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Assessing mental capacity: tensions, values and duties†

COMMENTARY

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SUMMARY

This is a commentary on two articles on assessing mental capacity in everyday practice and in the case of the suicidal patient. It explores some of the conceptual problems with capacity, including the lack of a 'right' answer and the value-laden nature of capacity assessments in suicidal patients. In England and Wales, in addition to the Mental Capacity Act 2005 clinicians must also consider their duty of care as part of the European Convention on Human Rights as enacted in the Human Rights Act 1998.

KEYWORDS

Capacity; Mental Capacity Act; Mental Health Act; suicidal patient; European Convention on Human Rights.

In England and Wales, the Mental Capacity Act 2005 (MCA) allows for substitute decision-making for patients lacking capacity. Professionals, experts and judges often disagree, however, about the right way to apply the MCA. It is perhaps ironic therefore that in the first of their two articles on mental capacity in practice Beale and colleagues do not offer clarity on whether the person in their fictitious case study has capacity or not for the decisions in question (Beale 2023a). This gives the impression that there is no 'right' answer and that following the process is all that matters. Although the MCA does require a binary outcome on whether or not a person lacks capacity for a specific decision, there is a sliding scale of capacity for different decisions, as emphasised in *Re T (Adult: Refusal of Treatment)* [1993], 'commensurate with the gravity of the decision', which in the context of suicide may be very significant indeed.

Beale et al make the important point that a presumption of capacity should not be used as an excuse to exclude people from treatment. Nor, if people disengage, should this be treated as synonymous with a lack of capacity. Practical steps and other reasonable adjustments are needed, especially for persons with sensory or communication difficulties. Considering best interests as more than merely medical interests, and putting sufficient weight on a person's wishes, are all essential.

Understanding and weighing

When discussing the importance of understanding within the MCA, the authors give the example of a person (Mr A) with delusional beliefs and ask whether this prevents him from understanding what is being said to him. He does not believe that his depot injection is medication for schizophrenia but instead believes that the government increases persecution when he stops it and he is brought back into hospital for reinsertion of a tracking device.

What is meant by 'understand'? As a narrow abstract cognitive concept, Mr A may intellectually assent to the idea that some people have medication in depot form for mental disorders. A more holistic approach to understanding, however, might entail him accepting that he has schizophrenia and needs medication to treat it. The need for belief in *Re C (Adult: Refusal of Medical Treatment)* [1994] has not explicitly been incorporated into the MCA but it could be argued that a person who does not believe something to be true for them cannot really understand what is at stake. Mr A's delusions appear to prevent him from having this more holistic understanding in the sense that he does not believe that the information applies to him.

When it comes to weighing information in the balance the authors point out that a person may decline medical assistance even when they are not mentally unwell. Mr A, however, has believed that doctors wish to experiment on him for years 'even when his mental state is most stable'. It is hard to argue that his avoidance behaviour is entirely his own authentic wishes and not influenced by his chronic paranoid delusions.

Unwise decisions

Value-laden concepts surrounding making an unwise decision are complex (Coggon 2021). There is an inherent tension between capacitous unwise decisions (MCA section 1(4)) and the need to be protected from the same unwise decisions in persons lacking capacity by way of best interests (MCA section 1(5)). Using the term 'unwise' in the MCA introduces a subjective judgement. Capacity assessors are at risk of bias if they consider a decision to be unwise because a person generally has the right

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to make an unwise decision only if they have capacity. Nevertheless, in *Wye Valley NHS Trust v Mr B* [2015] significant weight was given to the (non-delusional) religious beliefs of a man lacking capacity even though refusing a leg amputation might be considered unwise.

The landmark case of *Re T (Adult: Refusal of Treatment)* [1993] demonstrates that capacitous refusal of treatment by an adult can be done 'notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent'. Nevertheless, reference to unwise decisions was considered relevant in determining capacity in both *D v R (Deputy of S) & S* [2010] and *Royal Borough of Greenwich v CDM* [2018].

The authors do not focus much on Mr A's understanding or ability to weigh up information in relation to the endoscopy. If he is refusing because of paranoid delusions that he will be experimented on, it is perhaps surprising that the authors do not feel able to conclude that he probably lacks capacity for both an endoscopy and depot antipsychotic medication since his delusions have a direct influence on his decision-making ability.

