

Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital

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INTRODUCTION

In this paper, the second of two, we consider the capacity of those assessed with respect to their ability to consent to admission to also consent to their treatment with medication. The results of our assessment of capacity to consent to admission are described in our first paper along with the policy background to the study¹. In comparison to admission decisions, for treatment decisions there is an extensive body of literature and case law that provides guidance on the key principles. In English law (i.e. the law in England and Wales) the wishes of a competent adult offered treatment for a physical disorder must be respected². However, with treatment for a mental disorder the decision of a competent person to withhold consent can still be lawfully overridden using mental health legislation if the health or safety of the person concerned is at risk, or if it is necessary for

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1 Bellhouse, J., Holland, A.J., Clare, I.C.H., Gunn, M. & Watson, P. (2003) Capacity based mental health legislation and its impact on clinical practice:1) admission to hospital. *Journal of Mental Health Law* (2003) page 9.

2 Re C (Adult: Refusal of medical treatment) [1994] 1 All England Law Reports 819; Re T (Adult: Refusal of treatment) [1992] 4 All England Law Reports 649; For discussion see Gunn, M. (1994) The meaning of incapacity. *Medical Law Review* 2, 8–29.

the protection of others. At present for those detained under the *Mental Health Act 1983* capacity has only to be considered in two situations. First, when psychosurgery or the surgical implantation of hormones to reduce male sexual drive is proposed (section 57 of the MHA), and secondly, when treatment for a physical disorder is required. However, treatment for a mental disorder has been increasingly widely defined, for example, to include forced feeding³.

The presumed inevitability of a person's incapacity to consent to treatment when he/she has a mental disorder has been challenged both within the courts⁴, and also in empirical studies, in particular the MacArthur Treatment Competence Study⁵. In this large, multi-centred study, decision making ability with respect to treatment was assessed in over 400 men and women newly admitted to hospital with diagnoses of schizophrenia or depression. Most importantly, a group with physical illnesses and a group without any disorder were included for comparison. The study showed that, although decisional abilities were compromised in many individuals with a mental illness, more than half of those who participated performed at a level similar to that of their counterparts with physical health problems, or no health problems at all. Deficits in decisional ability were more frequent in the group with schizophrenia than in the group with depression. The conclusion that a blanket assumption of incompetence among those with mental ill health was not sustainable has been supported by the findings of other investigators⁶. A 'status' approach to the assessment of decision-making ability has therefore been discredited, and a 'functional' model focusing on a person's ability to make a particular decision at a specific point in time, is now accepted⁷.

In England and Wales the Expert Committee proposed using a definition of incapacity based on the recommendations of the Law Commission for England and Wales⁸, that is, a person is without capacity if at the material time he or she is:

- (1) Unable by reason of mental disability to make a decision on the matter in question. That is, if the disability is such that, at the time the decision needs to be made, he or she is unable to:
 - Understand relevant information
 - Retain this information
 - Make a decision based on the information given

3 *B v Croydon District HA [1994] 22 Butterworth's Medical Law Reports 13*

4 *Rogers v Commissioner of Mental Health 390 Massachusetts Reports 489 (1983).*

5 MacArthur study – Appelbaum, P. S. & Grisso, T. (1995). *The MacArthur Treatment Competence Study. I Mental illness and competence to consent to treatment. Law and Human Behavior 19, 105–126*; Appelbaum, P. S., Grisso, T., Mulvey, E. & Fletcher, K. (1995). *The MacArthur treatment competence study. II Measure of abilities related to competence to consent to treatment. Law and Human Behavior 19, 127–148*; Grisso, T. & Appelbaum, P. S. (1995). *The MacArthur Treatment Competence Study. III Abilities of patients to consent to psychiatric and medical treatments. Law and Human Behavior 19, 149–173.*

