District Health Authority [1995] 1 W.L.R. 294; 1 All E.R. 683*.

31 *Re MB [1997] 2 F.C.R. 541; 2 F.L.R.426*.

*treatment. The judge found that this was the position so far as Mr B was concerned in that he did not accept even the possibility that he might be mentally ill and thus in need of treatment*<sup>32</sup>.

Thus legal narrative accepts an elision of different definitions of capacity - even in the face of statutory language that might suggest a more restrictive approach - and resists formulating a closed definition of what it means to have, or to lack, mental capacity for a particular decision. This is not a recent phenomenon of legal practice. Indeed Bartlett<sup>33</sup> has provided an historical account, arguing that legal tests of capacity operative throughout much of the nineteenth century were based upon the presence or absence of delusion, at least until cases in the 1880s began to consider the intellectual or cognitive function of persons with delusory beliefs. According to this account, when the terminology of 'delusion' fell into misuse in medico-legal practice during the twentieth century, the courts increasingly focussed on loosely-formulated conceptions of cognitive capacity, but without having successfully articulated what it was that they had moved to consider. This indeterminacy extends from civil cases relating to such matters as healthcare or financial decisions, to the use of notions of concepts of mental capacity in determining culpability for criminal acts.<sup>34</sup>

### The indeterminacy of capacity as a test in clinical practice

The practical application of a concept such as mental incapacity or impaired decision-making is more frequently a matter solely for clinicians than the courts. In general terms, 'capacity is a state of affairs granted by the doctor'<sup>35</sup>. There is some evidence that clinicians use a variety of capacity tests, including status and outcome approaches<sup>36</sup>, and that findings of incapacity may be poorly evidenced in such a way that it is not always apparent how and why the finding was made<sup>37</sup>. There is, in any case, no single definition of mental capacity for use in a clinical context. The British Medical Association's five-point test, for example, although referring directly to the standard legal test of capacity set out in *Re. C*, differs from it both by addition (for example the BMA test includes the ability to 'make a free choice' – i.e. one that is 'free from pressure') and by subtraction (the BMA test excludes the *Re. C* elements of believing the relevant information and of weighing it in the balance in arriving at a choice). The Mental Capacity Act 2005 widens the traditional English legal test a little with its inclusion of the ability to 'use or weigh ...information as part of the process of making the decision' (s.3(c)), but it remains an essentially cognitive approach based on functional tests and may be interpreted to exclude the element of belief.

A more sophisticated capacity test is established by the MacArthur Competence Tool for Treatment (the MacCAT-T test), widely used in both research and medico-legal practice in North America and

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32 *R (on the application of B) v (1) Dr SS (Responsible Medical Officer) (2) Second Opinion Appointed Doctor (3) Secretary of State for the Department of Health, Court of Appeal, 26th January 2006, paras 33-4.*

33 Bartlett (1996) *op cit*; Bartlett and Sandland (2003) *op cit*, p.581

34 For our discussion of the capacity thresholds determining "insanity" and "unfitness to plead" in criminal law, see MHAC (2006) *op cit*, p.353-358.

35 Kennedy, I and Grubb, A (2000) *Medical Law Texts and Materials*. London: LexisNexis Butterworths.

36 Scott J (2003) 'Tests for Decision-making Capacity in Medical Treatment – Practical or merely theoretical?' unpublished LLM Dissertation, University of Northumbria, December 2003; Helmes A, Lewis V E, and Allan A (2004) 'Australian lawyers' views on competency issues in older adults' *Behav. Sci. Law* 22:823-831.

37 See, for example, Suto, W M I, Clare, I C H, and Holland, A J (2002) 'Substitute financial decision-making in England and Wales: a study of the Court of Protection' *Journal of Social Welfare and Family Law* 24(1):37-54

elsewhere<sup>38</sup>. Researchers have found good inter-rater reliability of assessments using this tool<sup>39</sup>, although some of this research may have been testing for the appearance of significant impairment that should not necessarily be equated with a legal threshold of incapacity to make a decision<sup>40</sup>. The MacCAT-T test includes an element of 'appreciation' that is absent from, or at least different to, the tests described above<sup>41</sup>. 'Appreciation', whilst itself inherently quite a loose term, is defined in the literature<sup>42</sup>, and generally implies a recognition of the value or significance of something, or an understanding of a situation. As a criterion in evaluating capacity, appreciation is less to do with the straightforward assimilation of facts required by cognitive tests, than with choices and decisions based upon an evaluation of personal possibilities.

