editorial

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VANESSA RAYMONT

'Not in perfect mind' – the complexity of clinical capacity assessment

'I am a very foolish fond old man.
Fourscore and upward, not an hour more nor less;
And to deal plainly,
I fear I am not in my perfect mind.'
Shakespeare, *King Lear* (1606) Act IV, Scene VII

Sadly those without capacity rarely have this level of insight into their difficulties, and the assessment of capacity and how we should treat those lacking it has recently been the topic of great debate in both psychiatry and law. Although the notion of informed consent was recognised in medical practice as early as the 1700s, it was not until the advent of the voluntary boarder status in the Lunacy Act 1890 and the voluntary patient in the Mental Treatment Act 1930 that the issue of capacity and consent for psychiatric treatments was first raised in non-detained patients (Fennell, 1996). Even then mental illness was thought to imply incapacity to make valid, autonomous decisions. In the 1970s concerns were finally expressed about whether it was lawful to treat any psychiatric patient (detained or not) without consent, following evidence of research carried out on incapacitated patients, and a growing appreciation that mental illness and incapacity were not necessarily synonymous. Capacity plays a pivotal role in determining whether a person can exercise autonomy in making choices in all aspects of life, including his or her medical or psychiatric treatment. Therefore, patients lacking mental capacity pose complex legal and ethical problems to clinicians. Given its broad role, the concept of capacity has now evolved into a sophisticated ethical and legal construct – but how useful are our definitions for clinicians assessing competence to make treatment decisions?

The legal history

Although there had been legal rulings on the restraint of those with mental illness under common law in the past (Fennell, 1985), it was not until the late 1980s that the courts began to develop clear common law principles governing treatment without consent. The current power under common law to treat incapacitated adults without consent, but in their best interests, was laid down in case law in the 1960s (*Re F* v. *West Berkshire Health Authority*, 1990). The ruling stated that doctors have the power, and in certain circumstances the duty, to treat incapacitated patients in their best interests. The legal definition of incapacity, though, remained ambiguous.

The case of *Re C* (1994) established criteria for incapacity in case law, and involved a patient with schizophrenia refusing amputation of his gangrenous leg. It established the 'Eastman' test of capacity (*Re C*, 1994), that is to comprehend, take in and retain information, believe it, and weigh it up in order to make a choice, but also emphasised that to be competent a patient does not have to blindly accept medical evaluation and can have a level of self-assessment of any consequences. In 1995 the Law Society and British Medical Association provided a similar joint definition of capacity for clinicians. In the same year recommendations from the Law Commission for a 'Mental Incapacity Act' were published (Law Commission, 1995). Following consultation, the UK Government has now issued proposals for law reform (Lord Chancellor's Department, 1999) based on these recommendations. They define legal incapacity and detail statutory 'best interest' procedures for the medical treatment of incapacitated patients (with both mental and physical disorders), aimed at replacing current common law principles. The legislation proposes a definition of incapacity as being 'unable by reason of mental disability to make or communicate a decision' (where mental disability includes 'any disability or disorder of mind or brain, permanent or temporary, resulting in an impairment or disturbance of mental functioning') (Lord Chancellor's Department, 1999: p. 8). Notably (and building on the *Re C* test) inability to make a decision is defined as 'inability to understand or retain the information relevant to the decision, or inability to make a decision based on that information' (Lord Chancellor's Department, 1999: p. 8). This is similar, but not identical, to the Eastman test of incapacity, as it omits the requirement of belief. This suggests that those who do not have full insight or make unusual decisions may not be deprived of their decision-making capacity under such a law. Also, the fact that the definition of incapacity includes the presence of mental disability (rather than mental disorder, as required by the Mental Health Act 1983) means those with transient states of impaired

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judgement caused by pain, for example, may be included. Such broad operational criteria may add difficulty to the assessment of capacity however, and how we deal with those lacking insight would remain unclear.