6 For example Grossman, L. & Summers, F. (1980). *A study of the capacity of schizophrenic patients to give*

informed consent. Hospital and Community Psychiatry 31, 205–206; Kitamura, F., Tomoda, A. Tsukada, K. Tanaka, M. Kawakami, I. Mishima, S. & Kitamura, T. (1998). *Method for assessment of competency to consent in the mentally ill: rationale, development and comparison with the medically ill. International Journal of Law and Psychiatry 21, 223–244*; Wong, J. G., Clare, I. C. H., Watson, P., Gunn, M. & Holland, A.J. (2000). *The capacity of people with a "mental disability" to make a health care decision. Psychological Medicine 30, 295–306.*

7 Wong, J., Clare, I.C.H., Gunn, M.J. & Holland, A.J. (1999) *Capacity to make health care decisions: its importance in clinical practice. Psychological Medicine 29, 437–446.*

8 *The Law Commission (1995) Mental Incapacity (Law Commission No 231). London: The Stationery Office. paras 3.14, 3.17.*

- (2) Unable to communicate a choice on that matter because he or she is unconscious or for any other reason.

This definition was formulated for forthcoming legislation concerning proxy decision-making for mentally incapacitated adults. It represents a synthesis of previous case law and academic work⁹ and is intended to be relevant to many types of decision-making, not simply to decisions relating to healthcare. The abilities and information necessary to make a legally valid decision about treatment have been examined in several English court cases and guidance is also provided in the *Mental Health Act Code of Practice*¹⁰. These sources indicate that, in English law, specific abilities and information are considered relevant to treatment decisions. The Law Commission's definition of capacity differs in some respects from definitions adopted in case law in England and in other jurisdictions. It does not explicitly demand 'appreciation', that is, the ability to believe that the information applies to oneself. This was part of the test proposed in *Re C* and was part of the assessment process in the MacArthur Study. In fact, its introduction to the proposed legislation was considered and was deliberately avoided because of problems inherent in the concept¹¹. Instead the Law Commission proposed that "a decision based on a compulsion, the overpowering will of a third party or any other inability to act on relevant information as a result of mental disability is not a decision made by a person with decision-making capacity."¹² The belief in relevant information is not assessed or weighed, but a strong lack of belief, or disbelief, of relevant information may make the decision invalid.

In the leading case, *Re C*¹³, the decision making process was considered to consist of "weighing information in the balance, balancing risks and needs, so as to arrive at a choice". Similarly, in the MacArthur study¹⁴ the decision making process was assessed under the heading "thinking rationally about treatment". In the case of *Re MB*¹⁵, the judge said "a competent woman may for religious reasons, other reasons, irrational reasons or for no reason at all choose not to have medical intervention". The difficulties of separating capacity from rationality have also been recognized¹⁶. English law does acknowledge that in certain situations people are unable to use information to arrive at a decision, for example in *Re W*¹⁷ concerning a young person with anorexia nervosa refusing food. Whilst care should be taken in applying cases concerning those less than 18 years of age to adults, part of this case is relevant as it was said that anorexia nervosa "creates a compulsion to refuse treatment or only to accept treatment that was likely to be ineffective". Essentially, the decision to refuse is incompetent because he/she cannot *but* refuse it. Under these

9 Lord Chancellor's Department (1999). *Making Decisions. The Government's Proposals for Making Decisions on Behalf of Mentally Incapacitated Adults: A Report Issued in the Light of Responses to the Consultation Paper "Who Decides?"* (Cm 4465) The Stationery Office: London.

10 See *Re C (Adult: Refusal of medical treatment)* [1994] 1 All England Law Reports, 819; *Re T (adult: refusal of treatment)* [1992] 4 All England Law Reports, 649 and Jones, R. (2003). *Mental Health Act Manual*. Eighth Edition. Sweet and Maxwell: London.

