mentalwelfare commission for scotland

GOOD PRACTICE GUIDE

Consent to Treatment: A guide for mental health practitioners

Reviewed January 2017

This guide has been updated to reflect key changes to the Mental Health Act implemented on 30 June 2017. This version replaces the previous 2010 version.

Contents

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Chapter 1

Introduction

Scope of the guide

This is a guide to best practice in relation to consent to treatment for mental disorder. It is written to help mental health practitioners, but will also be of interest to service users, carers and independent advocates. The main aim of the guide is to examine issues of consent in the light of the Mental Health (Care and Treatment) (Scotland) Act 2003.[1] It has been updated in light of the Mental Health (Scotland) Act 2015.[2] The guide also covers treatment for mental disorder where the person is not subject to that Act but where the Adults with Incapacity (Scotland) Act 2000[3] applies. We hope that it will help practitioners to interpret the legal basis for treatment and to give treatment in line with best legal and ethical practice.

We are restricting the scope of this guidance to adults (i.e. people aged 16 or over). Issues of consent and capacity for children under 16 are covered in other guidance. We do, however, make reference to some of the new provisions of the 2003 Act in relation to children.

This guidance should not be taken as legal advice. While we quote from the law and give our interpretation of best practice, we cannot produce a guide that anticipates every possible scenario. In individual cases, practitioners may wish to discuss difficult cases with us and may need to consult their own legal advisors.

Legislative framework

In law, adults have the right to make decisions affecting their own life. This right does not necessarily depend on any particular form of reasoning. The reasons given for decisions may be rational, irrational, unknown or, in some cases, possibly even non-existent. There is a presumption in law in favour of capacity. A general rule is that an adult is deemed to have capacity to consent to treatment, unless there is evidence to the contrary.

Mental disorder may impair capacity to consent to treatment. In general, the presumption will still be in favour of capacity. Any person subject to compulsory treatment under civil powers of the 2003 Act (see below) will, by definition, have or be likely to have, impaired ability to make decisions about medical treatment. Therefore, in this case, the person's capacity to consent cannot be presumed. If the person is being treated under powers for mentally disordered offenders, the test for decision-making ability does not apply.

Mental Health (Care and Treatment) (Scotland) Act 2003

The 2003 Act is based on a set of guiding principles. Anyone "discharging functions" under the Act must take into account:

- The person's past and present wishes about their care and treatment;
- The care and treatment that will be of most benefit;
- The range of options available for care and treatment of the individual;
- The person's individual abilities and background;
- The person's age, gender, sexual orientation, religion, racial origin or membership of any ethnic group.

An adult is deemed to have capacity to consent to treatment, unless there is evidence to the contrary.

People giving care and treatment should also make sure that:

- Any restrictions on a person's freedom are the least necessary;
- The person being treated under the Act shouldn't be treated any less favourably than anyone else being treated for a mental illness or other mental disorder;
- The needs of carers are taken into account (other than when making a decision about medical treatment);
- The person being treated is getting services that are right for him or her;
- When a person is no longer receiving compulsory treatment, he or she should continue to get care and treatment if needed.

Due consideration should be given to the need to balance the various principles in the Act where there may be competing or conflicting interests and pressures. For medical treatment, it may be that the treatment that is likely to be of most benefit may not be in line with the views of the patient. We believe that it is important for practitioners to demonstrate how they have balanced the principles when making treatment decisions where the person lacks capacity and/or refuses treatment.

Medical treatment is broadly defined under the 2003 Act. In addition to medication, it includes nursing, care, psychological treatments, habilitation and rehabilitation. Part 16 of the 2003 Act deals with medical treatment. We will consider the provisions of that part of the Act in particular.

The Adults with Incapacity (Scotland) Act 2000

The 2000 Act also covers treatment for mental disorder. This Act is founded on clear principles.

Principle 1
The intervention must be of benefit to the individual.

Principle 2
The intervention must be the least restrictive in relation to the person's freedom in order to achieve the desired benefit.

Principle 3
Interventions should take account of the past and present wishes of the adult.

Principle 4
Interventions should take account of the views of relevant other parties.

Principle 5
Interventions should encourage the adult to use existing skills and develop new skills.

Part 5 of the 2000 Act covers medical treatment. We will examine how this Act allows for treatment for mental disorder and how it interacts with the 2003 Act.

The guide also draws on existing guidance, Codes of Practice for both sets of legislation and relevant case law. Our duty to promote best practice, in relation to the 2003 Act, involves promoting the principles of the Act. We also recognise the importance of the principles of the 2000 Act. We have therefore examined how the principles can be applied to difficult treatment decisions, when legal interventions are being considered.

Chapter 2

Consent to treatment

This part of the guide deals with some general aspects of consent to treatment. Under normal circumstances, medical treatment needs consent. If a practitioner gives medical treatment without valid consent, he/she could be open to allegations of assault.

The nature of consent depends on the intervention. Some simple interventions may only need implied consent. An example would be rolling a sleeve up to allow blood pressure to be checked. Verbal consent is the rule for many forms of treatment, for example taking medication. More invasive procedures, especially when carried out under anaesthetic, need written consent.

The 2003 Act extends the range of treatments that need written consent. It is therefore important to examine the process of consent.

What is valid consent?

There is general agreement that a number of aspects relate to valid consent.

Consent must be:

- Given freely, without duress or coercion (see Chapter 4);
- Given by someone who is legally capable (or competent) of consenting (see Chapter 3);
- Specific and cover the intervention or procedure to be performed;
- Informed (the person understands what is involved) (see below);
- Enduring (for treatment given over a period of time).

If any of these areas are deficient then the person may not be giving valid consent to treatment.

Information-giving and consent

The General Medical Council gives the following advice to doctors on information-giving:

- Use up-to-date written material, visual and other aids to explain complex aspects of the investigation, diagnosis or treatment where appropriate and/or practicable;
- Make arrangements, wherever possible, to meet particular language and communication needs, for example through translations, independent interpreters, signers, or the patient's representative;
- Where appropriate, discuss with patients the possibility of bringing a relative or friend, or making a tape recording of the consultation;
- Explain the probabilities of success, or the risk of failure of, or harm associated with options for treatment, using accurate data;
- Ensure that information which patients may find distressing is given to them in a considerate way. Provide patients with information about counselling services and patient support groups, where appropriate;
- Allow patients sufficient time to reflect, before and after making a decision, especially where the information is complex or the severity of the risks is great. Where patients have difficulty understanding information, or there is a lot of information to absorb, it may be appropriate to provide it in manageable amounts, with appropriate written or other back-up material, over a period of time, or to repeat it;

The 2003 Act extends the range of treatments that need written consent.

- Involve nursing or other members of the health care team in discussions with the patient, where appropriate. They may have valuable knowledge of the patient's background or particular concerns, for example in identifying what risks the patient should be told about;
- Ensure that, where treatment is not to start until some time after consent has been obtained, the patient is given a clear route for reviewing their decision with the person providing the treatment.

