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Psychiatric Bulletin (2009), **33**, 461–464. doi: 10.1192/pb.bp.108.020115

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Mental capacity assessments in secure care: an unnecessary complication?

SUMMARY

This is a review of the key criteria and implications of the Mental Capacity Act 2005 for patients in forensic care detained under the Mental Health Act 1983. Both Acts were amended by the Mental Health Act 2007 and its subsequent Code of Practice; the impact of these changes will be explored here. Through review of the Code of Practice and hypothetical clinical scenarios, I argue that capacity judgements in mental disorder are inherently complex, unreliable and inextricably linked to risk assessment, and that an overemphasis on capacity when making decisions about patient management in secure care can paradoxically obscure the more central issue of risk and proportionality. The key clinical implication is a call for secure services to be balanced in how they adopt best practice principles from the new Mental Capacity Act so that the spirit of the Act, such as valuing patient autonomy, is preserved and that the debate about what practices in secure care are truly proportionate and justified remains at the forefront of clinical thinking.

The Mental Capacity Act and the subsequent Code of Practice[1] set out the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make decisions for themselves. Everyone working with, and/or caring for, an adult who may lack capacity to make specific decisions must comply with this Act. The same rules apply regardless of whether the decisions concern life-changing events or everyday matters. The Mental Capacity Act Code of Practice also outlines the relationship between the Mental Capacity Act and the Mental Health Act 1983 which has been amended by the Mental Health Act 2007 and its Code of Practice.[2,3] This paper, while outlining the key concepts of the Mental Capacity Act and its implications for all psychiatric patients, aims to focus on the direct impact for patients in secure forensic care. I will argue that:

- making capacity judgements in patients with mental illness or personality disorder is complex and controversial;
- capacity judgements are inextricably interdependent on risk assessment;
- undue focus on assessing capacity to make decisions in such areas as relationships, finances and other freedoms in detained patients, although seeming like progressive practice and respecting patient autonomy, may in fact be a distraction and divert away from the central debate of risk and proportionality.

Mental Capacity Act: main provisions

Section 1 of the Mental Capacity Act outlines its fundamental principles.

(1) A person must be assumed to have capacity unless it is established that he lacks capacity.
(2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
(3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
(4) An act done, or decision made, under this Act, for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(5) Before the act is done, or decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Sections 2, 3 and 4 of the Act set out the two-stage test of capacity.

1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way the mind or brain works (it does not matter whether the impairment is temporary or permanent)?
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

A person is unable to make a decision for themself if they are unable to:

special articles

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making a decision
- communicate their decision (whether by talking, using sign language or other means).

The information relevant to a decision must be presented in ways suitable to the patient's circumstances, for example using simple language or visual aids; it includes information about the reasonably foreseeable consequences of deciding one way or the other or failing to make the decision. Lack of capacity is judged on the balance of probabilities (more likely than not); it cannot be established due to just age, appearance or aspects of behaviour. Best interests involve a consideration of the expressed wishes and values of the person, and the views of a person with lasting power of attorney; acts, in particular restrictions, must be a proportionate response to the likelihood of the person suffering harm and the severity of that harm.

The Mental Capacity Act Code of Practice outlines the relationship between the Mental Capacity Act and the Mental Health Act 1983. This paper will focus on the impact of the Mental Capacity Act on those already detained, whether they lack capacity or not. However, as a counterpoint to the rest of the paper, it is worth exploring the legal changes to the care and provision for patients who lack capacity that may not involve use of the Mental Health Act 1983. These changes were introduced as amendments to the Mental Capacity Act 2005 by the Mental Health Act 2007, in particular the deprivation of liberty safeguards.

Bournewood case

The deprivation of liberty safeguards were introduced to fill a legal gap highlighted by what is popularly known as the Bournewood judgment, although the case involved a series of judgments that forced a change in the law. In 1997, H.L., a person with profound autism and other intellectual disabilities, was under the care of foster parents. After an incident, H.L. was admitted to hospital 'in his best interests', but not detained under the Mental Health Act 1983. His foster parents disagreed with the admission and challenged it. Initially, the trust had no case to answer as a judge ruled that H.L. was not detained, but the Court of Appeal ruled that he was detained because 'had he attempted to leave the hospital, those in charge of him would not have permitted him to do so'.[4] Furthermore, they said that 'powers to act under the common law doctrine of necessity can arise only in relation to situations not catered for by the Mental Health Act'. In effect, H.L. was illegally detained in hospital and he was later discharged by the hospital managers (after having been formally detained following the ruling). The ruling of the Court of Appeal carried wide-ranging implications for thousands of patients in hospitals and care homes who lacked capacity and were being cared for in similar circumstances and who could potentially be detained under the Mental Health Act 1983, which most care homes were not registered for.