The differences between the tests of capacity described above are more than mere differences in drafting, and *would* have practical implications for the application of such tests *if* they were attended to carefully by those who apply them. Such a difference could be described in terms of the subtle distinction between *capacity* as the ability to take in or hold information and *competence* in having sufficient abilities in the rivalries and demands of life to use that information. A test of competency in the latter sense raises thorny problems of normative judgments, and it is perhaps understandable that the theory and practice of the law reverts to tests of cognitive ability and the view that the threshold for capacity should not be too demanding<sup>43</sup>. The Mental Capacity Act 2005, for example, allows that short-term memory may be adequate for capacity, which implies a model of capacity reliant upon an intellectual or cognitive ability to take in and hold information long enough to use it. But *competence*, as previously described, may require longer-term memory essential to maintain the beliefs that make us what we are.

A sophisticated capacity test (and certainly any test to determine impairment in decision-making ability) must look beyond the question of cognitive capacity. Such a test should address the interplay between cognition (knowing), emotion (evaluating) and volition (acting). A person's 'reasoning defect' may be linked to any of these 'capacities', and perhaps is more likely to result from an emotional or psychological deficit than any obvious failure in cognitive function. Impairment of decision-making ability is often a result of diminished or absent emotions, such as embarrassment, sympathy and guilt, that may be related to an impairment of emotion-related signals and the failure to activate an emotion-related memory<sup>44</sup>. Emotion-related signals are especially important as they are associated with the future outcome of actions

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38 Grisso T, Applebaum P S, and Hill-Fotouhi (1997) 'The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions' *Psychiatric Services* 48:1415-1419.

39 Cairns, R., Maddock, C., Buchanan, A., et al (2005a) 'Reliability of mental capacity assessments in psychiatric in-patients'. *British Journal of Psychiatry*, 187, 372-378; Raymont et al (2004) *op cit*, n.17 above.

40 The study of Raymont et al, which deal with elderly medical patients, used a modified version of the MacCat-T that set aside the question of the patient's understanding of their disorder, and did not take account of potential risks and benefits of treatment to establish what the particular 'legal' threshold of capacity might be in each case. It may be that it is this aspect of capacity testing, rather than medical agreement that there is significant impairment of capacity, that is most liable to variability.

41 Grisso, T and Appelbaum, P S (1995) 'Comparison of standards for assessing patients' capacities to make

treatment decisions' *Am J Psychiatry*; 152:1033-1037.

42 Grisso T, and Applebaum P S (1998). *Assessing Competence to Consent to Treatment: A Guide for Clinicians and Other Health Professionals*. New York: Oxford University Press, p.49-51.

43 *i.e.* Hale LJ in R (on the application of Wilkinson) v Broadmoor Hospital, Responsible Medical Officer & Ors [2001] EWCA Civ 1545, para 80: "Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify". That the threshold is in fact low may be disputed: it may rather depend upon the perception, in the assessor, of the seriousness of the decision or likely outcome involved. See MHAC (2006) *op cit*, para 3.28.

44 Damasio A. (2003). *Looking for Spinoza. Joy, Sorrow and the Feeling Brain*. London: Heinemann, p. 144

and self-preservation. They “...signal a prediction of the future, an anticipation of the consequences of actions”<sup>45</sup>. If emotion-related ability is severely damaged it may undermine completely a person’s ability to appreciate and to weigh in the balance the necessary facts of the case, even if those facts can be understood at a cognitive level.

Although some account may be taken of a person’s ability to ‘weigh in the balance’ information relating to a healthcare decision, we do not believe that the above aspects of capacity-testing are articulated clearly in court decisions or in many day-to-day clinical judgments. For example, patients suffering from major depression without psychotic features may be assessed as having retained capacity (when this is measured in terms of the “cognitively skewed” model in general use), even though they show indifference and lack of drive to act on the appropriately appreciated benefits and risks of treatment and the disorder impacts on treatment preferences to the extent that they are not consistent with previous wishes<sup>46</sup>.

However, many clinical and judicial assessments of capacity, usually for the best of motives, consider not only cognitive but also other forms of capacity. In extending the reach of what is ostensibly a test of cognitive capacity, such pragmatic use of the law paradoxically at once incorporates *and* marginalises proper consideration of other forms of capacity. The key question is whether such practice can, nevertheless, provide a sufficiently robust approach necessary for considering treatment of an individual against his or her will, applying compulsory powers, or taking away a person’s liberty as a result of mental disorder. Without explicit recognition of the way the assessment has been undertaken a person may be found to be incapacitated, not on cognitive grounds but on unstated or inadequately defined emotional or volitional grounds, but which are elided into the legal definition of capacity in a way that cannot readily be challenged.