Information must be sufficiently specific and detailed to give the person as full an understanding as possible on the nature, purpose and likely effects of the treatment. This must include:

- What the treatment consists of. The explanation will vary depending on the person's ability and wish to understand. *For drug treatment, this includes the type of drug, its main effects on the person and any additional monitoring that is needed. For ECT, this includes a full description of the procedure, the way ECT is thought to act and the fact that it is a series of treatments;*
- The main beneficial effects of the treatment. *This includes an estimation of the likelihood of benefit, what effects the person might experience and how long it will take for the treatment to have effect;*
- Risks and unwanted effects. *The person must be warned of common side effects and any uncommon but serious adverse effects.*

Clinicians must give an honest and sensitive explanation of potential serious adverse effects of treatment. In doing so, they are more likely to gain the trust of people they treat. Here are examples of how to do this.

ECT and memory loss: *"You may well find that your memory is not as good as usual during a course of ECT. It might be difficult to remember things that have happened recently. Some people find gaps in their memory for the time they had the treatment. ECT should not cause any lasting damage to your memory. However, if you find that there are personal memories of the past that are more difficult to recall, please let us know straight away. We would need to stop the treatment or make a major change to the way we give it."*

Antipsychotic drugs and movement disorders: *"Sometimes these drugs can make it difficult for you to control your movements or make you feel restless. We think that newer drugs make this less likely but it may still happen for a few people who take the drugs. If you feel restless and have trouble sitting still or if you, or anyone else, notice that your mouth and tongue are restless in a way they weren't before, let us know straight away. We would need to change your treatment."*

Withholding information and deception

Information should not be withheld unless it is judged that the disclosure of that information would cause a patient significant harm. It has been argued that it is irresponsible to share certain information with the patient if it may have a detrimental effect[4]. However, withholding an essential piece of information can reduce a patient's understanding of his or her circumstances[5]. In situations where information is withheld from a patient, this should be documented as these decisions may need to be explained and justified.

Education tools

Using additional educational tools and support can enhance a person's capacity to consent. Lapid et al[6] found that using video and greater time for discussion on the use of ECT enhanced people's capacity. The authors suggest that for those with a limited understanding of a treatment being recommended, educational interventions can be helpful.

Reviewing consent

It is also important to recognise that consent is not a 'one-off' procedure but something which may need to be reviewed. Most mental health treatment is an ongoing process, not a single event. There is a responsibility on the mental health team to ensure that consent is always current. For example, the General Medical Council recommendations cite that consent should be reviewed particularly where:

- *significant time has elapsed between obtaining consent and the start of treatment;*
- *there have been material changes in the patient's condition, or in any aspects of the proposed treatment plan, which might invalidate the patient's existing consent;*
- *new, potentially relevant information has become available, for example about the risks of the treatment, or about other treatment options.*

When does the 2003 Act require consent for treatment?

Part 16 (sections 235-248) of the Act set out the conditions under which treatment may be given to patients who are either capable or incapable of consenting to specific treatments. For treatments that do not need special safeguards, section 242 of the Act requires either written consent from the person or, if the person does not consent or consents other than in writing, a statement as to why the treatment is in that person's best interests. The Responsible Medical Officer should make a clear record of the reasons for any such decision.

Where the person consents, the RMO must be satisfied that consent is valid and informed. While consent in writing is important, a signature on a consent form does not, in itself, mean that the person is giving valid and informed consent. The practitioner must be able to demonstrate how consent was obtained. It would be best practice to record this process in writing.

Some treatments are subject to special safeguards. In all cases, the same basic principles governing consent apply where the person is regarded as consenting to treatment. Some of these treatments may be administered in the absence of consent. The Act and associated codes of practice cover the law in detail. The table on page 18 sets out the safeguards for particular treatments.

When a person consents to treatment provided under the Act, there needs to be a clear plan of treatment. This should be discussed with the person and recorded in writing. Appendix 1 gives guidance on treatment plans.

Best practice points

- Ensure that you have given the person information about the treatment in a way that is appropriate to his/her needs and abilities;
- Consider appropriate educational media to enhance the person's understanding of the treatment;
- Allow the person appropriate time and support from others, including independent advocacy;
- Follow the GMC guidance on giving information;
- Document consent and the way in which it was obtained;
- Document any concerns the person has and any disagreement about treatment.

Chapter 3

Capacity, competency and impaired decision-making

Definitions of capacity

This section will focus on capacity to make treatment decisions in line with the law and not other aspects of capacity (for a full discussion on capacity see Atkinson et al[7]). Capacity in Britain is a legal term and competency is used more widely to describe general or specific areas of functioning. Unlike capacity, which is decided legally, competency is usually a clinical decision. In the United States, however, competency is more usually the legal term, although in some places capacity is used.

There is no presumption, either in common law or in mental health legislation in Britain, that the presence of a mental disorder automatically indicates the absence of capacity. However, capacity can be impaired by poor memory, lack of ability to process information, or poor judgement because of disorders of mood and thinking.

Capacity and "significantly impaired decision-making ability"

The 2003 Act introduces significantly impaired decision-making ability (SIDMA) as a criterion that must be either satisfied, or likely to be satisfied. This criterion applies to people subject to civil orders. Criteria for mentally disordered offenders differ.

The relationship between SIDMA and capacity to consent is difficult and worth further study. However, it is important to remember that SIDMA refers to decisions about medical treatment in general. The individual might be able to make decisions about some treatments but not others. We advise assessment of capacity to consent to each individual treatment. *For example, a person may have the capacity to decide to take a certain medication for mental disorder but may lack the capacity to decide on the level of nursing care and observation necessary for his/her safety.*

The 2000 Act defines incapacity as:

- being incapable of acting; or
- making decisions; or
- understanding decisions; or
- communicating decisions; or
- retaining the memory of decisions.

In relation to medical treatment, the guidance on assessing capacity in this chapter will help to determine whether a person is incapable in accordance with this definition.

Assessment of capacity

There are a number of approaches to capacity but the current position, as recommended by the Law Commission[8], is to use a 'functional approach' in determining whether a person has the capacity to make a decision. What this approach focuses on is *'whether an individual is able to make a decision at the time when that decision has to be made.'*[9] This means that an individual may be deemed incapable of making a decision at one specific point in time but capable at another point in time. There will be situations where an individual is capable of making some decisions while being incapable of making some others.

Just because a person's decision is regarded as unwise, does not in itself mean he or she lacks capacity.

To demonstrate capacity individuals should be able to:

- *Understand broadly what the treatment is, its purpose and nature and why it is being proposed;*
- *Understand its principal benefits, risks and alternatives and be able to make a choice;*
- *Understand in broad terms what the consequences will be of not receiving the proposed treatment;*
- *Retain the information long enough to use it and weigh it in the balance in order to arrive at a decision; and*
- *Communicate that decision.*

A problem for this definition, and the definition in the 2000 Act, is the issue of memory. Our view is that the person must be able to retain information for long enough to make a decision. In addition, we believe he/she must:

- Remember the decision; and/or
- Make the same decision consistently given the same information; and/or
- Agree with a record of that decision when presented with a record of it.

Although the 1984 Mental Health Act[10] did not specifically mention capacity it could be seen, in practice, to treat capacity as 'all or nothing'. Under this Act, by virtue of having a mental disorder, the person may have his/her decisions over-ruled by use of the Act. The 2003 Act requires an assessment of impairment in decision-making in addition to a diagnosis of mental disorder. Most definitions, and thus assessments of capacity, emphasise understanding and reasoning skills.

