
Is Capacity “In Sight”?

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“Oh we didn’t talk much about capacity – we used to talk about insight”

Consultant Psychiatrist’s comment at the inquest into a patient’s death

“The MHAC has great concern that ‘consent’ is equated with ‘insight’...”

MHAC, *Risk, Rights, Recovery* 12th biennial report para 6.24

Introduction

Convicted of rape, Mr B was sent to Broadmoor.² His psychiatrist diagnosed bipolar affective disorder and wanted, if necessary, to compulsorily treat him with anti-psychotic medication. In his professional opinion, Mr B lacked insight into his condition and lacked the capacity to refuse the treatment. Baroness Hale once remarked that “psychiatry is not an exact science”.³ If there was ever a case to confirm that view, this is it.

At a tribunal hearing, the medical member of the panel thought that Mr B had schizophrenia. Another doctor could not find any mental disorder at all. The one acting for the Home Office diagnosed schizo-affective disorder but agreed with the responsible clinician that the patient lacked capacity to consent. Meanwhile, the Second Opinion Appointed Doctor (‘SOAD’), called in to approve the RC’s treatment plan, initially diagnosed schizo-affective disorder but then changed his mind to bipolar affective disorder. In his opinion, Mr B *lacked* insight but *had* capacity to refuse.

There was more evidence to follow: two Professors were brought in. Both agreed that Mr B had bipolar affective disorder. The Professor of Psychiatry also agreed with the SOAD on the issue of capacity. In short, the patient was not impaired by his illness and had the capacity to refuse.

So by the time the case reached the courtroom there was some degree of consensus, at least as to diagnosis: Mr B had bipolar affective disorder. But so far as the proposed treatment was concerned, two psychiatrists thought he had capacity to refuse it; two did not. No-one seemed to suggest he had insight.

Disagreement in diagnosis inevitably confuses patients. All of us prefer to believe that we are of sound mind. Mr B preferred to believe that he was mentally well. The most he was prepared to accept was that he was one of those 10% of bipolar affective disorder patients who would not relapse: optimism which the judge described as “an understandable and natural human reaction”. The patient’s ability to recall earlier discussions with doctors around treatment was said to be “remarkable”. And the judge decided that he was able to comprehend and retain all the relevant information.

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² *R (on the application of B) v Dr SS* [2005] E.W.H.C. 1936; [2006] E.W.C.A. Civ. 28.

³ *R (on the application of B) v Ashworth Hospital Authority* [2005] 2 A.C. 278.

In those circumstances, did it really matter whether Mr B had insight into his condition? Was the issue not simply whether or not he had capacity to refuse the drugs? What is the relationship between these psychiatric and legal concepts?

Is Capacity In Sight?

Our understanding of mental capacity is not what it used to be, thank goodness. Long gone are the days when those with mental disorder were automatically assumed to be incapable of making decisions. Thanks to another one of Broadmoor's residents, Mr C who was diagnosed with schizophrenia, English law saw fit to "clarify" (if not invent) the capacity test. He had to decide whether to have a gangrenous leg amputated. The judge held that he would lack capacity if he was unable to comprehend, retain, believe, or weigh the relevant information or if he could not communicate his decision. You might think that Mr C's delusions of medical grandeur and his persecutory thoughts might have prevented him from weighing the information. But they did not. The law therefore respected his decision to die with two feet rather than to live with one.⁴

Nowadays, strictly speaking, mental capacity has two meanings in mental health law. Firstly, under the *Mental Capacity Act 2005 (MCA)*, we lack capacity if at the material time, due to an impairment or disturbance in the functioning of our mind or brain⁵, we are unable to do any one of four things. That is, if we are unable to understand information relevant to the specific decision; unable to retain that information for as long as is required to make the decision; or to use or weigh that information as part of the decision-making process; and, finally, if we cannot communicate our decision.⁶ Notice that there is no mention of *belief*.

Secondly, the amended *Mental Health Act 1983* refers to being capable of understanding the nature, purpose and likely effects of treatment. Baroness Hale (I think rightly) suggests⁷ that the MCA test should be used. Otherwise, the same treatment decision would invite two different legal tests depending on whether the person was informal or detained.