### **Problems in capacity-based thresholds for coercive psychiatric admission / treatment**

These problems would become critical in the cases of the many patients whose cognitive capacities are not clearly ineffectual, but whose decision-making capacity may be undermined by lack of motivation or delusional thinking related to mental disorder<sup>47</sup>. For example, in many clinical situations where patients present with psychotic delusions or hallucinations it is unclear whether an act or a failure to act is a result of defective or impaired judgement or impaired volition. It may be difficult to gauge whether a patient with anorexia who presents as understanding her condition but continues to behave in a way that is detrimental to her future physical health displays an underlying ‘failure’ of evaluation or judgement or a ‘failure’ to act on the information. Cognitively she may well have capacity and be able fully to understand and discuss her condition. Compulsory treatment under these conditions, using the current elastic version of (legal) capacity, either subsumes the patient’s beliefs and emotional evaluations as demonstrating a lack of cognitive capacity (on the ‘common sense’ approach that no-one with capacity would interpret the available information in that way), *or* allows the clinician to implicitly substitute an evaluative (or possibly volitional) test. In this context ‘failure of judgement’ is itself highly value laden and judgmental.

Such problems of subjectivity would not necessarily be overcome through the articulation of an

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45 Damasio A. (2003) *op cit*, p.147.

46 Rudnick A (2002) ‘Depression and competence to refuse psychiatric treatment’ *Journal of Medical Ethics* 28:151–55.

47 Silver, M (2002) ‘Reflections on determining competency’ *Bioethics* 16(5) 455-468



'appreciation' model of incapacity that is central to the idea of 'impaired decision-making'. In such a model, capacity is not simply the dry intellectual ability to process particular sorts of information, but a component part of 'self' that is historically, culturally and developmentally determined, and must be perceived in the historical timeframe of the construction of the 'self'. Only by understanding such formative influences can anyone who is concerned with individuals' decision-making ability understand the values they bring to their choices. If the clinician or other mental health professional assessing capacity does not understand or is ill-prepared (or otherwise unable) to recognise the very different formative influences on the service user compared to her, then the assessment may be flawed because of discriminatory assumptions based not necessarily on irrelevant criteria but on relevant criteria that are wrongly weighted.<sup>48</sup>

Yet there are bound to be difficulties inherent in making such subjective judgements of a persons 'holistic' capacity. Although we would welcome any system that encouraged professionals to pay greater attention to a patient's own views, values and personal life choices when considering questions of compulsion, in such circumstances it may be questionable whether the values of the decision-maker (i.e. involving the protection of human life and a risk-based approach to safety) are either easily or justifiably set aside.

Developing 'values-based practice'<sup>49</sup> that is robust enough to survive the pressures of decision-making in compulsion will be something of a challenge; but if it can result in practice that truly takes account of the personal viewpoint of a prospective patient, and can avoid the problems of generalisation or "abstract humanism"<sup>50</sup>, then there are potentially great benefits to be had.

There are, however, other inherent problems in operating evaluations of mental capacity as a legal thresholds. Lack of 'appreciation' in the MacCAT-T equates, or should equate, centrally with the particular kind of loss of evaluative or judgmental ability (sometimes called 'insight') that is characteristic of the group of disorders that are most likely to be treated on an involuntary basis, namely the functional psychotic disorders such as schizophrenia, hypermania and major depressions. However, the possible use of this as a criteria for compulsion raises the problem identified by Robinson<sup>51</sup> of how a measurement of 'lack of insight', which the Oxford Textbook of Psychiatry deems to be 'not simply present or absent, but rather a matter of degree', is to be translated into a determination of capacity, which must be considered to be either present or absent if it is to serve as a medico-legal threshold for the use of compulsory powers. There are serious questions as to the justiciability of criteria for compulsion resting primarily upon professional assessments of patients' own understanding and beliefs about their mental disorder and its treatment, (however much these are based on a full understanding of the patient's 'values') rather than upon evidenced judgements about the nature of that disorder and the likely consequences of it not being treated<sup>52</sup>.