The concept of emotional decision-making may also be relevant and important. Practitioners should recognise that there is a need to understand a patient's experience of illness and treatment and decisions based on these experiences. This may lead to decisions being made which, for example, might be based on fear. Information and education may help if this is the case. Alternatively, some people may have legitimate reasons for making an emotionally-based decision which may tie in with philosophical, religious or cultural beliefs. It is important to remember that just because a person's decision is regarded by others as unwise, this in itself does not mean he or she lacks capacity. Under section 328 of the Act it is stated that *'a person is not mentally disordered by reason only of …acting as no prudent person would act.'* (see also chapter 4 on refusal of treatment).

Being able to consider and compare the benefits and risks of a proposed treatment is regarded as an important part of being competent to make treatment decisions.[11] Capacity can also be seen on a sliding scale, where the threshold takes account of the complexity of the decision, the risk involved, significance of and consequences of that decision.

Clinicians may need to judge whether a decision that is made on an emotional basis is merely unwise and imprudent or based on lack of understanding of, or inability to process, the information and more likely to indicate incapacity.

Compliance and capacity

Compliance, i.e. accepting treatment if it is offered, does not in itself constitute consent. A person may take treatment because it is given. Accepting treatment without knowledge of its nature, purpose and likely effects does not indicate informed consent. Likewise, a signature on a consent form does not, in itself, mean that the person is giving informed consent. The clinician must be able to demonstrate that the person has made the decision to opt into treatment knowing the nature of the treatment and its likely benefits and risks. A person who accepts treatment but does not meet the tests for capacity should be treated under an appropriate legal framework. The roles of the Adults with Incapacity and Mental Health (Care and Treatment) Acts are outlined in Chapter 5.

Clinical or research assessment tools

There are a number of tools to assess capacity for use in either clinical or research settings. Probably the best known of these is the MacArthur Competency Assessment Tool produced by Grisso and Applebaum.[12] A list of useful web sites and literature for different types of tools is given in Appendix 2.

In clinical situations, clinicians are unlikely to use formal tools. They must, however, be able to demonstrate how they arrived at a decision when they decide that a person lacks the capacity to consent.

Fluctuating capacity

If an individual has difficulty retaining information, or is only intermittently capable of making a decision, assistance should be provided, to make an informed decision. Decisions made should be recorded while the person is capable. Decisions made while capable should be reviewed at appropriate intervals to establish that the person's views are consistently held and can be relied upon.

Best practice points

- Use a functional approach to capacity, based on the process by which the person makes a decision, rather than whether you think their decision is the right one;
- If treatment is ongoing, or if there has been a gap between the person giving consent and the treatment starting, ensure that the person still consents and still has the capacity to do so;
- Capacity can fluctuate. Consult those who are in regular contact with the person and get another opinion from a colleague, if in doubt.

Refusal of treatment must be one of the patient's options, if the process of seeking consent is to be meaningful.

Chapter 4

Refusal, persuasion and coercion

What is a valid refusal?

Refusal of treatment must be one of a patient's options, if the process of seeking consent is to be meaningful. A competent person can refuse consent to treatment for a good reason, for an irrational reason or, indeed, for no reason at all. The Law Commission recommended a 'presumption against lack of capacity' and suggested that the resulting decision should not be regarded as invalid just because it *'would not be made by a person with ordinary prudence'*[8] (Law Commission 1995).

If a patient refuses treatment the practitioner should document the informed refusal in the patient's medical notes and include the following information:

a) the patient's refusal of treatment

b) documentation that the need for the treatment has been explained

c) a statement that the consequences of the refusal, including possible jeopardy to health or life, have been discussed.

Where a person suffers from mental disorder, it is important to consider whether he/she has the capacity to refuse. This can be a difficult clinical judgement. The tests for capacity on page 12 may give some guidance. Particular difficulties occur where:

- The patient is suffering side effects of treatment and judges these to be so severe that it would be better to risk staying, or becoming, ill.

  Example – Person with schizophrenia who knows that medication stops distressing hallucinations but who refuses continued treatment because of sedation or weight gain. This may well be a valid refusal. It is important to consider the range of options and examine other treatments.

- The patient distrusts the explanation of the treatment or of the need for it.

  Example – "I understand that you think I am ill, I understand your proposed treatment and potential consequences of my taking or not taking the treatment, but I am not ill." While this person understands the nature and purpose of the treatment, it may be that he/she does not understand why it is being proposed.

- The patient objects to the treatment on religious or moral grounds.

  Example – Member of the Scientology movement who refuses any medication on the basis of religious belief. Respect for diversity is an important principle of the 2003 Act. It would be very important to respect this person's beliefs.

- The patient understands the treatment and the need for it, but decides to refuse because the burden of ongoing treatment would be too great and he/she would rather die.

  Example – person with an eating disorder who feels so tortured by the illness that she would rather die than struggle on with treatment. Faced with this situation, clinicians should listen to the views of others who know the person well and would be best advised to get another professional opinion.

- The patient is making an imprudent decision but not because of mental disorder.

  Example – A patient understands the need for treatment but has always disliked taking medication and prefers to "soldier on" despite attempts to persuade him/her of the benefits. The clinician may consider this unwise but that would not be sufficient to constitute incapacity and may well be a valid refusal.

In situations where there is doubt and the person has the capacity to make a valid refusal, the practitioner responsible for treatment should consult the multidisciplinary team, others who know the person well and the named person. It is wise to ask a colleague for a second opinion.

Coercion

The definition can range from formal or legal coercive measures such as compulsory treatment in a hospital or within the community to other pressures such as 'persuasion', 'leverage' or 'threats'.[13]

There is a very wide range of literature on coercion in relation to psychiatric health care which relates to issues such as the use of coercion in psychiatric settings[14], patient perceptions of coercion[15 16 17 18], the development of tools to assess patients' perceptions of coercion as well as how professionals define coercion and relate it to their work experiences.[19]

Perceptions of coercion are subjective. The relevant questions that need to be asked are whether the person knew that treatment could be refused, or felt pressured to have it. Studies have highlighted that how a particular treatment option is brought up is important in determining whether someone has felt coerced. For example, for a professional to say: *"I want you to have ECT. You're not sectioned at the moment, but I will section you if you refuse"* [18] highlights the imbalance of the power relationship between professional and patient, but also the differences in balancing the need to provide clear information about consequences without this becoming coercive.

In seeking to avoid detention or compulsory treatment, professionals may use what they believe are persuasive techniques to convince a person to go into hospital or accept treatment voluntarily. These techniques may still be experienced by the patient as coercive. An example of this may be spending several hours 'persuading' which may be experienced by the individual as a 'wearing down' process. Perceptions of coercion may differ between professionals and patients.

Best practice points

- Check that the person has all the information necessary to make the decision and remind him/her if necessary;
- Discuss the range of options with the person. If one option clearly offers the greatest benefit, it is important to emphasise this. There may be other treatment options that the person finds more acceptable;
- Consider carefully the reasons why the person is reluctant to proceed. Be very careful about attempting to persuade a person who objects on religious or moral grounds;
- If you intend to use the Act to overcome an objection to treatment, it is important to tell the person. If the person agrees to treatment solely on the basis that he/she would otherwise be treated compulsorily, it is very doubtful that this is valid consent. Any practitioner proceeding with treatment on this basis should seek an opinion from a colleague before doing so. The person should also have the support of an independent advocate.