The concept of capacity plays a far more significant role now than it used to. Indeed, some might describe it as a pivotal role. Greater clarity in the law, combined with more reliable empirical research, have each contributed to the cause. For example, studies suggest that "the frequency of incapacity in psychiatric in-patients ... [does] not differ greatly from that in general hospital in-patients".⁸ Okai and others went so far as to suggest that most psychiatric in-patients are capable of making key treatment decisions. It is therefore difficult to disagree with Geneva Richardson who said:

*"While some people with mental disorder will no doubt lack rationality or judgment, by any definition, many will not, and it is the growing realisation that people with mental disorder are still capable of considered judgement that has cast doubt on the old assumptions."*⁹

Such doubt has bred reform. Capacitous foresight, for example, has been reinforced by the MCA: not only can we make advance decisions to refuse treatment; we can now appoint others to make personal welfare

4 *Re C* [1994] 1 All E.R. 819. Such grandeur was no doubt reinforced when, contrary to expert opinion, the gangrene cleared up with medication alone.

5 S.2(1) *Mental Capacity Act 2005*.

6 S.3(1) *Mental Capacity Act 2005*.

7 *R (on the application of Wilkinson) v Broadmoor Hospital Authority* [2002] 1 W.L.R. 419 at para 66. *MHA Code*

of Practice (2008) at p201 agrees with this view.

8 D. Okai et al, 'Mental capacity in psychiatric patients: Systematic review' (2007) 191 *British Journal of Psychiatry* 291, 295.

9 G. Richardson, 'Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions' (2002) 65 *Modern Law Review* 702, 706.

decisions for us in the event of us subsequently losing capacity. Under the deprivation of liberty safeguards, neither PCTs nor local authorities can deprive the liberty of those capable of deciding on their accommodation arrangements. Even for those incapable of making that decision, detained residents retain the right to make those other decisions for which they have capacity. Moreover, the capacitous decisions of 16 and 17 year olds who refuse to be informally admitted can no longer be overridden by their parents.¹⁰

The capacity concept has not surged quite so far into the crevices of the 1983 Act, although that has not stopped the old assumptions from being firmly tested. Unlike the position in Scotland¹¹, capacity still plays no explicit role in the decision to detain, although many professionals take it into account as a matter of good practice. The law also denies detained patients the right to refuse treatment for their mental disorder. Medication can be compelled upon them, at least for three months¹², at which point their capacitous refusal can still be trumped by a SOAD.

And yet Bellhouse found that “a majority of people detained under the present MHA had the capacity” to make decisions for themselves.¹³ It could be argued that capacity is playing an ever-growing role in MHA detentions. All detained patients with capacity are able to refuse all treatment that is not for their mental disorder. Brain tissue cannot be destroyed, nor hormones surgically implanted, without the patient’s capacitous consent and a second medical opinion.¹⁴ Electro-convulsive therapy can no longer be given in the face of a capacitous refusal unless it is immediately necessary to save life or to prevent a serious deterioration in health. Valid and applicable advance decisions to refuse ECT, or those of donees or deputees, must similarly be respected for incapacitated patients.¹⁵ And no treatment can be compulsorily given to capacitous patients on CTOs unless they are recalled to hospital.

So, with capacity making such big legal strides, what is the legal relevance of insight?

Is Capacity Insight?

My concern is that recent research has attempted to use insight as a measurement of capacity. In their empirical study, Cairns and others suggested there is conceptual overlap between insight and mental capacity.¹⁶ They argued that ‘insight’ was the strongest predictor of incapacity.

“The degree of patient insight has a close relationship to capacity and the need for involuntary treatment. It remains possible that this construct, although no less complex than capacity, is more intuitive to mental health professionals and may provide a more reliable basis for coercive-treatment decisions.”

Hotopf¹⁷ acknowledges the strong association between the concepts but contends that it is not an absolute one: it is possible to have insight and lack capacity, and vice versa. That certainly was the view taken by some of the doctors in Mr B’s case.

But what is insight?! Does it sit somewhere between foresight and hindsight? It is a clinical concept which

10 MHA s.131.

11 Mental Health (Care and Treatment) (Scotland) Act 2003 requires judgment to be significantly impaired before detention can occur.

12 MHA s.63 and 58.

13 J. Bellhouse et al, ‘Capacity-based mental health legislation and its impact on clinical practice: 1) Admission to Hospital’ (2003) *Journal of Mental Health Law* 9; J. Bellhouse et al, ‘Capacity-based mental health legislation

and its impact on clinical practice: 2) Treatment in Hospital’ (2003) *Journal of Mental Health Law* 24, 35.