Even a well structured test of 'appreciation' does not lead to a readily workable boundary to capacity. Grisso and Applebaum<sup>53</sup> have described four types of evaluative processes that should be considered in

48 See Campbell and Heginbotham (1991) *op cit* for a fuller discussion of this point.

49 See Fulford B, Dickenson D L, Murray T (2002) *Healthcare Ethics and Human Values: An Introductory Text with Readings and Case Studies*. Oxford: Blackwell Publishers; Mental Health Act Commission (2003) *Placed Amongst Strangers. Tenth Biennial Report of the Mental Health Act Commission 2001-03*. London, Stationery Office, p.56-60; Woodbridge K, Fulford B (2004) *Whose Values?: A Workbook for Values-based*

*Practice*. London: Sainsbury Centre for Mental Health

50 Mulholland, J (1995) 'Nursing, humanism and transcultural theory: the bracketing out of reality' *Journal of Advanced Nursing* 22, 442-449

51 Robinson, R (2000) 'Capacity as the gateway: an alternative view' *JMHL* 3; 44-8, p.47

52 Robinson, R (2000), *op cit* p.48.

53 Presented at a NIMHE/CSIP conference in September 2004

determining capacity. Of these, two, possibly three, would lead to a determination of incapacity; but the line between capacity and incapacity remains defiantly hazy. Type A are those patients that apply false beliefs with patently (and provably) false premises, related to illogical and rigidly held beliefs that lead to a distorted perspective on meaning, and often associated with psychotic disorders. Type B is where the patient applies what Grisso and Applebaum refer to as significantly 'impoverished perspectives', often associated with developmental disability or cognitive dementias. Type C patients apply adaptive distortions or subjective transformations that are functional in reducing anxiety and uncertainty, but at the risk of maladaptive ideas or perspectives. Such patients are not applying patently false beliefs as in Type A, but have developed defence mechanisms which may or may not lead to lack of decisional capacity. This group may or may not be considered to lack capacity. Finally, Type D are those patients that apply non-logical evaluative premises or use unprovable (non-falsifiable) belief systems which are taken to extremes or are held rigidly. These are often associated with subjective presumptions about the world or are rooted in religious beliefs and moral convictions that may in themselves be not unreasonable if applied appropriately in differing situations. Whilst these categories assist in describing capacity more fully they do not of themselves offer a workable capacity threshold.

The problem of determining when decisional impairment becomes a legal threshold of decisional incapacity is compounded by the judiciary's determination that the more serious the decision, the greater the (cognitive) capacity needed for that decision<sup>54</sup>. This raises a number of difficult logical points, such as, for example, that it creates an asymmetric test where a person could be considered competent to agree to an intervention but not to refuse it<sup>55</sup>. Furthermore, given that capacity determinations in relation to healthcare decisions are made most frequently by doctors who are proposing or considering a medical intervention, the practical capacity threshold that would validate a treatment refusal could be beyond the reach of many people refusing medical treatment, because of the danger of circularity, whereby the refusal of medical advice is itself seen as a result of impaired judgment<sup>56</sup>. Indeed, there is a scandalous logical *reductio ad absurdum* which would say that none of us may be competent to take the most serious (i.e. life or death) decisions in the face of a different view from a medical professional whose scientific understanding claims to be greater than our own. Loosely-drawn criteria for determining mental capacity increase the likelihood of subjectivity or circularity, or both, in its application as a threshold for intervention.

Formulating a workable capacity test is thus fraught with difficulty. In practice, the present legal definition may be serviceable in covering most aspects of capacity in relation to mental disorder, with the possible exception of those who have deeper emotional or evaluative problems concerned with fundamental presentations of the self, rooted in historical and personal constructions and formative influences and which underpin or contextualise the evaluative judgements which go to inform decisions. It would undoubtedly be difficult to enact the complexities of an 'appreciation' model of incapacity, that would encompass such cases, into a statutory definition that could serve as a threshold of coercive psychiatric treatment. If it could be done, there might be a danger that this would either establish (or at least imply) an unworkably *high* threshold of capacity, so that too many people would fail it, or it would allow too *broad* a discretion to decision-makers, reducing the test's utility as a threshold for interventions.

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54 *Re M B* [1997] 2 F.C.R. 541

55 *Culver, C M and Gert, B* (1990) 'The inadequacy of incompetence' *Milbank Quarterly* 68(4):619-43;

*Buchanan, A* (2004) 'Mental capacity, legal competence and consent to treatment' *J R Soc Med* 97:415-20.

56 *Mental Health Act Commission* (2006) *op cit*.