Chapter 5

Treatment without consent

This section outlines best practice in giving treatment for mental disorder without the person's consent.

General considerations

Treatment in the absence of consent can be a distressing experience. Whichever piece of legislation is being used, principles should guide best practice. If a person is being treated in the absence of consent, this does not remove the duties of the practitioner to:

- Give the person as much information as possible about the treatment in a way the person can understand;
- Take the person's views about the treatment into account;
- Take account of any previously expressed wishes, including an advance statement (see Chapter 6);
- Take account of the views of others;
- Ensure that any treatment will benefit the person. Maximising benefit is an important principle of the 2003 Act, but this may need to be balanced against the person's wishes and the views of relevant others;
- Respect the person's religious and cultural beliefs, where these beliefs impact on decisions about treatment;
- Think about the range of options available for the person. It may be that he/she would find some treatments more acceptable than others. Again, this must be balanced with the principle of maximising benefit.

Treating a person who lacks capacity to consent

a) Treatment under the Adults with Incapacity (Scotland) Act 2000

It is appropriate to use this Act when:

- The person is not subject to compulsory treatment under the 2003 Act, and
- The person lacks capacity to consent to treatment for mental disorder, and
- There is no requirement for force or detention (except as an emergency measure).

Therefore, it is not necessary to use the 2003 Act to treat a person for mental disorder where the above conditions exist. We do however advise using the 2003 Act if it is necessary to give treatment for mental disorder and the person resists or objects to that treatment.

Treatment should be given with regard to the principles of the 2000 Act. Part 5 of the Act requires a certificate of incapacity. Appending a treatment plan to a patient's file is the best way to provide complex and detailed plans of treatment. While the Code of Practice for this Act suggests a format for this, it is acceptable to use a plan as outlined in Appendix 1.

Remember that under the AWI Act some treatments carry special safeguards. These safeguards apply, for example, to drug treatment to reduce sex drive and to electroconvulsive therapy. These treatments need an independent opinion from a second opinion doctor, arranged by the Mental Welfare Commission.

Treatment in the absence of consent can be a distressing experience.

Figure 1: Requirements of the 2003 Act for consent to treatment

Treatment	Capable and consents	Capable and refuses	Incapable, but does not resist or object	Incapable and resists or objects
Neurosurgery and deep brain stimulation	Needs DMP opinion and lay opinions from MWC	Cannot be given	Needs DMP opinion and lay opinions from MWC. Must then be authorised by Court of Session	Cannot be given
Electroconvulsive therapy, vagal nerve stimulation and transcranial electromagnetic stimulation	Written consent and certification on form T2	Cannot be given	Needs DMP opinion on form T3 and can be given if in the person's best interests	Needs DMP opinion on form T3 and can be given to save life, prevent serious deterioration or alleviate serious suffering
Drug treatment for more than 2 months, medication to reduce sex drive and artificial nutrition	Written consent and certification on form T2	DMP opinion on form T3 with statement as to why treatment should be given	Needs DMP opinion on form T3 and can be given if in the person's best interests	Needs DMP opinion on form T3 and can be given if in the person's best interests
Other treatments (Section 242) e.g. medication within first 2 months, psychological therapies	Written consent	Best interests test – RMO records reasons for treatment in writing, with reasons for giving treatment in spite of refusal	Best interests test – RMO records reasons for treatment in writing	Best interests test – RMO records reasons for treatment in writing

b) Treatment under the 2003 Act

A person subject to compulsory treatment under this Act can be treated without consent if he/she:

- Is incapable of consenting; or
- Refuses to consent.

There are safeguards for some treatments and some require an independent opinion from a Designated Medical Practitioner appointed by the Mental Welfare Commission. Readers should consult the Act and Code of Practice for a detailed description of the Act's requirements. A brief synopsis is shown in Figure 1 (page 15).

Force

The 2003 Act only authorises force where the person is in hospital. See below for guidance where the person is not in hospital. Force should only be used if:

- Administration is necessary and cannot be achieved in other ways;
- The person persistently resists treatment. It is best practice to wait and try again at a later point in time, unless the situation is urgent;
- The principles of the Act are applied. In particular, there must be careful consideration of alternatives, consultation with appropriate others and minimum restriction of the person's freedom. Any force should be the minimum necessary and only for as long as necessary.

Emergencies

In emergencies, treatment may be given if it is in a patient's 'best interests' and follows the requirements of the Act. Under Part 16 (section 243) of the Act, urgent medical treatment may be given when a patient does not consent, or is incapable of consenting, if the purposes of the treatment are to:

(a) save the patient's life;

(b) prevent serious deterioration in the patient's condition;

(c) alleviate serious suffering on the part of the patient; and

(d) prevent the patient from behaving violently; or

(e) being a danger to the patient or others.

Emergency treatment should only be given if it is unlikely to entail *'unfavourable, and irreversible, physical or psychological consequences'* (except to save life) or *'significant physical hazard to the patient'* (except to save life or prevent serious deterioration). This section of the Act does not authorise the use of ECT for patients who are capable of consenting, but who refuse this treatment.

Emergency treatment under the 2003 Act should be recorded on form T4. This will include treatment that is urgently necessary but is:

- Not covered by a consent or best interests statement under section 242; or
- Subject to special safeguards, but urgently necessary before DMP opinion can be arranged; or
- Not covered by an existing treatment plan for treatment given over a period of time.

There are some problem situations where the provision of emergency treatment is uncertain:

a) Including emergency treatment in a treatment plan to which the person consents on a form T2.
It is best practice to anticipate possible emergencies and to discuss with the person how these will be managed. In many cases the person will be able to agree with and consent to these measures. A particular problem is the use of medication by injection for emergency purposes. While the person may agree in advance with this treatment, it is important to record the person's consent when treatment is being given. At that time, if the person is not giving valid informed consent, the treatment should be regarded as emergency treatment under section 243 and recorded on form T4.

b) Emergency detentions.
The Act only authorises emergency treatment when a person's detention is authorised by an emergency detention certificate. It does not authorise treatment without consent during the time between the signing of the certificate and admission to hospital. In this situation, any treatment can only be given under the general principle of necessity. The prescribing practitioner should record the reasons for administering treatment.

c) Emergency treatment when treatment is authorised but the person is not in hospital.
The 2003 Act does not authorise the use of force in administering treatment where the person is not in hospital. In emergency situations, it may still be necessary to administer treatment by force. Again, practitioners should record the reasons for this.

In some instances, it may be possible to foresee a need for forcible treatment in the future. For example, a person with severe learning disability, in his own tenancy with support, may need sedation to allow personal care tasks. In an emergency this would be acceptable, under duty of care. Practitioners should, of course, still take good practice in the use of force into account. There is however no authorisation for this under the 2003 Act. It would not be appropriate to include this on a treatment plan where the person is not in hospital. Part 5 of the 2000 Act authorises treatment by force in emergency situations only. The Commission would be interested to hear of situations where this prevents a person receiving appropriate care outside a hospital setting.