The trust appealed, and in 1999 the House of Lords upheld their appeal stating that H.L.'s admission was lawful under the common law doctrine of necessity.[5] The case then went to the European Court of Human Rights, where H.L.'s admission was considered to be in breach of Articles 5(1) and 5(4) of the European Convention on Human Rights (as set out in Schedule 1 of the Human Rights Act 1998).[6] Article 5(1) was breached, as under common law there was no procedural framework for determining whether detention/deprivation of liberty was allowable. The Human Rights Act allows liberty to be deprived under certain circumstances, including 'being of unsound mind'. However, under the then law there was no requirement to assess whether a person had a mental disorder or not. Article 5(4) states each person's 'right to a fair trial', whereas there was no framework for judicial review of whether admission was in the person's best interests or whether it remained so over time.

Changes in legislation

The deprivation of liberty safeguards introduced by the Mental Health Act 2007 came into force in April 2009. They provide a statutory framework that addresses the gaps discussed above. Hospitals and care homes can now apply for an independent assessment that involves determination of whether someone has a mental disorder, whether treatment is in their best interests and whether or not such treatment constitutes 'deprivation of liberty' (this will be judged on a case-by-case basis). If the treatment does constitute deprivation of liberty, care remains legal subject to approval from the best interests' assessor and review at least every 12 months. There is also the right of appeal or review by the Court of Protection.

Two important points need to be highlighted here: first, detention under the Mental Health Act 1983 may still remain the best option for the incapacitated but resistive individual; second, the Mental Capacity Act 2005 and the amendments in the Mental Health Act 2007 were to address gaps in the legal provision for incapacitated but adherent patients and were not a backdoor attempt to introduce capacity-based mental health act legislation.

Implications for detained individuals

So what are the implications of these changes to those detained under the Mental Health Act 1983, a group that constitutes the majority of patients in forensic services?

The guidance states that many people detained under the Mental Health Act have the capacity to make decisions about themselves, and Section 13.26 of the Mental Capacity Act Code of Practice[1] states that 'there is no reason to assume a person lacks capacity to make their own decisions just because they are subject to detention'.

https://doi.org/10.1192/pb.bp.108.020115 Published online by Cambridge University Press

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Patients can be given treatment under Part IV of the Mental Health Act whether they have capacity or not, although capacity to consent for drug treatment is still assessed after 3 months, and for those unable or unwilling to consent a safeguard of approval of the treatment by a second opinion approved doctor is provided. The concept of 'treatment' is broader than just the use of drugs, and includes nursing and other interventions aimed at alleviating or preventing deterioration in the mental disorder. However, this does not include the rules and restrictions on patients found in secure care (e.g. restricted access to lighters, passports, the internet, pornography) are not considered 'treatment' under Part IV of the Act.

Implications for the Human Rights Act

These restrictions have an impact on the Human Rights Act 1998, in particular Article 8 ('right to respect for private and family life'). A hospital is allowed to impose rules that do not contravene Article 8(2), if it is 'necessary in a democratic society for the interests of national security, public safety or the economic well being of the country, the prevention of disorder or crime, for the protection of health and morals, or for the protection of the rights and freedoms of others'. In essence, any interference or restriction would have to be proportionate to the identified risk to self and others. This echoes the sentiments of actions taken in the best interests of patients who lack capacity, which should also be proportionate to risk (in other words, lack of capacity does not give services *carte blanche* to 'do anything' to, or on behalf of, the patient). It also aligns itself with the 'least restriction principle' of the Mental Health Act 2007. More pertinently for a detained patient, even if they have capacity to make a particular decision, Article 8(2) allows restriction on this, proportionate to risk. What then is the value of a capacity judgement in this context?

There are some clear implications of the Mental Capacity Act in secure care, such as the powers of attorney to make healthcare decisions on behalf of a patient, and a renewed emphasis on the role of advance directives for issues such as how the patient wants to be treated when violent or what medications they would prefer to have (these were already part of related National Institute for Health and Clinical Excellence guidance).[7] What would be the other implications?

Capacity judgements in mental disorder are complex

Before looking at this question in more detail through the use of a hypothetical case scenario, a number of practical difficulties that arise when trying to determine capacity in patients with mental disorder are worth touching upon here.

Unlike in most physical healthcare decisions, the mental disorder itself influences the criteria by which one assesses capacity. In some cases this will be straightforward, such as the inability to retain information in advanced dementia. In other cases, for example in people with depression, the situation can be more complex. Feelings of hopelessness, pessimism or lack of energy will directly influence the ability to 'weigh in the balance' of the options for that person, or indeed to believe the information presented to them. Patients with features of psychopathy who lack empathy may intellectually know that certain choices may affect others badly, but they may not particularly care or may feel it is irrelevant to the decision to be made; does this mean that they are unable to weigh in the balance a decision?

