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Commentary: test of capacity has little practical benefit

Derek Chiswick

In a civilised society mental health laws protect insightless seriously mentally ill people from themselves and protect citizens from the actions of those who are seriously mentally ill. These principles have been the cornerstone of mental health law for 50 years. But legislation must be fit for today. It should embrace contemporary concern for patient autonomy but at the same time deliver what society requires of it. Should decision making capacity have a place in modern mental health law? Of course it should. Should capacity be the over-riding factor that trumps all other considerations as it does with physical illness? That goes too far.

Capacity has not earned this pivotal status in routine clinical psychiatry for four reasons: it is a poorly defined concept; it is consequently difficult to assess; its assessment adds little of practical benefit when considering the clinical grounds for compulsory treatment; and its alleged presence will be used as a convenient device to legitimise rejection and delay in the treatment of mentally ill patients.

Definition and assessment

Capacity is a shaky concept in psychiatry. Scottish legislators opted instead for “decision making ability.”² It is difficult to distinguish the two, and indeed, “similar factors will be taken into account” when assessing both of them.³ Decision making ability, we are told, is in the mind whereas capacity is a function of the brain. Both depend on the ability to understand, reason, make an informed choice, and communicate. We do not have a “metacognoscope,” and we must therefore rely on clinical judgment and research schedules. Researchers are pretty good at agreeing whether capacity is present.⁴ But an assessment of capacity alone will not tell the clinician whether any particular patient should be detained for treatment.

Capacity is a fluctuating commodity. The state of mind of a patient is often ambiguous; patients may apparently resist treatment but hope that someone will intervene. Capacity varies over time and in degree. It is easier to assess capacity in people with a chronic but stable condition such as a learning disability or dementia than in those with an acute mental illness, in which fluctuations in capacity are the rule rather than the exception. Comparisons with physical illness are stretched as psychiatric treatments tend to be much

more complex than single surgical treatments. Is it possible to assess a patient's capacity separately for use of an antipsychotic, an antidepressant, and a mood stabiliser?

What does capacity add?

Doyal and Sheather cite with approval recent Scottish legislation implemented in October 2005.¹ The Scottish Act has five criteria for a compulsory treatment order, all of which must be present (box).

It is difficult, if not impossible, to see what the test of decision making adds to the other four criteria. If a mentally disordered patient is deemed a serious risk to self or others, if treatment is available, and if the patient refuses voluntary treatment because he or she lacks insight, how will consideration of capacity affect the clinical decision to treat? For example, what useful information does an assessment of capacity tell us about three patients who have, respectively, jumped from a third floor apartment window to flee persecutory hallucinations; been evicted from accommodation after sawing through domestic gas pipes to counter atmospheric pollution; and given a display of naked gymnastics to children in the street while under the conviction of being an athlete of Olympic standard. All gave what was for them a persuasive reason for the appropriateness of their behaviour, an acknowledgment that others might find it peculiar, a conviction that it was based on reality, and a determination to avoid being seen as mentally ill. They were all opposed to compulsory psychiatric treatment.

How do they fare with the components of decision making? They understood perfectly an explanation

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Five criteria for Scottish compulsory treatment order²

- A mental disorder
- Medical treatment that will alleviate or prevent worsening
- Significant risk to self or others
- Significantly impaired ability to make decisions about treatment
- Necessity of making the order

that they were mentally ill but did not accept it; they fully appreciated the importance of information given to them, but they reasoned that treatment would be harmful. They expressed a choice to have no treatment, even if it left them homeless. Do they have capacity? I do not know. However, their lack of insight into a dangerous, harmful mental illness makes compulsory treatment appropriate. Whether they have capacity is an entirely academic consideration; it is neither measurable nor relevant.

Rejection

Supposing these patients were also known to be difficult to treat because of histories of substance misuse and previous violence when in hospital. A capacity test gives an over-stretched and reluctant mental health service an opportunity to reject the patient and passively facilitate entry to the criminal justice system. Indeed Doyal and Sheather recommend that mentally ill people who threaten others but are believed to retain capacity should be referred to the police.¹ They do not say if, how, or where treatment for these people should be provided.

Conclusion

Patient autonomy is of the utmost importance in medical practice. But it is a fact of life that detained psychiatric patients lose autonomy. This is why the whole process of compulsory detention must be governed by sophisticated legislation that provides for scrutiny by independent statutory bodies. Crucial decisions about compulsory treatment cannot turn solely on an assessment of capacity. A capacity test will lead to delay or rejection in doctors' implementation of compulsory measures of care. Is (self inflicted) death with human rights preserved a more desirable outcome than compulsory treatment?

Competing interest: DC is a medical member of the Mental Health Tribunal for Scotland.

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Commentary: Who benefits from the new act?

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Depriving someone of their liberty is one of the most serious actions that a state can take. To do this when someone has committed no crime is more serious still. If, in addition, the state then administers chemical and physical treatments that carry a substantial risk of disabling, and sometimes irreversible, damage, it must have the best possible justification for doing so.

The government's proposal to replace the current mental health act gives us an opportunity to assess whether the proposed legislation is fit for purpose. An analysis of the issues around capacity suggests it leaves much to be desired in that respect.¹ This is important, but it is not the only way in which the current proposal fails to justify the denial of basic rights.

Misnomer

What is proposed (and, in fact, what we currently have) is not a mental health act but a compliance with treatment act. This was made explicit by Paul Boateng, who, when he was parliamentary under secretary of state for health, said that: "Non compliance can no longer be an option"² (though this quote is partial in both senses, and I will complete the sentence and put it in context later). The underpinning assumption is that doctor knows best and that patient has no right to decide otherwise. I want to set out the view from "the other end of the needle." At this point I should declare my primary interest: I have twice been detained under the current act and have no wish to score a dubious hat trick.

What's wrong with what we have?

Plenty of evidence shows that mental health services are failing particular groups. One report found: "Black people see using mental health services as a degrading and alienating experience" and that "Service users expressed fears about being admitted to hospital and most strikingly a fear that involvement with mental health services could eventually lead to their death."³ In addition, a recent Cochrane review found no strong evidence that compulsory treatment reduces use of health services or improves patients' social functioning. It also concluded that a lack of data made it impossible to assess the effect on costs, mental state, and other aspects of patient or carer satisfaction.⁴ And, finally, the government has clearly said that the proposed legislation does not introduce a new power of preventive detention.⁵

The legislation therefore needs to offer something really important to offset these existing and potential problems. One principle that would make an important difference is that of therapeutic benefit. This is the idea that compulsion can be justified only if the resulting treatment will help the person forced to take it. This is not a particularly radical notion. Like capacity, it forms one of the principles of the Scottish legislation (though the term benefit is used). Therapeutic benefit also forms part of the notion of reciprocity recommended by the expert committee² and the Mental Health Alliance (a coalition of 75 mental health organisations from the professional, voluntary, and service user sectors). The amendment of the proposed conditions for compulsion to include therapeutic