Regaining capacity to consent or refuse

Practitioners may decide to embark on a course of treatment when a person lacks capacity to consent. However, the ability of the person to consent is not static but may fluctuate. As treatment takes effect, it may be that the person regains capacity to consent. Practitioners need to reassess the situation if this is the case. Points to consider are:

- Has the person recovered enduring capacity to consent? Sometimes, the person's condition improves temporarily, only to slip back. Practitioners must be satisfied that the person has regained the ability to consent for long enough to accept his/her decision on treatment;
- Sometimes, this may result in the person deciding to refuse treatment before its completion. Remember that, in order to be capable of refusing treatment, the person must be able to understand the likely consequences of that refusal. There may be a delicate balance between continuing an effective treatment, where the person dislikes the treatment or experiences adverse effects, and risking a relapse by stopping the treatment. Practitioners need to judge whether the person is capable of making that choice. Again, independent advocacy and an opinion from a colleague may be helpful;

Figure 2: Procedures to follow for person who regains capacity to consent

Treatment	Regains capacity and consents	Regains capacity and refuses
Neurosurgery and deep brain stimulation	If decision was made in the absence of capacity, a full reassessment is needed	Cannot proceed
Electroconvulsive therapy, vagal nerve stimulation and transcranial electromagnetic stimulation	Document consent on form T2 and proceed on that basis	Cannot proceed if person continues to have capacity and understands the consequences of refusal
Drug treatment for more than 2 months, medication to reduce sex drive and artificial nutrition	Document consent on form T2 and proceed on that basis	Will need new DMP opinion to include reasons for continuing to give treatment to capable person who refuses
Other treatments (Section 242)	Proceed on basis of signed consent	RMO records reasons for continuing treatment to capable person who refuses

- When a person regains capacity and agrees to continued treatment, it would not be appropriate to continue as if the person lacks capacity. It would be best practice to document consent and to proceed on that basis. This may necessitate a review of the care plan.

In addition, any person being treated under the 2000 Act who regains capacity to consent should be treated accordingly. Any certificate given under section 47 should be revoked. Certificates of independent opinion under section 48 will then no longer be valid. Any treatment may only proceed on the basis of informed consent.

Best practice points

- Follow the principles of legislation when providing treatment in the absence of consent;
- Review the person's ability to consent on a regular basis. It is not appropriate to continue to treat a person who regains capacity as if that person was incapable;
- Keep the care plan under review as the person's ability to consent changes;
- Consult the Acts and their Codes of Practice to ensure that legal requirements are obeyed. The forms also act as a guide;
- Use force as little as possible and only for as long as necessary;
- Carefully document any emergency treatment that is given on the principle of necessity but is outwith the authority of the Act(s).

Chapter 6

Advance statements

When a patient has lost capacity to consent or refuse treatment, there should be a check to see if that patient has made an advance statement. The 2003 Act gives legal standing to advance decisions about treatment made by capable individuals.

The Mental Health (Scotland) Act 2015 requires Health Boards to place an advance statement, or a document withdrawing an advance statement with the person's medical records. The Mental Welfare Commission must be notified by the Health Board of the making or withdrawing of an advance statement and will maintain a register of all advance statements.

The person who made the advance statement, or someone acting on their behalf (such as their Responsible Medical Officer, Named Person or Advocacy Worker) may 'inspect' the information on the register that is relevant to them.

What the Act says

Part 18, section 275 states that an 'advance statement' is a statement which specifies:

(a) the ways the person making it wants to be treated for mental disorder;

(b) the ways the person wishes not to be treated, in the event of the person becoming mentally disordered and the person's ability to make decisions about the matters referred to in paragraphs (a) and (b) above being, because of that, significantly impaired.

An 'advance statement is valid if:

(a) at the time of making it, the person has the capacity of properly intending the wishes specified in it;

(b) it is in writing;

(c) it is subscribed by the person making it;

(d) that person's description of it is witnessed by a person (the 'witness') who is within the class of persons prescribed by regulations… and who signs the statement as a witness to that subscription; and

(e) the witness certifies in writing on the document which comprises the statement that, in the witness's opinion, the person making the statement has the capacity referred to in paragraph (a) above.

Where an advance statement is not available, the patient's known wishes should still be taken into account.

Making advance statements

In making an advance statement the person is making a competent, informed choice about treatment which will apply in the future, when he/she has lost the capacity to make that decision.

Our Advance Statement Guidance provides information on the process of making an advance statement.

Opt-out decisions

Patients who intend to refuse certain treatments might be encouraged to consider what limitations they would put on this. For example:

A person wants to refuse ECT. He/she could consider whether to refuse ECT completely or to accept in certain circumstances, e.g. if other treatments had failed or if his/her life is at risk.

The 2003 Act gives legal standing to advance decisions about treatment made by capable individuals.

If a person wants to refuse medication, he/she should consider:

- Whether to refuse all medication, or accept some. If so, he/she should state which. It is also helpful to give reasons why a medication is refused and another preferred.
- For how long he/she would refuse medication. The person could consider stating that medication would be acceptable after a certain time if there was no improvement without it.

The person making an advance statement should also consider the consequences of their decisions and the management techniques which might be necessary if they refuse all treatment. In some circumstances this might include restraint or seclusion. Discussing consequences of decisions, and alternative treatments, will be especially important if a person is refusing treatment they have not experienced.

Opt-in decisions

People may decide to specify in advance, treatment that they would like to receive. Giving such treatment takes account of the person's previous wishes. However, if the person lacks capacity to consent at the time treatment is proposed, the advance statement cannot be regarded legally as "consent". Clinicians must still follow proper legal procedures. An advance statement cannot be used to demand any particular treatment.

Changing advance statements

The same requirements for competency, witnesses and so forth apply to changing or revoking an advance statement as to making one. Advance statements should be updated regularly, or the decision reaffirmed, so that they are seen as current.

Treatment that conflicts with an advance statement

If anyone gives or authorises treatment that is in conflict with an advance statement, then section 276 (8) of the Act requires him/her to give the reasons for this in writing.

This record should be kept in the person's case record and also given to:

- The person who made the statement;
- That person's named person;
- That person's welfare attorney;
- That person's guardian; and
- The Commission.

Any decision to override an advance statement needs to be justified by reference to the principles of the Act. A difficult decision would be where an incapable person, with an advance refusal of treatment, changes his/her mind and agrees to treatment. Those providing treatment will need to judge whether a present acceptance of treatment is more valid than an advance refusal. Given that he/she was capable when refusing and incapable when agreeing, it would not be appropriate to accept this as "consent". However, a decision to give treatment that conflicts with an advance statement might be in line with the principle of taking the person's present views into account.

Best practice points

- The person making the advance statement should indicate that he/she has considered the consequences;
- Practitioners should, when a person is well, suggest making an advance statement and give them every assistance in so doing;
- When giving treatment that conflicts with an advance statement, the practitioner should ensure that this is justified by referring to the principles of the Act and pay attention to the need to notify the Commission. The Commission will look carefully at all decisions to override advance statements.

Clear policies on when it might be appropriate to use covert medication should be in place.