Regarding best interests, the case of *Re F* v. *West Berkshire Health Authority* (1990) set in case law that any treatment may be provided to an incompetent adult if it is to save life, ensure improvement or prevent deterioration in health, and is in the patient's best interests. This case law utilised the 'Bolam standard' (*Bolam* v. *Friern Hospital Management Committee*, 1957), which states that a treatment fulfils the best interests criteria if it is in line with current competent medical opinion. The proposed Mental Incapacity Act introduces the concept of a legal general authority for those involved in any aspect of the care of an incapacitated adult to act in his or her best interests. It also employs a more sophisticated concept of best interests, encouraging a significant move away from the narrow medical and paternalistic model. It recommends that any action taken under best interests takes into account the person's wishes and those of carers, utilises personal autonomy wherever possible and is the least restrictive alternative.

In addition to these forthcoming changes, the current Mental Health Act (1983) is under review (Department of Health, 2000), with emphasis placed on the role of capacity assessment. It recommends that any assessment for detention should include an evaluation of capacity, proposes that clinical teams develop advanced agreements with those with chronic mental illness and that nominated deputies or carers are consulted in any treatment plans. There have even been recent calls for the Mental Health Act 1983 to be replaced solely by an Act based on incapacity (Szmukler & Holloway, 1998), to avoid further discrimination against psychiatric patients in treatment decisions. These changes herald a more patient-centred approach to incapacity and an attempt at conceptual clarification, yet in assessing those to whom such measures may apply, we are still left with rather vague definitions on which to judge capacity clinically.

Current approaches to capacity

Current law dictates that a competent adult can withhold consent to investigation and treatment, even if it leads to death, although more serious decisions generally require a greater level of capacity. The Mental Health Act 1983 allows treatment without consent in psychiatric illness, but not physical illness. So how can we proceed currently with any physical treatment of those without capacity? Certainly a full psychiatric assessment should be made initially. If it is felt the person is incapacitated, a clinician can immediately treat to preserve life, and if the patient has a more persistent lack of capacity, he or she can be treated using the best interests criteria. It is recommended that a second opinion is sought, that the situation is clearly documented (including reasons for incapacity and subsequent procedures), that relatives are informed, where possible, and that capacity is frequently reassessed (Hassan *et al*, 1999). At present (in England and Wales) relatives cannot legally give consent for an incapacitated adult, and those with power of attorney can only dictate on financial matters. The new Mental Incapacity Act would create continuing power of attorney (enabling a person to nominate another to make personal and health care, as well as financial, decisions should he/she become incapacitated) and would emphasise that advanced decisions about future care should be respected. Currently, advanced statements can have legal force if the specific circumstances occur, although patients cannot refuse basic care by this method.

A functional approach (that is examining the individual legally defined components) to capacity assessment is recommended by the Lord Chancellor's Department (1999) and is usual in current clinical practice. But there continues to be difficulties with the approach; it can be time consuming, legal standards often vary and, perhaps most fundamentally, there is uncertainty about at what threshold incapacity should be judged (Wong *et al*, 1999). A sliding scale of incapacity has been suggested, with the threshold reflecting the complexity, risk or significance of the decision. However, this again frequently leaves the clinician with imprecise guidelines to follow.

But capacity to consent is a spectrum phenomenon that can change over time and according to the complexity of the decision. It is a matter of degree, and what is most important is whether a patient has adequate capacity to make a particular decision. Adequate assessment therefore involves compound standards of performance that are not hierarchical but complementary, and that need to be objectively measured.