Further, a person should not be deemed to lack capacity simply on the basis of an unwise decision. However, poor decision-making is often used to justify the diagnosis of mental disorder (e.g. reckless spending as a symptom of mania).

As mental disorder fluctuates, capacity will also be expected to fluctuate, thus necessitating frequent capacity reassessments. Capacity judgements are decision-specific. In physical healthcare scenarios, decisions are usually clear-cut, for example whether or not to have a particular treatment. For other scenarios, the exact decision under scrutiny is open for debate. Let us consider the ability or capacity to manage one's money, a common challenge in forensic services. What specifically is the decision based on? Is it the capacity to manage £20 or £10 000, or to invest in the stock market? How can services monitor when the decision in question changes? What about the scenario of having relationships with another detained patient or indeed an external party? What is the team to assess the capacity for? In case law, the test for the capacity to marry (which the new Mental Capacity Act does not necessarily replace) involves the person understanding the nature of a marriage contract, specifically the responsibilities attached to marriage.[8] It involves a simple understanding of the role of a husband or wife and sets the threshold low. In the case of relationships, therefore, is one assessing the capacity to understand the basics of what a relationship is (which most patients would know) or is it the ability to have a stable relationship? Or to understand the consequences of having intercourse, including the risks of pregnancy? Again, how do services know when the decision in question changes, especially if contact is unsupervised? One could envisage a situation where individuals who lack capacity have the ability to marry but not consummate the marriage or have any other sexual contact (this has been the case in the special hospital system).

The threshold for capacity needs to be 'commensurate with the gravity of the decision'; this has the effect (along with the 'reasonably foreseeable consequences' criterion) of making capacity a shifting concept, as when the potential risks go up, one is more likely to be deemed not to have capacity. In essence, one is doing a risk assessment under the veil of a capacity assessment.

Whose responsibility is it to determine capacity? Is it a decision of the responsible clinician or the team? What if there are disagreements? Given the above complexities, what is the likely interrater reliability of a

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capacity assessment for matters such as money or relationships? I would suspect it may be low and give rise to broad disagreements within teams depending on the members' professional backgrounds and values.

Case scenario

Let us summarise the issues by looking at the considerations in a hypothetical case scenario, where patient A wishes to have a sexual relationship with patient B. Both patients are detained in a low secure unit. Intuitively, one would consider the capacity of both parties (indeed, the wording of the Mental Capacity Act suggests that where they may be lack of capacity, one is obliged to consider the Act). As noted above, what the team or the responsible clinician are assessing the capacity for is open for discussion: to understand what a relationship is? To understand the psychological effect on others in the unit, including the staff? To understand the psychological and physical impact of sexual intercourse? If one arrives at a decision that one or both parties lack capacity, then actions are taken in the best interests of the patient(s), taking into account their expressed wishes and ensuring that any interference will be proportionate to the level of identified risk. Is this not the same as when patients have capacity? Boundaries will still be placed, proportionate to the perceived risks to the patients' mental health and the effect on others, regardless of whether they are deemed to have capacity or not. In general, sexual activity between patients of any kind in forensic settings is not permitted (or even discussed), although there may be no clear policy in this area and sexual activity may be taking place clandestinely.[9] Would there be any difference in the boundary line if the patient did or did not have capacity? Possibly, although in my opinion this would stem from overly restricting the incapacitated patient due to a misapplication of the best interests test (see above) rather than allowing more 'risky' behaviours for those who have capacity. In any case, it is likely that the patients will be deemed not to have capacity if the potential risks are high (based on the argument that if they had truly weighed in the balance, they would not want to do it).

Add to this the additional complexities attached to making capacity judgements in patients with mental disorder, it raises the question as to whether capacity judgements for decisions around relationships, money or other restrictions on detained patients, although seeming like good practice and a victory for the autonomy of the patient, are in fact a distraction from the principal debate? Thus, are the restrictions and practices commonly found in forensic care really proportionate to the risks, or indeed, do they enhance the risks in the long term by restricting the ability to develop skills in the expected freedoms the patients will have upon discharge?

Conclusions

In summary, the spirit of the Mental Capacity Act 2005, and the concept of capacity in a wider sense, is to provide safeguards to those who lack capacity but respect the autonomy of those who do, so they can make decisions about their life for themselves. Application of capacity judgements for detained patients in secure care may seem a natural extension of this, particularly considering that enhancement of the autonomy of the patient is a recognised goal of psychiatric rehabilitation. However, this comes with complexities and caveats, both clinical and administrative, and may obfuscate a more central issue of risk assessment and proportionality under Article 8 of the European Convention on Human Rights. Services need to ensure an open debate about these issues along with altering practices to comply with the new Mental Capacity Act.

Declaration of interest

None.

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https://doi.org/10.1192/pb.bp.108.020115 Published online by Cambridge University Press