14 MHA s.57.

15 MHA s.58A.

16 R. Cairns et al, ‘Prevalence and predictors of mental incapacity in psychiatric in-patients’ (2005) 187 *British Journal of Psychiatry* 379, 384

17 Hotopf et al, (2008) *British Medical Journal* 337: a902.

seems easier to use than it is to define.¹⁸ Indeed, there is much disagreement over its meaning which is unfortunate, given the obvious, although in many ways unspoken, impact it has on detention, treatment and discharge decisions.

Sir Aubrey Lewis once described insight as “a correct attitude to a morbid change in oneself ... the realisation that the illness is mental ... to see ourselves as others see us”.¹⁹ And there are at least seven other definitions of the term in the literature. Jaspers, for example, described it as the feeling of being ill and changed, plus the ability to evaluate the nature and severity of that illness.²⁰ David described it as being able to relabel mental events as pathological; to recognise you are being affected by a mental disorder; and to admit you need treatment and will comply with it.²¹ I could go on: Greenfeld,²² Amador,²³ Fleming,²⁴ Beck,²⁵ and Marková and Berrios,²⁶ have all come up with their own suggestions.

Returning to Mr B for a moment, what was the correct attitude to his morbid change? Would he have been correct to accept he had bipolar affective disorder, schizophrenia or schizo-affective disorder? Was there in fact a morbid change? After all, two doctors did not even think he had a mental disorder. Can any patient be expected to have insight in the face of disagreement in diagnosis?

Not only does insight have different meanings; there are also different tests for measuring it. There is the Insight and Treatment Attitude Questionnaire;²⁷ the Scale to Assess Unawareness of Mental Disorder;²⁸ the Insight Scale;²⁹ Beck's Cognitive Insight Scale;³⁰ and Birchwood's Insight Scale.³¹ Not to mention David's Schedule for the Assessment of Insight.³² Høyer goes so far as to argue that the content of these tests is virtually meaningless: “[T]hose agreeing with their treating psychiatrist have insight, those who disagree have not”.³³ Is this really what insight boils down to? Agreeing with your doctor because s/he knows best?

The cases of Mr B and Mr C were decided before the MCA. Whether they *believed* the information was, back then, a factor taken into account in determining whether they had capacity. In relation to Mr B, the judge drew a distinction between those who accept that they are mentally ill, or realistically entertain that possibility because they accept that this is the honest and professional diagnosis of doctors; and those who

18 Fulford, 'Insight and delusion: from Jaspers to Kraepelin and back again via Austin' in *Insight and Psychosis* (ed. X. Amador and A. David, 2nd edn, 2004), pp.51–78

19 A. Lewis, 'The psychopathology of insight' (1934) 14 *British Journal of Psychiatry* 332.

20 K. Jaspers, *General psychopathology* (1963).

21 AS David, 'Insight and psychosis' (1990) 156 *British Journal of Psychiatry* 798.

22 D. Greenfeld, JS Strauss, MB Bowers, M Mandelkern, 'Insight and interpretation of illness in recovery from psychosis' (1989) 15 *Schizophrenia Bulletin* 245: The acknowledgement of 1) pathological processes and unusual experiences, 2) need of a treatment, 3) possibility of relapse, 4) pressure by psychosocial stressors.

23 X. Amador, D. Strauss, S. Yale, M. Flaum, J. Endicott, J. Gorman, 'Assessment of insight in psychosis' (1993) 150 *American Journal of Psychiatry* 873: The presence of 1) awareness of symptoms and 2) explanations about the causes of pathology.

24 JM Fleming, J. Strong, R. Ashton, 'Self-awareness of deficits in adults with traumatic brain injury: how best to measure?' (1996) 10 *Brain Inj* 1: Three-level model of

self-awareness: 1) awareness of the injury-related deficits, 2) awareness of the functional implications of deficits for everyday activities, 3) ability to set realistic goals and predict one's future state accurately.

25 A. Beck, E. Baruch, J. Balter, R. Steer, D. Warman, 'A new instrument for measuring insight: the Beck Cognitive Insight Scale' (2004) 68 *Schizophr Res* 319: Conceptualization of 1) intellectual insight versus emotional insight and 2) cognitive insight.