Chapter 7

Special situations

Covert treatment

The practice of administering medication covertly is controversial. In mentally capable patients it is a breach of autonomy and likely to constitute assault. For people who lack capacity (either permanently or temporarily), the question is whether the best interest of the individual is justification enough for covert practices. Studies show that the practice does seem to be used commonly for people with dementia who routinely receive their medication in their food or drinks.[20 21] The main concern raised is that if the practice is condoned in a few exceptional cases, as in an emergency, this could lead to a rise in the abuse of the practice.[22] A balance has to be struck between the potential harm to a patient of not having the medication, versus the breach of patient autonomy and the potential side-effects of any medication.[23]

Clear policies on when it might be appropriate to use covert medication should be in place because, without them, 'awareness and frank discussion of 'underground' practices, surreptitious practices will continue in secrecy'.[24] Guidelines should be provided to medical professionals and carers of adults with incapacity about how to act if the use of covert medication is considered. The UK Central Council for Nursing Midwifery and Health Visiting (UKCC) has issued guidelines which say that 'disguising medication in food or drink can be justified in the best interests of patients who actively refuse medication but who lack the capacity to refuse treatment. As such 'covert medication 'may be considered to prevent a patient from missing out on essential treatment where the patient is incapable of consent'.[25]

The Commission has separate guidance on the use of covert medication.

Treatment of physical health problems in people with mental disorder

The 2003 Act does not usually apply to treatment for physical illness. Where a person is being treated under the 2003 Act, and lacks capacity in relation to treatment for physical illness, treatment can be given under the Adults with Incapacity Act (the 2000 Act). This requires a certificate of incapacity under section 47 and adherence to the principles of the Act. If there is a welfare attorney, welfare guardian, or holder of an intervention order relevant to the treatment, that person must be consulted if reasonable and practicable. Force can only be used in an emergency and only for as long as is necessary.

For example, a person with mental illness and who also suffers from diabetes refuses treatment for the latter. Without this treatment, his/her health would be at significant risk. Under a section 47 certificate of incapacity, treatment may proceed. If the person resists, the clinical team may need to use force in view of the immediate necessity. If the person continues to refuse in the longer term, an order under part 6 of the 2000 Act (intervention order or guardianship) may be necessary.

If a person who lacks capacity refuses treatment for physical illness and treatment that is necessary, although the situation may be less urgent, we recommend an application under part 6 of the 2000 Act. For example, a person with chronic mental illness has cataracts and is blind. Surgery would help but he refuses, due to a delusional belief about his loss of vision. The Sheriff could appoint a welfare guardian with the authority to consent to treatment and, if necessary, issue an order that the person complies with the welfare guardian's decision.

Sometimes, physical illness is a cause or consequence of mental disorder. If so, the 2003 Act can be used to administer treatment. For example, delirium can occur as a result of a chest infection. It is appropriate to treat the chest infection as the cause of the delirium under the 2003 Act.

The Code of Practice also states that people who have deliberately self-harmed can be treated under the Act. However, this would only be appropriate if:

- The person meets the criteria for compulsion; and
- Procedures needed to use the Act will not delay the provision of treatment that is urgently necessary for the person's physical health. Despite all the legislation, there is still a place for the doctrine of necessity if a person is in serious and imminent danger.

Consent is based on the elements of information decisional capacity and voluntarism.

Chapter 8

Consent and research

Consent is based on the elements of information, decisional capacity and voluntarism. It has been argued that voluntarism in clinical and research consent is the least understood area of informed consent. Voluntarism *'encompasses an individual's ability to act in accordance with one's authentic sense of what is good, right, and best in light of one's situation, values, and prior history'*. [26] The capacity to choose without coercion is also critical. It is suggested that voluntarism in consent can be analysed according to four areas of possible influences:

1) *developmental factors: where capacity for voluntarism is affected by a person's development in terms of cognitive abilities, emotional maturity and moral character;*
2) *illness-related considerations: special mental symptoms and their nature, severity and temporal pattern may significantly affect an individual's capacity for voluntarism;*
3) *psychological issues and cultural and religious values: for example, psychological issues and values may influence impressions of what is good and what choices are acceptable when facing decisions; and*
4) *external features and pressures: which may include resource limitations or legislation, which determine the fundamental nature of the consent decision by defining what choices actually exist and affect an individual's motivation for accepting a particular intervention because of a lack of alternatives.* [26]

In relation to research (including clinical trials of drugs or treatments/causes of or possible treatment for a particular condition), what should be taken into consideration is:

- That the research is not contrary to a patient's interests;
- That a patient understands that it is research;
- That a patient is given adequate information on which to make a decision;
- That information should be presented in a way that is accessible and understandable to a patient.

Information should include:

- The risks/benefits involved;
- That it has been approved by an ethics committee;
- That a patient can withdraw their consent at any time.

In relation to the request for participation:

- Time should be given to allow a person to properly consider his/her potential participation;
- No pressure should be placed on a person to participate;
- The person should have enough support to make an informed choice;
- If consent is given this should be taken in writing.

It is likely that people with dementia or learning disabilities who do not have capacity to consent to research will come under the Adults with Incapacity (Scotland) Act 2000. This Act has a list of requirements that must be satisfied before research can proceed. The position of people who are detained/ compulsorily treated under the Mental Health (Care and Treatment) (Scotland) Act 2003 is not clear. For clinical research (involving treatment) the 2000 Act may have to be used. For non-intervention research (e.g. interviews to get patients' views on a topic) this may not be necessary.

There are a number of sources of advice from organisations about carrying out research on individuals without capacity, these can and should be sought.[27 28]

Acknowledgements

We would like to thank Dr Jacqueline Atkinson and Dr Jacquie Reilly of the Public Health Department of the University of Glasgow for their research which formed the basis of this guidance.

Related Mental Welfare Commission good practice guidance is available at http://reports.mwcscot.org.uk:

Covert Medication 2017

Nutrition by Artificial Means 2015

The Adults with Incapacity Act in general hospitals and care homes 2017

The Mental Health Act in general hospitals 2016

Advance Statement Guidance 2016

Appendix 1

Treatment plans

This section provides some guidance on best practice in writing a treatment plan in relation to part 16 of the Act. We recommend separate plans for electroconvulsive therapy (ECT) and for artificial nutrition. Medication for mental disorder beyond two months and medication to reduce sex drive can be authorised on one form (either T2 if consenting to both or T3 if not consenting to both).

ECT

Treatment with ECT should be regarded as a course. However, where the person consents, this consent must be reviewed prior to each treatment. It would be best practice for the person being treated to confirm, either in writing or verbally, with a witness, that he/she is willing to continue with treatment.

When documenting a course of ECT on a treatment plan, we recommend that the plan includes:

- Whether treatment will be administered as unilateral or bilateral (or that either method is acceptable)
- The maximum number of treatments per week that the person can receive (usually two)
- The maximum number of treatments authorised by the certificate (usually no more than 12)
- The duration of the authority of the certificate
- The plan may include a statement on the maximum allowed intervals between treatments. This is not essential. However, we advise that a new certificate is required if the last treatment was more than 14 days ago.

