Mental health legislation should respect decision making capacity

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New legislation should raise the moral standards of professional and personal life, but the proposed new mental health bill fails to deal with serious ethical problems in the existing act

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The government is introducing new mental health legislation in England and Wales. Critics have argued for some time that the 1983 Mental Health Act is outmoded, unable to provide the flexibility required after changes in psychiatric practice and social attitudes towards mental illness. Case law has also shown that the act has to be changed to ensure compatibility with human rights legislation. A draft bill was published in September 2004,[1] and, after a report by a cross-party scrutiny committee in March 2005,[2] the government announced its intention to introduce a new bill in autumn 2005. Concerns have been raised, however, by both user and professional groups about both the Mental Health Act and the draft legislation. The most serious of these is the lack of respect for the autonomy of mentally ill people, which we believe strikes at the heart of the legislation's moral legitimacy.

Autonomy

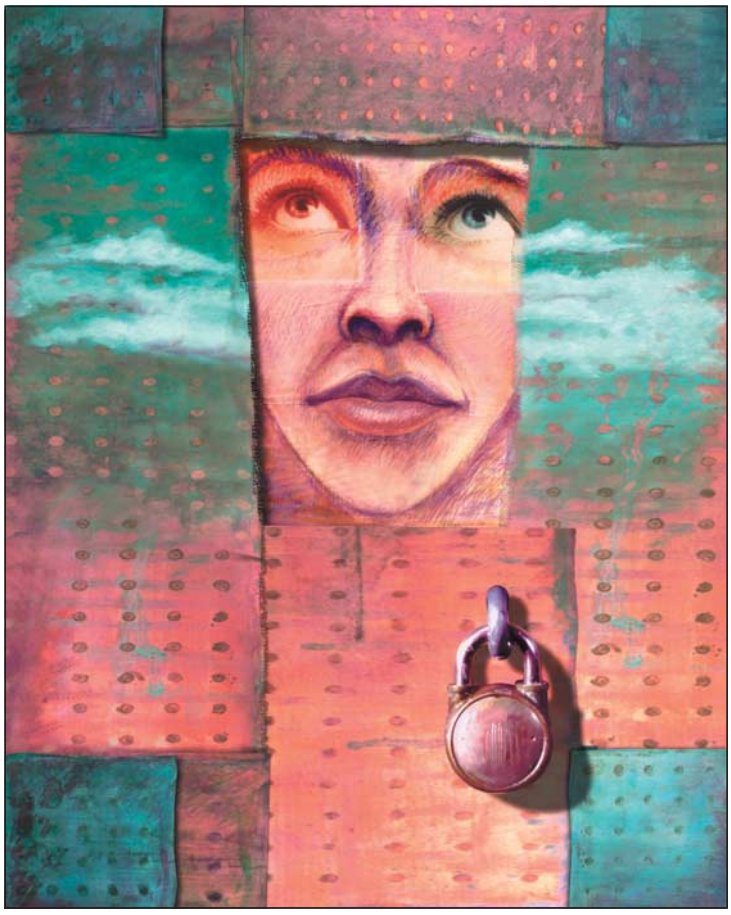
Concerns about autonomy can be traced back at least as far as the 1999 review of the Mental Health Act by a Department of Health expert committee led by Professor Genevra Richardson.[3] Her report raised questions about whether the act demands respect for the autonomy of patients that is equal to that demanded for patients with physical illnesses. Although a competent person with a physical illness can reject treatment that is clearly in his or her best interests, mental health legislation permits compulsory treatment even if the patient retains the capacity to make decisions. As a result, the Richardson report suggested that any new legislation, "Must be expressly concerned with preserving … autonomy."[3] Crucially, new Scottish mental health legislation, enacted in 2003, makes impaired capacity to make decisions one of the central criteria for the use of compulsory powers, thereby establishing clear statutory precedent.[4]

However, the government's new mental health legislation rejects both Professor Richardson's analysis and the Scottish example. In its response to the joint scrutiny committee's report on the new legislation, it argued that, "It is not safe to assume that there is a link between the severity of a condition—and therefore the need for treatment—and the person's ability to make decisions,"[5] effectively ducking the central moral issue. So what is the problem that Richardson's report highlighted and has the government got it right?

Effect of mental illness on patient autonomy

In ordinary circumstances, the clinical duty of care to protect life and health is trumped by the duty to respect autonomy. Competent patients have the right to refuse any form of medical intervention, however grave the personal consequences of doing so. Thus, it is both legally and professionally unacceptable for doctors to force treatment on competent patients because they think it is in their best interests. In this context, competence is widely accepted to entail the capacity of adult patients to understand and remember appropriate information about their clinical circumstances, to weigh up or reason about choices posed by such information, and to believe that this information applies to them. Moreover, this competence is accepted to be task related. Adult patients may be competent to refuse some types of treatment but not others. For example, patients with some forms of neurological damage are competent to refuse their hospital dinner but may not be competent to refuse antibiotics for pneumonia.