11 Slobogin, C. (1996). "Appreciation" as a measure of competency: some thoughts about the MacArthur group's approach. *Psychology, Public Policy and the Law* 2, 18–30; Roth, L. H., Appelbaum, P.S., Sallee,

M., Reynolds III, C.F. & Huber, G. (1982). *The dilemma of denial in the assessment of competency to refuse treatment*. *American Journal of Psychiatry* 139, 910–913.

12 See note 8 at paragraph 3.17.

13 See note 10 – *Re C*.

14 See note 5

15 *Re MB (An Adult: Medical treatment)* (1997) 38 *Butterworths Medical Law Reports* 175.

16 Pomerantz, A. & de Nesnera, A. (1991). *Informed consent, competency and the illusion of rationality*. *General Hospital Psychiatry* 13, 138–142.

17 *Re W (A Minor)(Medical Treatment)* [1992] 4 All England Reports 627.

circumstances there is no decision-making process. Similar reasoning was applied in the case of *Re MB*, where the judge quoted from an earlier case saying “one object may so force itself upon the attention of the invalid as to shut out all others that may require attention”¹⁸. Thus, the decision-making process is presumed intact unless it is clear that the mental disorder precludes the ability to “weigh up” the information to reach a decision.

In English law if, because of the presence of a mental disorder, capacity is in doubt, the person has to be shown to understand the following information, if he/she is to be considered to have capacity (see Jones¹⁹): (i) The nature of treatment (ii) the purpose of treatment (iii) the risks of treatment and (iv) the risks of non-treatment. The level of information demanded is in “broad terms and simple language”, a standard adopted from the case *Chatterton v Gerson*²⁰ and later adopted by the Law Commission²¹.

Given the ethical considerations stated by the Expert Committee, and the central importance of decision-making capacity in case law in the treatment of physical disorder, it is surprising that capacity-based mental health legislation has been rejected²², and nor is it in the legislation of other countries²³. This may, in part, reflect concerns as to whether ‘capacity’ can be reliably assessed in persons with mental disorders, and whether it will enable the detention of those people with mental disorders in need of treatment. This study specifically set out to investigate, in as naturalistic a way as possible: a) the capacity of people to consent to both admission²⁴ and treatment for a mental disorder; b) the reliability of the capacity assessments undertaken; and c) the relationship between capacity to consent to treatment, diagnosis, and present legal status.

Similar hypotheses obtained in this part of the study as in the capacity to consent to admission part of the study. In addition, we were able to examine the extent to which there was a correlation between the two separate decisions (admission and treatment).

METHODS

The purpose of the semi-structured interview developed for the study (see below) was to maximize the reliability of that judgment, and ensure its validity by basing it on the legal definition of capacity and on the legal guidance of what was required to be known in order to be capable.

Participants

The same consecutive series of patients between the ages of 16–65 years newly admitted to hospital in the local mental health and learning disability services were asked to participate in this part of the study.

18 See note 15

19 See note 10

20 *Chatterton v Gerson* [1981] *Law Reports: Queen's Bench* 432.

21 See note 8 at paragraph 3.18

22 At the time of writing the proposed shape of the new Mental Health Act is not clear. However, if the White Paper (see

www.doh.gov.uk/mentalhealth/whitepaper2000.htm) is a guide to intent, it seems likely that the principles of the Richardson committee will not be central.

23 Appelbaum, P.S. (1997) *Almost a revolution. An international perspective on the law of involuntary commitment. Journal of the American Academy of Psychiatry and the Law* 25, 135–147.

24 See note 1

Developing the capacity assessment interview

A semi-structured interview, based on the four elements considered legally important for capacity, (the nature and purpose of treatment, and the risks of treatment, and of not receiving treatment) was developed for the study. The semi-structured interview was designed to explore the person's understanding of the relevant information, his/her ability to retain that information, and to make and communicate a decision based on the information about each of these four elements, and also understanding overall. Following a pilot study a question about the participant's 'perception of his/her illness' was added to the interview schedule as part of the exploration of the person's understanding of the 'purpose of treatment'. Also the section concerned with 'understanding the nature of drug treatment' divided naturally into two parts, one part related to understanding the legal issues pertaining to taking medication and the other, the practical aspects.

