

Capacity as the Gateway: an alternative view

*Robert Robinson**

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the Percy Commission) in its 1957 report put the case for providing “forms of control, within stated limits, over people suffering from mental disorder which do not apply to other people”. Paragraph 314 (i) of the report offers the following justification for compulsory treatment in the interests of the patient’s health: “When an illness or disability itself affects the patient’s judgment and appreciation of his own condition, there is a specially strong argument for saying that his own interests demand that the decision whether or not to accept medical examination, care or treatment should not be left entirely to his own distorted or defective judgment. Admission to hospital against the patient’s wishes at the time may be the only way of providing him with the treatment or training which may restore his health or enable him to take his place as a self-supporting member of the community or to develop his limited capabilities to the greatest possible extent. The better the prospects are of treatment or training being successful, the more important this consideration becomes.” The report goes on to say: “No form of mental disorder should be considered to be, by itself, a sufficient ground for depriving a person of his liberty. It is necessary to balance the possible benefits of treatment or training, the protection of the patient and the protection of other persons, on the one hand, against the patient’s loss of liberty on the other.”

This rationale, which is reflected in the provisions of the 1983 Act, is rejected in the Report of the Expert Committee on the Review of the Mental Health Act 1983 because it discriminates against the mentally disordered by depriving them of the right to patient autonomy, that is the right of people to make effective treatment choices. Crucially, the right depends upon the patient having capacity to make such choices: “Patient autonomy brings with it an inevitable emphasis on capacity.” (para.2.4) The purpose of this paper is to argue that the Expert Committee’s approach is flawed. First, because it would merely, to use the terminology of discrimination law, replace direct discrimination with indirect discrimination. Second, because in conceptualising the detainable mentally ill patient as lacking capacity to make choices about treatment it erodes the validity of other choices which such a person may make. Third, that it tends to weaken the criteria for compulsion to what is, in effect, a best interests test. Fourth, that the justiciability of questions of capacity is problematic where the incapacity both results from mental illness and is considered in the context of treatment for mental illness.

Discrimination

It is instructive to compare the Percy Commission's justification for compulsion with the Expert Committee's discussion of the application of the concept of incapacity to those suffering from mental illness: "Thus we propose a broad model of incapacity which accepts that a person may lack capacity where, although intellectually able to understand and apply the information, that person nonetheless reaches a judgment which s/he would not have reached in the absence of the disorder." (para.7.5) If the proposals of the Expert Committee on the use of compulsion rest on the same analysis as those of the Percy Commission, namely that mental illness may deprive the sufferer of the insight necessary to seek treatment, then it is hardly surprising that broadly the same group of people for whom the justification for compulsory treatment now amounts, in the opinion of the Expert Committee, to discrimination would still be subject to compulsion under their proposals. That this is the case can be demonstrated with reference to those parts of the Expert Committee's report where they analyse the impact of their proposals on the compulsory treatment of mental illness. The clearest example is the Committee's analysis of "The patient with a Deteriorating Condition" in paragraphs 7.12 - 7.14 where we find the following statement: "Under a proper understanding of the boundary between capacity and incapacity we would consider that such a person [who has no current symptoms of mental illness but who is refusing treatment] should be regarded as lacking capacity provided that there is a clear history of relapse and positive response to treatment." It can thus be seen that the concept of incapacity applies to the mentally ill in a unique way and will apply disproportionately to people suffering from mental illness as opposed to those suffering from other illnesses. The principle of patient autonomy is more a matter of form than substance for a person diagnosed as suffering from a serious mental illness who declines to accept medical treatment. If a capacity test leads to this result is it not a form of indirect discrimination? Or does this not simply demonstrate that the concept of discrimination is unhelpful in this area of law.