Artificial nutrition

This is most likely to be used for people with eating disorders. It could be indicated for people with other forms of mental illness where the person is unwilling or unable to eat because of mental disorder. If the person needs artificial nutrition because of physical illness, it would be more appropriate to use the 2000 Act. The plan should specify the form of artificial nutrition, e.g. nasogastric or PEG tube. It should also specify duration of the authority to treat. Usually, this should be no more than three months. We do not think that giving fluids intravenously constitutes artificial nutrition. The Mental Welfare Commission has issued separate guidance on Artificial Nutrition.

Medication

Under the 2003 Act, only medication for mental disorder needs to be recorded on a treatment plan. Treatment for side effects of drugs for mental disorder does not constitute treatment for mental disorder. This might include treatment for drug-induced Parkinsonism or constipation. Also, it is not necessary to include drug treatment for epilepsy. Anti-convulsant drugs are often used to treat mental disorder and should be recorded on the plan if used for that or if used for both purposes.

Best practice in recording medication on treatment plans includes:

- Record the class or classes of drug treatment by referring to the section number in the British National Formulary (BNF). Responsible Medical Officers (RMOs) and Designated Medical Practitioners (DMPs) are best advised to have an up-to-date BNF available when completing a treatment plan. If naming a particular drug, use the British approved name.
- State the route of administration (e.g. oral or intramuscular injection).
- State the maximum permitted dosage; usually, referring to BNF maximum doses and frequency of administration does this best. It may be necessary to specify lower doses for some people. See below for high doses.
- Specify any drug treatment for “as required” use separately on the plan. Be especially careful about the dosage and frequency to ensure that treatment will not exceed BNF limits. Oral medication and medication by injection should be specified separately.
- For certain treatments, the plan may state that the administration of the drug should achieve a certain serum level.
- If medication authorised by the plan exceeds the recommended BNF maximum, the plan should state a requirement for special monitoring in accordance with guidance from the Royal College of Psychiatrists.
- Clozapine is a special case and should be documented by name. The plan should state that it also covers associated blood tests. (NB this is only the case for clozapine because of its product licence. Other drugs, e.g. lithium, also need blood tests but a treatment plan cannot authorise these. In both cases, practitioners will need to consider whether blood monitoring will be possible. In theory, it could be enforced to monitor clozapine although the distress this would cause the person might outweigh the possible benefits of treatment.)

Where the patient gives capable consent to treatment, it is best practice to specify the actual medication(s) on form T2, rather than give broad classes. It would also be good practice to record the purpose of the medication on the form. The form can be saved electronically and, with the patient’s agreement, altered at a later date if necessary.

If the patient does not consent, it is reasonable for the treatment plan to be broader by including classes of medication. The Mental Welfare Commission will provide a proforma for outlining a proposed treatment plan. A DMP will visit and will authorise an agreed treatment plan on form T3. The RMO and DMP will need to agree a plan that is broad enough to ensure that appropriate changes to treatment are possible without a further DMP visit. The plan must, however, be relevant to the individual. The plans should also only include treatment that is currently necessary, or likely to be needed, should present treatment be ineffective.

Appendix 2

Capacity tools and their use

Appelbaum, P.S., Grisso, T., Frank, E., O'Donnell, S., & Kupfer, D.J. (1999) Competence of depressed patients for consent to research, *American Journal of Psychiatry*, 156:1380-1384.

Appelbaum, P.S., & Grisso, T. (2001) *The MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR)*, Professional Resource Press: Sarasota, FL.

Bean, G., Nishisato, S., Rector, N., & Glancy, G. (1994) The Psychometric Properties of the Competency Interview Schedule, *Canadian Journal of Psychiatry*, 39(8):368-376.

Bellhouse, J., Holland, A.J., Clare, I.C.H., Gunn, M., & Watson, P. (2003) Capacity-based mental health legislation and its impact on clinical practice: 1) admission to hospital, *Journal of Mental Health Law*, July: 9-24.

Bellhouse, J., Holland, A.J., Clare, I.C.H., & Gunn, M., & Watson, P. (2003) Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital, *Journal of Mental Health Law*, July: 24-37.

Carney, M., Neugroschl, R., Morrison, R. et al (2001) The development and piloting of a capacity-assessment tool, *Journal of Clinical Ethics*, 12:17-22.

Dymeck, M., Marson, D., & Harrell L. (1999) Factor structure of capacity to consent to medical treatment in patients with Alzheimer's disease: an explanatory study. *Journal of Forensic Neuropsychology*, 1:27-48.

Eastman, N., Dhar, R. (2000) The role and assessment of mental incapacity: A review, *Current Opinion in Psychiatry*, 13:557-561

Elyn, R., Saks, J.D., Dunn, L.B., Marshall, B.J., Nyak, G.V., Golshan, S., Jeste, D. (2002) The California Scale of Appreciation: a new instrument to measure the appreciation component of capacity to consent to research, *American Journal of Geriatric Research*, 10:166-174.

Etchells, E., Darzins, P., Silberfeld, M. et al (1999) Assessment of patient capacity to consent to treatment, *Journal of General Internal Medicine*, 14:27-34.

Gilman, R.B., & Billick, S.B. Assessing capacity instruments in inpatient legal proceedings. (2003), *American Journal of Forensic Psychiatry*, 24:45-52.

Glass, K. C. (1997) Refining definitions and devising instruments: Two decades of assessing mental competence, *International Journal of Law and Psychiatry*, 20(1):5-33.

Grisso, T., Appelbaum, P.S., Mulvey, E., & Fletcher, K. (1995) The MacArthur Treatment Competence Study: II. Measures of abilities related to competence to consent to treatment, *Law and Human Behavior*, 19:127-148.

Grisso, T., & Appelbaum, P.S. (1998) MacArthur Competence Assessment Tool for Treatment (MacCAT-T), Professional Resource Press: Sarasota, FL.

Studies Using the MacCAT-T.

Janofsky, J.S., McCarthy, R.J., & Folstein, M.F. (1992) The Hopkins Competency Assessment Test: A brief method for evaluating patients' capacity to give informed consent, Hospital and Community Psychiatry, 43(2):132-135.

Kitamura, F., Tomoda, A., Tsukada, A. et al (1998) Method for assessment of competency to consent in the mentally ill: rationale, development and comparison to the medically ill, *Journal of Law and Psychiatry*, 21(3):223-244.

Lapid, M.I., Rummans, T.A., Poole, K.L., Pankratz, S., Maurer, M.S., Rasmussen, K.G., Philbrick, K.L., & Appelbaum, P.S. (2003) Decisional capacity of severely depressed patients requiring electroconvulsive therapy, *The Journal of ECT*, 19:67-72.

Lapid, M., Rummans, T., Pankratz, S., & Appelbaum, P.S. (2004) Decisional capacity of depressed elderly to consent to electroconvulsive therapy, *Journal of Geriatric Psychiatry and Neurology*, 17:42-46.

Marson, D.C., Ingram, K.K., Cody, H.A. et al (1995) Assessing the competency of patients with Alzheimer's disease under different legal standards: a prototype instrument, *Archives of Neurology*, 52:949-954.

Molloy, D.W., Silberfeld, M., Darzins, P. (1996) et al: Measuring capacity to complete an advance directive, *Journal of the American Geriatric Society*, 44:660-664.