The suicidal patient

When it comes to a suicidal patient, many would consider this a paradigmatic example of an unwise decision, although perhaps only in the context of mental disorder. Debates surrounding assisted dying demonstrate that we may be too quick to pathologise suicidality. Nevertheless, as emphasised in *Aintree University Hospital NHS Foundation Trust v James* [2013] there is a strong presumption that it is in a person's best interests to stay alive.

In their second article, Beale et al use a fictitious example of a woman with emotionally unstable personality disorder who feels suicidal (Beale 2023b). They shift the focus away from the MCA towards Article 2 (the right to life) of the European Convention on Human Rights (ECHR). By quoting the cases of *Savage v South Essex Partnership NHS Foundation Trust* [2008] and *Rabone and another v Pennine Care NHS Foundation Trust* [2012] they emphasise both that Article 2 is engaged and that the state has an operational duty to act if there is a real and immediate risk of suicide, regardless of a person's capacity. There may be situations where clinicians ought to use the Mental Health Act 1983 (MHA) to protect a person's Article 2 rights rather than relying on the MCA to allow the person to make a capacitous unwise decision that could lead to their death.

The authors also distinguish between a person ending their life in crisis as opposed to being allowed to end their life within the meaning of ECHR Article 8 (the right to respect for private and family life) in what would presumably be a more considered decision. Involving family or friends if possible is also extremely important, because personal autonomy often exists in the context of wider relationships.

The MHA and the MCA

The authors discuss the relationship between the MHA and the MCA. The case of *B v Croydon Health Authority* [1995] demonstrates that treatment for mental disorder within section 63 (treatment not requiring consent) of the MHA can include a range of acts ancillary to the core treatment the patient is receiving. Elsewhere this has included nasogastric feeding, dialysis, a blood transfusion and even a Caesarean section. Treatment to mitigate a suicide attempt could theoretically be given under section 63, and the emphasis on Article 2 of the ECHR leaves little alternative if a patient has capacity to refuse life-saving treatment.

When assessing capacity the authors emphasise the need to compare the patient's current choices with her usual beliefs and values. Unlike with delusions however, there is not a neat qualitative difference between pathological and non-pathological states in personality disorder. It may be impossible to distinguish between behaviour that is part of her disorder and behaviour that is not. People with personality disorder may retain capacity as in *King's College Hospital NHS Foundation Trust v C and V* [2015] although as in *Royal Borough of Greenwich v CDM* [2019] it may also fluctuate.

Conclusions

Given the tension between Article 2 of the ECHR and the MCA, in emergencies clinicians should preserve life regardless of a person's capacity, if necessary using the MHA. Protecting a suicidal patient's Article 2 right to life will always remain of central importance.

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Declaration of interest

None.

References

Beale C, Lee-Davey J, Lee T, et al (2023a) Mental capacity in practice part 1: How do we really assess capacity? *BJPsych Advances* [Epub ahead of print] 28 Feb 2023. Available from: https://doi.org/10.1192/bja.2022.81.

Beale C, Lee-Davey J, Lee T, et al (2023b) Mental capacity in practice part 2: Capacity and the suicidal patient. *BJPsych Advances* [Epub ahead of print] 28 Feb 2023. Available from: https://doi.org/10.1192/bja.2022.82.

Coggon J, Kong C (2021) From best interests to better interests? Values, unwisdom and objectivity in mental capacity law. *Cambridge Law Journal*, **80**: 245–73.

Cases

Aintree University Hospital NHS Foundation Trust v James [2013] UKSC 67.

B v Croydon Health Authority [1995] 1 All ER 683.

D v R (Deputy of S) & S [2010] EWHC 2405.

King's College Hospital NHS Foundation Trust v C and V [2015] EWCOP 80.

Rabone and another v Pennine Care NHS Foundation Trust [2012] UKSC 2, [2012] 2 All ER 381.

Re C (Adult: Refusal of Medical Treatment) [1994] 1 All ER 819.

Re T (Adult: Refusal of Treatment) [1993] Fam 95.

Royal Borough of Greenwich v CDM [2018] EWCOP 15.

Royal Borough of Greenwich v CDM [2019] EWCOP 32.

Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74, [2009] AC 681.

Wye Valley NHS Trust v Mr B [2015] EWCOP 60.