Autonomy and the detainable patient

Almost all those who are subject to compulsion under the 1983 Act are classified as suffering from mental illness as opposed to other forms of mental disorder. Of these the great majority are treated as having capacity, in that the presumption of capacity has not been rebutted. The only point at which the Act requires a consideration of capacity is when the patient's consent to treatment must be sought under section 57 or 58. But the capacity test in those sections is cognitive ("is capable of understanding its nature, purpose and likely effect") and is therefore satisfied by those patients who are "intellectually able to understand", without further enquiry into whether the patient believes that he is mentally unwell and will benefit from treatment. A patient lacking in insight may therefore give a legally effective consent to treatment. Similarly, the mentally ill patient faced with a formal assessment for compulsory admission has the choice to opt for informal admission. This is regarded as a voluntary choice, albeit constrained by the patient's circumstances, and the patient is in effect treated as if he has capacity. Such a person is exercising a form of patient autonomy, although no enquiry is made into his capacity to do so.

The effect of the Expert Committee's proposals would be not only to make capacity fundamental to the admission process, but to impose a capacity test which, as the Committee acknowledge in paragraph

5.100 of their report, most mentally ill people who may be subject to the use of compulsory powers will fail. A person, such as “the patient with a deteriorating condition”, who does not believe he suffers from mental illness or that medication is therapeutic will fail the capacity test. If he wishes to opt for voluntary admission, fully understanding that he will be expected to stay in hospital and take medication for his mental illness, should his choice be respected, given that he fails the capacity test on which true patient autonomy depends? If we deem him to lack capacity, why should we be parties to his decision to opt out of the statutory safeguards provided for detained patients? The answer must surely be that it is obviously far better that such a patient should be treated as capable of making a valid choice, regardless of his beliefs about his medical condition and treatment. The alternative is to consign him to the ranks of the Bournewood-type patients, compliant but incapacitated, and turn him into an object of paternalism. It can therefore be argued that there are important features of existing mental health law which promote autonomy. This is because in general mentally ill patients are treated as being capable of making choices and exercising rights, even if their judgment can be overridden by the use of compulsion.

The criteria for compulsion

The policy of existing mental health law is that those invoking or reviewing the use of compulsory powers must be satisfied that the patient’s mental disorder is of a nature or degree which makes hospital treatment appropriate. This test is rightly criticised by the Expert Committee as being open to many different interpretations. They say that a capacity test, which would in their view be apt to cover compulsion both in hospital and in the community, would lead to “a more precise and objectively justifiable use of compulsory powers”. (para. 7.10)

The difficulty with what the Expert Committee propose, when setting out the criteria for compulsion in paragraph 5.95 of their report, is that in practice, where the (mentally incapacitated) mentally ill patient is concerned, the criteria amount to little more than a best interests test, coupled with a requirement that the proposed treatment is the least restrictive alternative. This is consistent with the general law on medical treatment of the mentally incapacitated which confers on doctors power to give treatment which they judge to be in the patient’s best interests. It should be contrasted with the notion that in detaining a person and treating them without consent we are acting in opposition to their wishes and against what they judge to be in their own best interests. The model within which we now operate says in effect that the patient’s wishes are to be respected unless and until his mental illness becomes so serious, whether in its nature or degree, that his wishes should be overridden, to the extent that this is necessary to provide appropriate treatment. The incapacity model simply fails to capture this and for this reason is not apt to provide for the balancing of competing interests which was referred to by the Percy Commission. It is driven by the logic of its own paternalism to treat the patient in a way consistent with what others deem to be his best interests. Indeed, it is difficult to see why, in considering treatment for the mentally incapacitated, we should, except in a clinical sense, act differently according to the nature or degree of the incapacitated patient’s condition. After all, we do not regard other forms of medical treatment for the mentally incapacitated as representing an infringement of their rights: the only relevant right of the incapacitated patient is to be treated in accordance with “best interests”. This represents a

fundamental difference of approach. While the present statutory criteria no doubt provide scope for misinterpretation and abuse of compulsory powers, they do at least have the potential to act as barriers which hardly seem necessary or appropriate if the patient is mentally incapable.