Final interview schedule

The interview was therefore revised to assess the person's ability, as described above, with respect to the following six elements of information relevant to treatment decisions:

1. The illness necessitating pharmacological treatment
2. The nature of the proposed treatment in practical terms
3. The nature of the treatment in legal terms
4. The purpose of treatment
5. The risks of treatment
6. The risks of non-treatment.

The semi-structured interview was administered by one of the authors (JB), an experienced psychiatrist. Initially a single prompt was used to elicit general understanding of treatment, and then further prompts used to assess understanding within each of the elements. After this first assessment, information sheets providing all the relevant knowledge were read to the participants and the same questions repeated to determine whether capacity had been improved.

Criteria for, and determination of, capacity

Guidance from common law was used to establish criteria for judging the adequacy of responses provided by participants. These were reviewed by one of the authors (MG – a mental health lawyer). These are set out element by element in Figure 1.

The different elements did not explicitly carry different weights, and the final decision as to whether the person should be considered to have overall capacity was a judgment based on all the available information. Some participants were considered capable overall despite unsatisfactory performance in one or more elements. For the purpose of analysis, judgments about final capacity and performance on individual elements were based upon the highest level of understanding whether that was before or after the use of the information sheet. Once the best level of performance had been graded, the level of performance prior to and following the disclosure of relevant information was assessed in order to examine the contribution of the information sheet

Figure 1 – Criteria for judging responses of each element relevant to a treatment decision

The following indicated a satisfactory understanding within each element

Element	Understanding required
Perception of illness requiring treatment	That there was a problem internal to the participant not simply due to external factors or physical illness even if these had played a role in causation. That this problem would be appropriately treated with medication.
Nature of drug treatment - Practical	The physical aspects of that medication e.g. for a tablet, that it was a tablet to be swallowed.
Nature of drug treatment – Legal	Informal participants – Understanding that the drug treatment was voluntary Detained participants – Understanding that treatment might be legally forced upon them
Purpose of treatment	The potential of treatment to alleviate the disorder or significant symptoms due to the disorder.
Risks of treatment	The potential of the treatment to cause side effects. Specific side effects did not need to be known unless they were serious or very likely to occur.
Risks of non-treatment	To understand the risk of not getting better, getting better at a slower rate or deteriorating without treatment

to that participant’s understanding. The contribution of the disclosure was graded on a simple scale (see Results).

Statistical analysis

Described in the first of the papers (See note 1).

RESULTS

Participant characteristics

During the course of the study, 67 people newly admitted to acute psychiatric and learning disability in-patient services were approached. Forty-nine agreed to be interviewed. There were no significant differences between this group and those who did not participate with respect to gender, diagnosis, legal status, or place of admission. Three left the interview after completing a related

study²⁵. Of the remaining 46, three were being observed in a medication-free state, and two were not receiving medication for treatment. Therefore, forty-one participants (61%) completed an assessment of their capacity to consent to treatment with medication. Sixteen agreed to be re-interviewed one week later. The mean interval between admission and first interview was 44 hours.

The group (n=41) was composed of 25 men and 16 women with a median age of 36 years. Four (9%) were recruited from the learning disability services; seven (17%) were detained under the *Mental Health Act 1983*, a figure comparable to the proportion of people admitted formally to local mental health services (twenty percent, personal communication, Cambridgeshire Social Services). The composition of the group who participated is shown in Figure 2.

Admitting diagnosis	n
Schizophrenia	9
Psychosis – not yet classified	2
Psychosis – drug induced	1
Bipolar disorder	
Manic	1
Depressed	4
Unipolar depression	
Non-psychotic	12
Psychotic	2
Crises due to alcohol misuse	5
Deliberate self harm	3
Learning disability – no other diagnosis given	1
Total	41

Figure 2 –Diagnosis of participants (n=41)

Of these, seventeen had the following psychotic illnesses: schizophrenia (9), unclassified psychosis (2), psychotic depression (2), prominent hallucinations in the context of alcohol withdrawal (2), drug-induced psychosis (1) and mania (1).