26 IS Marková, GE Berrios, 'Insight in clinical psychiatry. A new model' (1995) 183 *J Nerv Ment Dis* 743; 'The object of insight assessment: relationship to insight structure'

27 McEvoy et al, (1981).

28 Amador et al (1993).

29 Marková and Berrios (1992) and (2003).

30 Beck et al (2004).

31 Birchwood et al (1994).

32 AS David, *ibid* n21.

33 G. Høyer, 'On the justification for civil commitment' (2000) 399 *Acta Psychiatrica Scandinavica* 101.

do not. Mr B did not accept the possibility. To cling on to his beliefs was “understandable”, said the judge, given that they were supported by at least one doctor’s views. However, not believing the other doctors was his downfall:

“In my judgment it follows that Mr B does not believe or accept a cornerstone of the factors to be taken into account in considering the information he has been given about his proposed treatment and therefore is not able to use and weigh in the balance the relevant information as to his proposed treatment in reaching a decision to agree to it or to refuse it.”

His mental illness had so coloured his comprehension of the information that he was not able to process it at a cognitive level. For the Court of Appeal, it was plain that “a patient will lack that capacity if he is not able to *appreciate the likely effects of having or not having the treatment*”.³⁴

In relation to Mr C, this case emphasised that to have capacity, a patient does not have to blindly accept medical evaluation and can have a level of self-assessment of any consequences, at least in so far as physical treatment decisions are concerned.

The requirement for belief is nowhere to be seen in the Mental Capacity or Mental Health Acts. Does this represent a significant change in the law? Is this Parliament’s way of pushing insight to the sidelines? Not according to Munby J:

*“If one does not “believe” a particular piece of information then one does not, in truth, “comprehend” or “understand” it, nor can it be said that one is able to “use” or “weigh” it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information.”*³⁵

Is this right? Are we able to use and weigh information relating to something we do not believe in? Can an atheist, for example, ever have the capacity to consent to a religious wedding if they do not believe in God? Can a Jehovah’s witness ever capacitously decide to have a blood transfusion if they think other people’s blood is evil? Surely it cannot be right; otherwise we would not be able to understand anything that we did not believe in. It would make it impossible to disbelieve a doctor and retain capacity.

Such are the demands of insight that even believing *everything* a doctor tells you may not be enough. Take *B v Croydon Health Authority*,³⁶ where a detained patient described as having a personality disorder spoke of wanting to punish herself and wanting to understand why. Lord Justice Hoffmann said: “It is however this very self-awareness and acute self-analysis which leads me to doubt whether, at the critical time, she could be said to have made a true choice in refusing to eat.”

The Dilemma of Denial

If the law is to recognise a role for insight, its meaning and relationship with capacity requires more thought and greater clarity. At present, the two concepts are like quibbling siblings. They are awkward so-and-so’s, misbehaving under the watchful eye of their parental figures, law and psychiatry. Often both siblings attend to a person’s decision. Occasionally one of them may decide to turn up without the other. Sometimes both siblings are absent.

34 [2006] EWCA Civ. 28 at para 34.

35 *Local Authority X v MM and KM* [2007] EWHC 2003 (Fam) at para 81.

36 [1995] 1 FL.R. 470.

The term, insight, does not appear in any mental health or capacity legislation. Nor does it appear in the MHA Reference Guide and only once is it mentioned in the Code of Practice.³⁷ And we talk about it all the time in mental health. Indeed, it has been described as the single most consistently discussed symptom of mental illness amongst tribunal members.³⁸

Should we be concerned? Diesfeld certainly is. He argues³⁹ that insight remains legally ill-defined and its frequent use as an extra-legislative criterion threatens legal safeguards. There is a risk, in other words, that clinical concepts like insight might become proxy or substitute criteria for legal decisions.

Insisting on one's mental order should not inevitably be seen as evidence of mental disorder. Nor should it inevitably be equated with incapacity. After all, psychiatry itself is not an exact science.

37 MHA Code of Practice at para 25.11.

38 E. Perkins, S. Arthur and J.Nazroo, 'Decision-making in mental health review tribunals' (Central Books, London, 2002) p.124.

39 K. Diesfeld, 'Insight on 'insight': the impact of extra-legislative factors on decisions to discharge detained patients' in *Involuntary Detention and Therapeutic Jurisprudence* (ed. K. Diesfeld and I. Freckelton, 2003) pp.359–382.