## Can a capacity test operate as the threshold for coercive psychiatric admission / treatment?

There appear to be two sets of practical problems in achieving a capacity test that would function as a threshold for coercive psychiatric treatment, however desirable such a test might be. The first set of problems, which turn on the definition of capacity used, are the principal focus of this paper; the second set of problems is associated with what would happen to persons in evident distress, especially those thought possibly to be a danger to others, but who retain capacity on whatever test is used. The Richardson Committee's answer to the latter problem was to propose mental incapacity as one amongst several criteria for compulsion, some of which (for example dangerousness) might take precedence in practical usage<sup>57</sup>. Whilst this position has been criticised by some commentators<sup>58</sup>, we think that such compromise may be inevitable and is certainly common in other jurisdictions. Nevertheless, there must be some doubt as to the effectiveness of a criterion of mental incapacity to promote 'autonomy' if it can be overridden by other criteria (such as a criterion relating to 'risk' or 'harm'), particularly in relation to *detention* (as opposed to *treatment*), given the pressures upon the psychiatric service to attend to 'risk-assessments' and the 'dangerousness' of its potential clients. In part this turns on the objective of legislation: is it to enable maximum autonomy for the patient, or is it concerned essentially with achieving an amalgam of patient and public safety with the emphasis firmly on the latter?

Making capacity the sole legal criterion for detention or treatment will not 'magic away' the pressures on psychiatry to attend to risk. The way in which concepts of 'risk' would be likely to influence or distort a broadly drafted criterion of incapacity (even if it was the sole operative criterion) is evident from the conclusion of the Richardson Committee that "most 'mentally ill' patients who present the required level of risk will not retain the necessary capacity"<sup>59</sup>. There is a striking similarity between this sentiment and that expressed fifty years ago by the Percy Commission which we quoted at the start of this paper. This similarity was noted by Robinson<sup>60</sup>, who argues that, by adopting a model of capacity that would apply to mentally ill people in a unique way through its equation of incapacity with a lack of insight, the Committee undermined its claim that a capacity test would end the discrimination between psychiatric patients in comparison to people undergoing treatment for somatic medical disorders, and in effect proposed looser criteria for compulsion than are presently operable under the 1983 Act.

It may be that the best hope for capacity-based mental health legislation is through a separation, as in Ontario law, between the criteria for detention and those for treatment, with a right to refuse the latter being based upon a threshold of capacity. In England and Wales this is already a "developing area of law"<sup>61</sup>, or is at least the subject of a sustained campaign of test-cases, starting with the *Wilkinson* case, aiming to show that the current legal overriding of autonomy in relation to treatment to be incompatible with the European Convention of Human Rights. Whether or not such an approach is ultimately successful, there are perhaps lessons from the fact that, after a decade of various forms of a right to refuse treatment in the United States, Appelbaum noted that "refusing patients almost always receive treatment in the end"<sup>62</sup>. This suggests to us that forms of coercion more subtle than the law are at work in such systems: to Appelbaum this "point[s] up the essential illogic of allowing committed persons to refuse treatment that would permit their freedom to be restored".

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57 Department of Health (1999b) *op cit*.

58 For example, Gunn, M (2000) 'Reform of the Mental Health Act 1983: the Relevance of Capacity to Make Decisions' JMHL 3; 39-43

59 Department of Health (1999b) *op cit*, p.72.

60 Robinson, R (2000), *op cit* p.45

61 Bowen, P (2002) 'Detained patients and the right to refuse treatment' JMHL, February, 59-66.

62 Appelbaum, P S (1988) 'The right to refuse treatment with antipsychotic medications: retrospect and prospect' Am J Psychiatry 145:413-419.

Service users may not welcome a separate capacity test for evaluative/emotional or volitional capacities (and such an approach might be far too unwieldy) but neither are they likely to accept thresholds relating to the imposition of compulsory powers that assess evaluative capacity implicitly, ostensibly as part a cognitive test, without making explicit the grounds on which the assessment is being conducted. To be workable as a practical criterion for psychiatric detention and/or compulsory treatment, a capacity test must be (i) defined carefully and explicitly so that it is understandable by all those that have to use it or are affected by it, (ii) sufficiently extensive so as to capture what matters but not so broad as to nullify limited but workable mental capacity, and (iii) clinically acceptable and meaningful, and sufficiently rigorous as to be replicable under similar clinical conditions and challengeable to an appeals system. Furthermore, the choice of test for measuring incapacity will affect the type and proportion of patients classified as incapable<sup>63</sup>. This presents a dilemma. Whilst the current Mental Capacity Act and *Re C* test could be relatively straightforward to implement, it may not meet the above criteria of establishing clear thresholds; and, if it does do so, may not 'capture' all that matters, and thus not cover all those who might benefit from compulsory admission and/or treatment.