Where a person was taking multiple drugs, understanding was assessed relating to the medication most relevant to the treatment of the mental disorder that had resulted in admission. The classes of drug chosen for the purposes of the assessment of consent to treatment at initial interview and follow-up are shown in Figure 3. At follow-up the medication was the same in all but in two people where mood-stabilizing medication had been started.

25 Bellhouse, J., Holland, A.J., Clare, I.C.H., Gunn, M. & Watson, P. (2003) *Capacity based mental health legislation and its impact on clinical practice:1) admission to hospital*, *Journal of Mental Health Law* (2003) page 9.

Class of drug	Admission (n=41)	Follow-up (n=16)
Neuroleptic	9	4
Atypical neuroleptic	7	3
Anti-depressant	17	7
Benzodiazepine	8	–
Mood stabiliser	–	2
Total	41	16

Figure 3 – Classes of medication used in the assessment of capacity to consent to treatment

Inter-rater agreement

Inter-rater agreement was assessed using the verbatim transcripts for eight of the 41 interviews (20%) on five of the elements; the legal significance of treatment was not included. A psychiatrist (AJH) independently rated these transcripts.

Agreement with respect to understanding in individual elements

Kappa correlations were calculated for agreement between the raters for each element relevant to a treatment decision. The level of agreement between the raters was statistically significant for three of the five elements. With respect to the two remaining elements, understanding of the purpose of treatment and the risks of non-treatment, the level of agreement was not statistically significant ($p=0.064$).

Agreement with respect to overall capacity

There was a satisfactory degree of agreement between the two raters about overall capacity ($k=0.750$, $p=0.28$). In only one of the eight cases was there disagreement.

Capacity to consent to treatment

Thirty-three of the 41 people (80%) assessed were judged to have the capacity to give or withhold consent to their treatment.

The group judged to have capacity

Eleven of the 33 (33%) participants with overall capacity had performed satisfactorily on all six elements. On average, the group displaying overall capacity performed satisfactorily on more than five elements (mean 5.22; range: 4–6).

The group judged not to have capacity

Two of the eight participants lacking the capacity to make treatment decisions did not demonstrate a satisfactory understanding of any of the separate elements. Two of the others only performed satisfactorily on one element. Overall these eight participants performed satisfactorily on less than two elements (mean 1.9; range 0–4).

Relationship between overall judgments of capacity and adequacy of response to each element

Using logistic regression analysis, significant relationships between incapacity and unsatisfactory performance on the elements (i) 'perception of illness needing treatment' (χ^2 (1df) = 3.819, $p < 0.05$) and (ii) 'purpose of treatment' and incapacity (χ^2 (1df) = 3.82, $p < 0.05$) were found. None of the other elements were significantly associated with overall capacity/incapacity.

Association between capacity to consent to treatment and legal status

Twenty-eight of the 34 informal patients (82%; 95% CI 72–95%) and two of the seven detained patients (29%; 95% CI 0–62%) displayed the capacity to consent to treatment. Being admitted informally was statistically significantly associated with being capable of making treatment decisions (Ratio of odds of capacity (informal/formal) = 11.67; 95% CI 1.81–75.08)

Association between capacity to consent to treatment and diagnosis

There was a significant relationship between having a psychotic illness and lacking capacity. All eight participants lacking capacity to consent to treatment had a psychotic illness (Ratio of odds of incapacity (psychotic/non-psychotic) = 1.89; 95% CI 1.20–2.96). These eight had the following diagnoses: psychotic depression (2), drug induced psychosis (1), unclassified psychosis (2), and schizophrenia (3). However, psychotic illness was not invariably associated with incapacity in that six of the nine participants with schizophrenia were capable of consenting to treatment. All twelve participants with depression were able to consent to their treatment.