Because of its effect on levels of competence, serious mental illness reverses the moral logic of the duties of care. Here, the patient's capacity may become so reduced that respect for autonomy no longer



Compulsory treatment of competent patients is unethical

legitimately trumps protection. Since the patients' illness removes the capacity for autonomous control over important aspects of their life, they may no longer have the ability to protect themselves. For example, a schizophrenic patient with delusions about being poisoned, and who is a danger to himself or to others as a result, may not be able to understand or believe any information that contradicts this belief.

Equality and the problem of consent

In her review, Professor Richardson pointed out an important inequality in the duty of care to respect the autonomy of competent patients. Both the Mental Health Act and the proposed legislation allow doctors to force psychiatric treatment on patients who are assessed as competent to refuse it. Yet competent patients with physical illness who refuse treatment must have their choice respected. Thus patients who are deemed competent by their psychiatrist to refuse electroconvulsive treatment may still have it forced on them whereas an accident and emergency consultant cannot force blood on a competent Jehovah's Witness who will die without it. The argument that the psychiatrist wishes to act in the best interests of such patients has little relevance; so does the accident and emergency consultant. It is also of no use to argue that the psychiatrist is uniquely concerned to protect the interests of others; similar arguments apply to the doctor presented with a patient who has just converted to the Jehovah's Witnesses and whose dependent family begs him to ignore the patient's wishes.

The situation becomes even more farcical when compulsorily detained patients develop physical illnesses. Since the treatment of such illness is not regulated by mental health legislation, a psychiatrist who diagnoses a patient to be competent to refuse treatment for physical illness must respect this decision even if the consequences are life threatening. So we are left with the prospect of the same patient being forced to have treatment for a non-life threatening psychiatric condition but being allowed to refuse life saving treatment for a physical illness.[6] This situation is difficult to justify. Of course, the competent refusal of treatment by some psychiatric patients may entail danger to others. However, given their competence, such a threat (like similar threats posed by patients who are not psychiatrically ill) should become a matter for the criminal justice system rather than the NHS.

Conclusion

All of these issues were highlighted in the Richardson report and in subsequent papers by her and others.[7 8] What is disappointing is the government's reluctance to use the current opportunity to draft new legislation to remedy this inequality.[1] In some fundamental respects the new legislation even exacerbates the problem: certain groups of patients who retain capacity lose their ability to consent to treatment under the draft bill. Some find it problematic enough for patients to be denied civil liberties on the grounds that they are no longer in adequate cognitive and emotional control of some parts of their lives. Although views differ here, to deny patients with adequate control such liberties—purely because they have a psychiatric rather than physical illness—is surely indefensible.

We already have an adequate moral and legal justification for detaining and imposing unwanted treatment on potentially dangerous psychiatric patients in an emergency and when there is uncertainty about their competence to refuse it and urgency about the threat. This justification—common law necessity—does not compromise the moral principle of equality, provided that the risks of non-intervention are proportional to the need for detention and treatment.

The legal doctrine of necessity evolved in relation to the provision of emergency treatment for unconscious patients and for patients who have already been diagnosed as incompetent to consent to or refuse medical treatment for other reasons but have made no valid advance directive.[9] This principle was reaffirmed for patients lacking competence in Bournewood and its review by the European Court, although this review rightly emphasised the importance of appropriate appeal procedures.[10 11] Common law necessity may also be used in emergencies when patients of dubious competence have taken overdoses and attempt to discharge themselves; the law seems to enable patients to be detained and possibly treated until competence can be ascertained.[12]

It seems sensible, therefore, to follow the same reasoning for emergency patients with suspected psychiatric disorder who, on the basis of good evidence, pose a serious threat to themselves or others. They too should be allowed to be detained and treated without consent, initially for the purpose of their protection and establishing their competence to refuse further treatment and detention. If they are diagnosed as incompetent because of a psychiatric disorder they should then fall under the jurisdiction of current mental health law. If they are believed to be competent and refuse further detention or treatment, their wishes should be respected. If doctors believe that so doing places others at serious risk, the police should be informed and the responsibility to protect the public transferred to them with whatever tools the criminal law provides for such prevention. Given the comparative small risks posed by psychiatric patients to the public,[13 14] good clinical practice should stick to these principles. In so doing, risks to both patients and the public can be appropriately protected without disproportionately jeopardising individual human rights.

Contributors and sources: LD has lectured and written widely on most aspects of bioethics, consistently emphasising the importance of respect for the autonomy of patients in clinical decisions. JS was co-author of the BMA's handbook of ethics and law. His main areas of interest are mental capacity and its limits, the ethics of psychiatric treatment, ethical issues in relation to children and young people, and health and human rights.

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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?[1] 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

Five criteria for Scottish compulsory treatment order[2]

- 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

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