A richer and more nuanced capacity test, which dealt explicitly rather than implicitly with emotional and volitional capacity impairments, could be legally and clinically complex. It would be thus at once difficult for clinicians, lawyers and lay persons alike to understand and communicate, but also more inclusive or elastic in its application. A further dilemma is that, unless it would be determined as acceptable for there to be different capacity tests for psychiatric patients in the context of compulsion to those otherwise operable for any other healthcare decision (in which case the tests would be open to a charge of discrimination), any broadening of the definition of mental incapacity in the context of compulsion could result in equivalent broadening of what it means to be incapable in other contexts. There is some evidence that mental incapacity, as currently defined, is often overlooked in general medical practice<sup>64</sup>. However, in a commentary on that study, O'Keefe has warned against imposing unduly challenging standards for competence to make treatment decisions, arguing that doctors should respect autonomy by seeking to identify and to maximise the decision-making abilities of patients, rather than declaring patients incapacitated, and describing as "chilling" the prospect that more extensive capacity-testing (even with a narrow cognitive focus) might be used "to regulate the freedom to decide" of patients such as elderly people with mild stages of cognitive impairment<sup>65</sup>.

The more a capacity threshold for coercive interventions is defined to incorporate evaluative notions such 'appreciation', the more danger there is of elasticity and result-oriented jurisprudence based upon general normative standards. Incorporating terms like 'weigh' or 'appreciate' can be used very flexibly in practice to determine whether a person does or does not have capacity. Whether consciously or not, and for the best of motives, clinicians would be able to tailor their assessment far too readily to their own view of the circumstances. An objection to these concerns is that tests such as the MacCAT-T are already in use in clinical situations, and there is little indication that the theoretical basis of such tests has collapsed under the weight of the problems that we have suggested. Furthermore, it is true that the existing criteria for compulsory detention and treatment are not above criticism for their potential for subjective interpretation, and (of course) for the fact that they 'discriminate' against people with serious mental disorders by denying them the same theoretical right to refuse treatment that would apply were they

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63 Grisso, T and Appelbaum, P S (1995) 'Comparison of standards for assessing patients' capacities to make treatment decisions' *Am J Psychiatry*; 152:1033-1037.

64 see, for example, Raymont et al (2004) *op cit*.

65 O'Keefe, S (2005) 'Mental capacity of inpatients' *The Lancet (correspondence)* Vol 365 February 12, 2005

suffering from somatic medical conditions<sup>66</sup>. It is possible that some valuable empirical information will emerge from the operation of Scottish legislation and, once it is operational, the Mental Capacity Act 2005. The use of the term 'weigh' in the Mental Capacity Act may become defined similarly to 'appreciation', and as such careful research into the criteria used by clinicians assessing incapacity may shed some light on the value of 'appreciation' as a test.

## Conclusion

The law of incapacity "creates roles of authority and dependence, discipline and control, power and subordination", engaging issues of institutionalisation and learned dependency, and risking conflict between the best or true interests of the incapacitated person and the view or personal convenience of the decision-maker<sup>67</sup>. A label of 'incompetence' may have a number of deleterious effects on a patient, including the inhibition of performance or motivation due to reduced self-esteem or altered conception of self; exacerbation of depressive symptoms; learned helplessness (i.e. the generalisation into a global sense of powerlessness of feelings generated by specific situations<sup>68</sup>); and social disadvantages due to the ways in which the label may alter the way others see or react with the patient<sup>69</sup>.

Whether or not the law of England and Wales adopts a capacity-based threshold for detention under the Mental Health Act, we believe that further research is needed into the nature of capacity and its determination before a capacity test can be used adequately in mental health law, and that careful guidance is required in the Code of Practice. To be used as a threshold test for compulsion, a sufficiently rich and robust understanding of capacity is required, based on practical assessments of capacity undertaken in the messy real world of mental health and other human services.

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66 Robinson (2000), *op cit*, questions whether the language of 'discrimination' is appropriate in this context.

67 Bartlett, P & Sandland R (2003) *Mental Health Law; Policy and Practice (second edition)*. Oxford University Press, p.582

68 See the 1970s research of the experimental psychologist Martin Seligman. A full list of references is in Winick, B J (1995) 'The Side Effects of Incompetency Labelling and the Implications for Mental Health Law' *Psychology, Public Policy, and Law* Vol 1, No 1, 6-42.

69 Winick, B J (1995) *op cit*, n.21