Improving clinical assessment

A more pragmatic approach to capacity assessment involves utilising existing clinical or research assessment tools. There are a number in the literature, including semi-structured interviews largely based on the Lord Chancellor's criteria (Draper & Dawson, 1990) recognition tests – subjects are asked questions about a short essay on treatment rights (Hopkins Competency Assessment Test; Janofsky *et al*, 1992) and questions based on patient-centred clinical vignettes (Fazel *et al*, 1999). It should be borne in mind that verbal disabilities have been found to correlate with lack of capacity in both schizophrenia (Rosenfeld *et al*, 1992) and Alzheimer's disease (Marson *et al*, 1995), and so recognition rather than recall of information may be preferable in capacity assessment. The tool quoted most frequently is the MacArthur Competence Assessment Tool for Treatment (MacCAT–T; Grisso *et al*, 1997). This is a semi-structured interview that examines four components of capacity:

(1) understanding of the disorder and its treatment, including associated benefits/risks
(2) appreciation of the disorder and its treatment (i.e. how the patient understands he/she may be specifically affected, which usually involves some level of insight)
(3) reasoning, which examines the processes behind the decision, and the ability to compare alternatives in the light of these consequences
(4) the ability to express a choice.

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The MacCAT–T rating allows the detection of inadequacies in any of these four areas, but the authors emphasise that it does not give an overall rating and should always be used to make a judgement of capacity in conjunction with a clinical assessment. It should be noted, however, that this tool does include the requirement of appreciation, which may make its application to future health law and psychiatric populations difficult, and continues to utilise rather vague operational criteria, making some capacity judgements challenging.

It has been suggested that a proportion of psychiatric patients have deficient decision-making skills (Grisso & Appelbaum, 1995). In law, an adult is presumed to have capacity to consent, and the onus remains on clinicians to prove otherwise. The recent emphasis on capacity in psychiatric practice means we will have to identify the incapacitated more carefully, undoubtedly leading to higher thresholds for decision-making abilities and even greater numbers assessed as lacking capacity. To date, the main associations with poor capacity skills have been found to be organic syndromes (Katz *et al*, 1995), psychosis and depression (Grisso & Appelbaum, 1995). Depression or anxiety disorders usually produce quite subtle distortions of decision-making, such as a lack of appreciation of personal importance or the benefits of treatment, thus making their influences on decisions difficult to detect. However, these distortions in thinking should be amenable to cognitive approaches. In schizophrenia, incapacity has been found to correlate more closely with cognitive impairment than symptomatology, and is sensitive to educational intervention (Carpenter *et al*, 2000). Finally, delirium (the most common diagnosis in hospitalised, incapacitated patients; Slaby & Erle, 1993) can disrupt decision-making ability by altering cognition, disrupting motivation and increasing anxiety. It has been recommended that even this can be aggressively treated, for example with flumazenil or haloperidol, to restore capacity temporarily (Bostwick & Masterson, 1998).

Capacity can be defined as ability to do a task and is situation-specific (Moore, 1999). Attributes that have been found to be fundamental to making decisions include attention, language and declarative memory. Hence it has been suggested that neuropsychological testing may aid capacity assessment (Jones, 1995), but has also been criticised as implying capacity is a general rather than a task-specific ability (Sutherby *et al*, 1996). Intentionality and voluntariness have also been described as executive functions vital to decisional autonomy, and have been linked to impaired capacity in those with frontal lobe deficits (Workman *et al*, 2000). The concept of voluntariness has been suggested to require the total absence of psychosis (Grimes *et al*, 2000), and that patients with psychotic disorders therefore require especially careful assessment of capacity. This raises the idea of specifically augmenting (although not replacing) current assessment tools with neuropsychological tests of executive function. Additionally cognitive and behavioural strategies could be implemented to restore decision-making components. Other criticisms of existing assessment tools include their failure to address specific legal thresholds for capacity, cultural decision-making influences or the assessment of fluctuating capacity (Moore, 1999). Decisions tend to be accepted unless there is obvious lack of capacity, and we do not expect totally rational reasoning in many decisions. However, illogical fears of psychiatric treatments may be common, and are often not explored. Only by approaching all of these shortcomings can we fundamentally improve our assessment of capacity in clinical settings.

Declaration of interest

None.

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Vanessa Raymont Clinical Researcher and Honorary Specialist Registrar, Department of Psychological Medicine, Guy's, King's & StThomas' School of Medicine and Institute of Psychiatry, 103 Denmark Hill, London SE5 8AZ

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