Of the 17 people assessed with respect to their understanding of treatment with an antidepressant medication, 15 had the capacity to consent to treatment. The remaining two both had a psychotic depression. Three of seven assessed with respect to treatment with an atypical neuroleptic appeared unable to consent, as were three of the nine prescribed and assessed with respect to typical neuroleptics.

Effect of information on understanding of treatment decisions

The effect of access to the information sheet was categorised using a three-point scale: 'no effect', 'some effect' or 'significant effect'. The latter category referred to a change in a person's response from unsatisfactory to satisfactory following their exposure to the information sheet. Figure 4 shows the effect of the information sheet on the performance of participants in the elements of understanding.

Overall, the information sheet improved the performance of two people so that they demonstrated capacity where they had not previously.

Element	No effect	Some effect	Significant effect
Illness	35	4	2
Nature of treatment – practical	36	5	0
Nature of treatment – legal	37	2	2
Purpose of treatment	37	2	2
Risks of treatment	36	1	4
Risks of non-treatment	36	2	3

Figure 4 – Effect of access to the information sheet on performance on the six elements relevant to treatment decisions. Numbers = number of participants improved (total = 41).

Follow-up interviews

Sixteen participants were re-interviewed one week following admission. Over the period of follow-up, improvement had occurred in the performance for some elements relevant to treatment decisions. However, of the 16, 13 had already demonstrated capacity at the admission interview; all of these people were found still to have capacity. Of the three who lacked capacity at admission, two still lacked capacity, but one demonstrated capacity at follow-up. This latter participant had achieved a significant improvement in his understanding of the purpose of treatment.

Understanding of treatment information

The performance of the participants on the different elements is considered here. The judgement of satisfactory or unsatisfactory performance was made after the whole interview, including the disclosure of the relevant information.

Perception of illness needing treatment

For five participants (12%) their perception of illness for which they required medication was judged unsatisfactory. All five lacked capacity overall (Ratio of odds of incapacity (unsatisfactory perception of illness needing treatment/satisfactory) = 12.00; 95% CI 4.06–35.46), and were in the group of participants suffering from a psychotic illness, also a significant finding (Ratio of odds of unsatisfactory perception of illness needing treatment (psychotic/non-psychotic) = 3.00; 95% CI 1.89–4.76). Two of these five participants were assessed using their understanding of antidepressant treatment for psychotic depression, and three were assessed with respect to neuroleptics. Four responses were unsatisfactory, e.g., “I’ve got no idea....I just can’t think...just to make me better”. One was an irrelevant response “ask the publishers.....it’s in their hands” (24 year old male with drug induced psychotic episode).

Understanding the nature of drug treatment (practical)

Twelve participants (29%) did not demonstrate a satisfactory description of the nature of their drug treatment, five of whom were in the group of participants found to lack capacity overall, a significant association (Ratio of odds of incapacity (unsatisfactory perception of practical nature of drug treatment/satisfactory) = 6.19; 95% CI 1.18–32.46).

Understanding the nature of drug treatment (legal)

Fourteen (34%) people did not satisfactorily understand the legal situation with respect to their medicine. The adequacy of understanding of this aspect of treatment did not correlate overall with capacity (Ratio of odds of incapacity (unsatisfactory understanding of legal nature of drug treatment/satisfactory) = 4.44; 95% CI 0.88–22.54). For informal patients (n=13), responses were judged unsatisfactory for two distinct reasons. In ten cases this was an inability to understand that their treatment while in hospital was voluntary, e.g., “I’ve got to take it...that’s the rules in hospital”. Three participants did not understand the question, and perceived treatment as involuntary because they were ill, despite repeated clarification, e.g. “No, doctor, I have to take it because I’m not well”. The participant detained under the MHA asserted that involuntary treatment was not allowed “I know my rights....they’re just not allowed to....OK”.