Palmer, B.W., Nayak, G.V., Dunn, L.B., Appelbaum, P.S., & Jeste, D.V. (2002) Treatment-related decision-making capacity in middle-aged and older patients with psychosis: a preliminary study using the MacCAT-T and HCAT, *American Journal of Geriatric Psychiatry*, 10:207-211.

Palmer, B.W., Dunn, L.B., Appelbaum, P.S., & Jeste, D.V. (2004) Correlates of Treatment-Related Decision-Making Capacity Among Middle-Aged and Older Patients with Schizophrenia, *Archives of General Psychiatry*, 61:230-236.

Rikkert, M.G., van den Bercken, J.H., Ten Have, H.A. et al (1997) Experienced consent in geriatrics research: a new method to optimise the capacity to consent in frail elderly subjects, *Journal of Medical Ethics*, 23:271-276.

Roth, L.H., Meisel, A.,& Lidz, C.W. (1977) Tests of Competency to Consent to Treatment. American Journal of Psychiatry, 134(3):279-234.

Saks, E.R., & Behnke, S.H. (1999) Competency to decide on treatment and research: MacArthur and beyond, *Journal of Contemporary Legal Issues*, 10:103-129.

Tan, J., Elphick, M. (2002) Competency and use of the Mental Health Act – A matrix to aid decision-making, *Psychiatric Bulletin*, 26:104-106.

Tan, J., Hope, T., & Stewart, A. (2003) Competence to refuse treatment in anorexia nervosa. (2003), *International Journal of Law and Psychiatry*, 26:697-707.

Vollman, J., Bauer, A., Danker-Hopfe, H., & Helmchen, H. (2003) Competence of mentally ill patients: a comparative empirical study, *Psychological Medicine*, 33:1463-1471.

Wirshing, D.A., Wirshing, W.C., Marder, S.R. et al (1998) Informed consent: assessment of comprehension, *American Journal of Psychiatry*, 155:1508-1511.

References

[1] Scottish Executive (2003) *Mental Health (Care and Treatment) (Scotland) Act 2003* and *Code of Practice*, Volume 1, Chapter 10.

[2] Scottish Executive (2015) *Mental Health (Scotland) Act 2015*

[3] Scottish Executive (2000) *The Adults with Incapacity (Scotland) Act 2000* and *Code of Practice for Practitioners Authorised to Carry Out Medical Treatment or Research under Part 5 of the Act*.

[4] Kitamura, T. (2000) Assessment of psychiatric patients' competency to give informed consent: Legal safeguard of civil right to autonomous decision-making, *Psychiatry and Clinical Neurosciences,* 4:515-522.

[5] Peay, J. (2003) *Decisions and Dilemmas: Working with Mental Health Law,* Hart: Oxford.

[6] Lapid, M.I., Rummans, T.A., Pankratz, V.S., & Applebaum, P.S. (2004) Decisional capacity of depressed elderly patients to consent to electroconvulsive therapy, *Journal of Geriatric Psychiatry and Neurology,* 17(1):42-46.

[7] Atkinson, J.M., Garner, H.C., Patrick, H., & Stuart, S. (2003a) Issues in the development of advance directives in medical health care, *Journal of Mental Health,* 12:575-584.

[8] Law Commission (1995) *Mental Capacity, Consultation paper No 231,* The Stationery Office: London.

[9] Van Staden, C.W., & Kruger, C. (2003) Incapacity to give consent owing to mental disorder, *Journal of Medical Ethics,* 29:41-43.

[10] Scottish Executive (2001) *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984* (Millan Committee), Scottish Executive: Edinburgh.

[11] Roe, D., Lereya, J., & Fennig, S. (2001) Comparing patients' and staff members' attitudes: Does patients' competence to disagree mean they are not competent?, *Journal of Nervous and Mental Disease,* 189(5):307-310.

[12] Grisso, T., & Appelbaum, P.S. (1998) *MacArthur Competence Assessment Tool for Treatment* (MacCAT-T), Professional Resource Press: Sarasota, FL.

[13] Szmukler, G., & Applebaum, P. (2001) *Treatment pressures, coercion and compulsion* in Thornicroft, G., & Szmukler, G. (eds.) Textbook of Community Psychiatry, Oxford University Press: Oxford.

[14] Hoyer, G., Kjellin, L., Engberg, M., et al (2002) Paternalism and autonomy: a presentation of a Nordic study on the use of coercion in the mental health care system, *International Journal of Law and Psychiatry,* 25:93-108.

[15] La Fond, J.Q., & Srebnik, D. (2002) The impact of mental health advance directives on patient perceptions of coercion in civil commitment and treatment decisions, *International Journal of Law and Psychiatry and Neurology,* 17(1):42-46.

16 Elbogen, E. B., Swanson, J.W., Swartz, M. (2003) Effects of legal mechanisms on perceived coercion and treatment adherence among persons with severe mental illness, *The Journal of Nervous and Mental Disease,* 191:629-637.

17 Kjellin, L., Andersson, K., Bartholdson, E., Candefjord, I.L., Holmstrom, H., Jacobbson, L., Sandlund, M., Wallsten, T., & Ostman, M. (2004) Coercion in psychiatric care – patients' and relatives' experiences from four Swedish psychiatric services, *Nordic Journal of Psychiatry,* 58:153-159.

18 Rose, D.S., Wykes, T.H., Bindman, J.P., & Fleishmann, P.S. (2005) Information, consent and perceived coercion: patients' perspectives on electroconvulsive therapy, *British Journal of Psychiatry,* 186:54-59.

19 Munro, W. (2004) *Coercion, persuasion and communication: Exploring aspects of Mental Health Officer practice in the process of hospital admission,* Thesis for Master of Community Care Degree, University of Glasgow.

20 Munro, W. (2004) *Coercion, persuasion and communication: Exploring aspects of Mental Health Officer practice in the process of hospital admission,* Thesis for Master of Community Care Degree, University of Glasgow.

21 Treloar, A., Beats, B., Philpot, M. (2000) A pill in the sandwich: covert medication in food and drink, Journal of Social Medicine, 93:408-11.

22 Kirkevold, O., Engedal, K. (2005) Concealment of drugs in food and beverages in nursing homes: cross sectional study, *British Journal of Psychiatry,* 330:20-24.

23 Scott, J., Williams, E.R.L. (1997) Concealed administration of drug treatment may represent thin end of the wedge, *British Journal of Psychiatry,* 314:299-300.

24 Lamnari, A (2001) Point-counterpoint: is it ethical to give drugs to people with dementia? Yes: It is ethical if it is in their best interests, *Western Journal of Medicine,* 174:228.

25 Ramsay, S (2001) UK nurses receive guidance on covert medication of patients, *Lancet,* 358:900.

26 Weiss-Roberts, L. (2002) Informed consent and the capacity for voluntarism, *American Journal of Psychiatry,* 159:705-712.

27 General Medical Council (2008) Consent guidance: patients and doctors making decisions together, General Medical Council: London (http://www.gmc-uk.org/guidance/index.asp).

28 Department of Health (2001) Reference guide to Consent for Examination or Treatment, Department of Health: London (http://www.dh.gov.uk/assetRoot/04/01/90/79/04019079.pdf

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk

Mental Welfare Commission (01/17)