Justiciability

The determination of whether or not a person who may be made subject to compulsory treatment does or does not have capacity would, under the Expert Committee's proposals, be the central issue for mental disorder tribunals in deciding whether to confirm compulsion. For people with mental illness this would seldom turn on their cognitive abilities. The argument would be directed towards the second limb of the Expert Committee's proposed capacity test which is to be found at paragraph 7.5 of their report. Applying this test, the question for the tribunal would be whether or not the patient "is able to make a decision based on the information relevant to the decision". This requires a consideration of whether the patient believes the medical information about diagnosis and treatment which is provided by the doctor and whether the patient is capable of weighing this information in the balance to arrive at a choice about treatment. The tribunal would therefore have to decide what information is relevant to the treatment decision such that if the patient did not believe it he would fail the capacity test. It would then have to go on to consider whether the patient does in fact believe the relevant information and whether the patient's decision to refuse treatment is based on a rational consideration of that information. The examples given in paragraph 7.9 of the Committee's report illustrate some of the difficulties. Example v) is: "A patient with schizophrenia who is known to respond well to medication is convinced he is well after an initial and incomplete improvement, and refuses medication although he is demonstrably still unwell." Example vi) is : "A patient with schizophrenia responds well to medication and after an initial improvement says he no longer wishes to take it because he can manage without. He appreciates that his condition may well deteriorate and if it does so he has authorised a friend to re-engage with the mental health services on his behalf." The Expert Committee's opinion is that the first but not the second would fail the capacity test. It is hard to avoid the conclusion that capacity is being equated with the psychiatric concept of insight. While it may make clinical sense to talk about partial insight since, according to the Oxford Textbook of Psychiatry, "insight is not simply present or absent, but rather a matter of degree", capacity is something you either do or do not have. At what point along the continuum does the patient's lack of insight amount to incapacity? Is this a question which can sensibly be asked, let alone be satisfactorily answered by a judicial process? While it must be conceded that under their present jurisdiction mental health review tribunals routinely have to consider the patient's insight as being relevant both to the nature and degree of the illness and to the question whether treatment could be given without compulsion, these are essentially medical issues and are a normal part of psychiatric assessment. Capacity is a different sort of concept, medico-legal in nature, which would be likely quickly to lose its objectivity and clarity in being reduced to a proxy for insight.

Returning to the two illustrative examples, the relevant differences can be well conveyed in terms of insight since the first patient, though apparently not the second, at least appears to acknowledge that he may be suffering from a persistent mental illness. While the suggested result accords with the outcome one might expect under the existing law, it is not clear why one but not the other is to be regarded as

incapacitated since neither seems to believe the treatment information, which flows from a diagnosis of schizophrenia, that he requires prophylactic medication to remain well. It is also unclear how the conclusion that the first patient has capacity can be reconciled with the example referred to above of “the patient with a deteriorating condition”. It would appear that the notion of capacity is being used pragmatically to reflect views about the appropriateness of compulsion based on qualitative assessments of a particular individual’s mental illness. If the capacity test were to be applied in this way, it is difficult to share the Expert Committee’s optimism that their proposals would result in “a more precise and objectively justifiable use of compulsory powers”. On the contrary, viewed purely as a judicial process, decisions about detainability and compulsion are more likely to command confidence if they continue to be articulated as judgments, supported by psychiatric and other evidence, about the nature of the patient’s mental illness and the consequences of it not being treated rather than appearing to be founded on an enquiry into the patient’s own understanding and beliefs about his condition and the need for treatment.

* *Consultant Psychiatrist, Leeds Community and Mental Health Services (Teaching) NHS Trust and Senior Clinical Lecturer, University of Leeds. Mental Health Act Commissioner.*

** *University Lecturer and Hon. Consultant Psychiatrist, Department of Psychiatry, University of Cambridge*

and Lifespan NHS Trust

1 *Reform of the Mental Health Act: Proposals for Consultation. Department of Health. (1999).*

2 *Report of the Expert Committee. Review of the Mental Health Act 1983. Department of Health. (1999).*