Understanding the purpose of drug treatment

Seven participants (17%) were unable to understand the purpose of their treatment. All seven of these were in the group found to lack overall capacity, a significant relationship (Ratio of odds of incapacity (unsatisfactory understanding of purpose of drug treatment/satisfactory) = 34.00; 95% CI 4.93–234.46). Five participants simply gave an unsatisfactory response, e.g., “I don’t know... I just don’t understand”. The other two displayed a non-therapeutic understanding of the purpose of treatment, e.g. “It’s to make me more tired so I can’t do anything” or “To cut off the deep thoughts and make me more shallow”.

Understanding the risks of treatment

Twelve people (29%) did not understand the potential of treatment to pose risks to their health. Five of these were in the group judged to lack capacity overall and seven in the group demonstrating capacity, an unsatisfactory response in this element, representing a significant risk of incapacity (Ratio of odds of incapacity (unsatisfactory understanding of risks of treatment/satisfactory) = 6.19; 95% CI 1.18–32.46). Four participants were judged unsatisfactory simply due to giving no relevant response. Two asserted that the medicine they were taking was completely without risks. One actively asserted wrong side effects “It causes cancer...all sorts”. Five gave irrelevant information about their treatment as a risk, e.g. “Well, it can’t make you any taller, that’s a fact”.

Understanding the risks of non-treatment

Eleven people (27%) were not able to identify the relationship between not taking their medication and adverse health outcomes. In three cases this was related to an unsatisfactory understanding of the illness needing treatment. Nine participants ventured no opinions about the risks of non-treatment. One participant saw trivial risks of not receiving their treatment, e.g. “I could do without it...I do at home – it’s a matter of willpower” (52 year old female receiving chlordiazepoxide after an extended period of continuous alcohol consumption). One participant perceived risks as positive, i.e., not as risks at all e.g. “I’d go down and then kill myself which would be best for everyone” (18 year old male with schizophrenia and depression who otherwise understood all aspects of drug treatment).

DISCUSSION

Whilst there are strong ethical arguments for including an assessment of decision-making capacity into mental health law and it was one of the central recommendations of the Government initiated review of current legislation in England and Wales, doubts have been expressed as to the practicality of assessing capacity in people with acute mental disorders and the consequences of such a proposal²⁶. This is the first study to examine the feasibility of a capacity assessment of men and women admitted for treatment to psychiatric or learning disability services. The Expert Committee proposed that capacity assessment might occur in the first week of detention and provide a gateway to extended detention.

Although approximately one-third of men and women newly admitted did not wish to take part in the study, this group of people did not differ in terms of age, diagnosis, or gender to those who took part. However, there were three people who the interviewer was not permitted to approach owing to a perceived risk of aggression. This group of people may pose particular problems for capacity assessment, as they do for assessment under current legislation. For a variety of reasons, the numbers seen for follow-up were small. Thirty participants agreed to a second interview, but only 16 were re-interviewed due to discharge, transfer, or a change of mind. This includes self-discharge or no longer wishing to take part in research.

Acknowledging the limitations of the study, we feel able to draw the following conclusions. First, decision-making capacity can be reliably assessed during the first week after admission, and healthcare practitioners familiar with capacity assessment can agree about capacity judgements. This is especially true where explicit criteria are used for judging the adequacy of responses. It is not known how the reliability of capacity assessment compares with the reliability of present MHA assessments, as no published figures exist for the latter. Secondly, as predicted, those with psychotic illnesses are at a high risk of incapacity, and therefore of incompetent decision-making when their illness is such that they require admission to hospital.

Two important findings were first, that a majority of people detained under the present MHA had the capacity to make this decision for themselves, and secondly, a proportion accepting treatment

²⁶ Fulford, K.W.M.(1989) *Treatment*. In *Moral Theory and Medical Practice*. Cambridge University Press: Cambridge; Sayce, L. (1998) *Transcending mental health law*. *Psychiatric Bulletin* 22,669–670.

voluntarily were not capable of consenting to it. Thus, in the case of the former group, if it had been physical illnesses they would have had the right to refuse treatment. In the case of the latter, capacity-based mental health legislation would provide a solution to what has been referred to as the 'Bournewood gap' (i.e. the lack of legal safeguards for assenting incapacitated people admitted to hospital).

Critics of a capacity test point out that there has been disagreement about how to define capacity. If the definition provided by the Law Commission becomes statute, that particular debate will have been settled, at least in England and Wales. However, uncertainty as to the nature and extent of 'relevant information' remains. We described in the Methods section how legal sources were used to provide elements of information relevant to treatment decisions and thresholds against which to judge the adequacy of the performance of participants in the study. All the elements of information used in the study were firmly based in case law except that of 'perception of illness', although it can be argued that this is implicit in understanding the 'purpose of treatment'. It was clear in the pilot studies that clarifying the participants' 'perception of their illness' at the start of the interviews allowed the discussion that followed to be conducted meaningfully. Using the Law Commission's terms, this information is highly relevant to the decision in question. It is important to stress that we did not demand that the person concerned agree that he/she had an "illness" requiring treatment, only that there was a possibility of a problem located within their psyche. Other models of distress were acceptable, although the problem had to be recognised as internal to the participant even if external causes were put forward.

There was a high level of agreement between the two raters, as one would expect when account is taken of the fact that both raters had explicit criteria for judging the adequacy of responses in each element. However, it was not possible to produce such criteria for making judgements of overall capacity. Still, both raters seemed to weigh performance on each element similarly and to come to the same conclusions overall. The weight given to the elements 'perception of illness' and 'purpose of treatment' in making overall judgments may reflect the judgements of clinicians as to what is the most relevant information for making meaningful treatment decisions. Other professional groups may believe that other informational components are of more importance, and service users might take a different view again. For example, legal opinion might emphasise the importance of understanding that treatment is voluntary, whereas service users might emphasise that meaningful decisions in this area can only occur if people understand the potential side effects of drug treatment and in some cases, that there are alternatives, such as established psychological and complementary treatments.

All participants unable to consent to their acute drug treatment had a diagnosis of a "psychotic illness". It has been suggested intuitively that the people in need of compulsory treatment are those with psychotic symptoms, rather than a specific diagnosis or risk²⁷. An emphasis on the alleged risk posed by people with a mental illness might mean detaining people who fall outside this ethical "intuition" and a capacity test might usefully narrow the applicability of risk-based criteria. It may be, though, that the correlation between incapacity and psychotic symptoms would leave people suffering from non-psychotic disorders at risk of suicide and other adverse health outcomes.

27 Fulford, K. & Hope, T. (1994) *Psychiatric Ethics: a Bioethical Ugly Duckling*. In *Principles of Health Care Ethics* (ed. R.Gillon). John Wiley and Sons: Chichester.

Seven participants were detained using the existing legislation, the *Mental Health Act 1983*. Five of these were able to consent. This might indicate that capacity-based mental health law is so different from current law that it renders liable to detention a very different group of people, although the numbers detainable are similar²⁸. An alternative explanation is that detention using the MHA is related to one's understanding of admission decisions and the need to be in hospital, rather than one's understanding of treatment decisions (see note 1).

Empirical studies cannot illuminate the ethical aspects of the debate regarding the use of capacity in making detention decisions. However, if the principle that a person who can make decisions should be allowed to make them is accepted, then the practical questions raised by importing this doctrine into mental health law become the issue. Two important practical aspects of such a proposal are defining capacity satisfactorily and the consequences of such a change in the law. Future debate about the practicality of such legislation ought to be informed by empirical work and it is hoped that the data presented here will inform that debate.

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²⁸ See note 25 above.