

# Understanding 'significant impaired decision-making ability' with regard to treatment for mental disorder: an empirical analysis

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**Aims and Method** To capture psychiatrists' reasons for 'significant impaired decision-making ability' (SIDMA) as there is no definition of SIDMA in the Mental Health (Care and Treatment) (Scotland) Act 2003. One hundred consecutive mental health reports from January to February 2008 were examined using a questionnaire.

**Results** More than half the mental health reports noted lack of insight as the main cause of SIDMA. Other reasons for SIDMA included limited cognitive function and presence of psychotic symptoms.

**Clinical implications** Five reasons for SIDMA were identified: lack of insight, cognitive impairment, presence of psychosis, severe depressive symptoms and learning disability. We recommend psychiatrists working in Scotland give full descriptions of SIDMA, indicating how this has an impact on the patient's ability to make decisions.

**Declaration of interest** None.

The Mental Health (Care and Treatment) (Scotland) Act 2003 was introduced into clinical practice in October 2005. One fundamental change brought in by the Act was the introduction of 'significantly impaired decision-making ability' (SIDMA) as a criterion for compulsory treatment. This is a new concept in mental healthcare, and has been described as a manifestation of a disorder of the mind occurring when an individual's understanding or reasoning regarding the medical treatment for their mental disorder is distorted or impaired, as a consequence of that mental disorder (see online supplement).<sup>1</sup> It is a separate but related concept to capacity<sup>2</sup> and the threshold for SIDMA is believed to be lower than that for capacity or competence.

Significantly impaired decision-making ability is necessary but not sufficient for an individual to be treated under civil compulsory powers in Scotland. The Act requires the medical practitioner to state the reasons for believing the criterion of SIDMA is satisfied, in the mental health report.<sup>3</sup> This criterion is further described<sup>1</sup> as not simple disagreement with professional medical opinion, but rather characterised by elements of impaired comprehension or retention of information. Also possibly important may be a diminished ability to weigh information; to arrive at an informed choice; along with difficulty communicating a particular choice. Furthermore, SIDMA, like capacity, is commonly thought to fluctuate with mental state phenomena. Mania, psychosis, poor insight, delusions and ethnic minority status have previously been associated with treatment decisional incapacity,<sup>4</sup> but it is not known if these factors are also associated with SIDMA.

We set out to assess medical practitioners' assessment of how the SIDMA criterion was met in the long-term treatment order, a compulsory treatment order – as the medical practitioner must be satisfied that SIDMA is present in any such application. We wanted to determine if the practitioner had documented the reasons for the individual having SIDMA, and systematically analyse these reasons, as well as documenting evidence of best (and worst) practice.

## Method

One hundred consecutive mental health reports received by the Mental Welfare Commission for Scotland were identified. The compulsory treatment orders chosen ran between January and February 2008. Mental health reports are completed by specialist psychiatrists approved under Section 22 of the Act as having 'special experience' in the diagnosis and management of mental disorder. However, the code of practice to the Act recommends that the second mental health report accompanying any compulsory treatment order application is completed by the individual's general practitioner (GP), with a view to better capturing the family and social background to a case.

A standardised proforma questionnaire was developed by the authors after review of the extant literature and pooling of their clinical experience, in order to systematically examine the relevant demographic and clinical details in the mental health report. The age, location, gender and diagnosis of the patient were noted. Also, it was specifically noted whether lack of insight; cognitive

impairment or disability; and active psychotic symptoms were listed as clinical reasons underpinning the SIDMA criterion along with a judgement by the authors as to whether this represented a valid justification for the criterion. Finally, specific examples of good and less than good free text descriptions of SIDMA by the completing psychiatrist were recorded, with a consensus on quality being independently achieved by two of the authors (E.S. and D.L.). The proforma questionnaire was initially piloted on ten reports to test its utility, prior to the full study.

**Results**

The 100 mental health reports for compulsory treatment order applications were identified and collected, and were made by consultant psychiatrists, specialist registrars and staff grade psychiatrists across Scotland. A total of 14% of mental health reports were from GPs, i.e. there were 14 reports from GPs and 86 from psychiatrists.

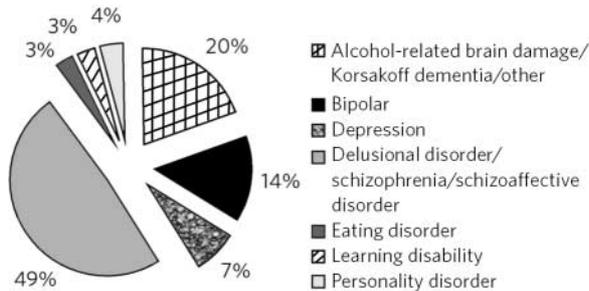
The 100 reports were on 59 males and 41 females. The mean ages of individuals were as follows: 48 years (range 13–94), with male mean age 49 years (range 21–94) and female mean age 46 years (range 13–91). The geographic

distribution of compulsory treatment order applications largely replicated the population distribution in Scotland, with 27 from Greater Glasgow; 16 from Lothian; and 15 from Fife; although only 6 came from Grampian (Aberdeen area).

A wide range of diagnostic categories were described in the 100 reports, as illustrated in Fig. 1. The main reasons given for the individual exhibiting SIDMA are classified in Tables 1 and 2. Only one report had illegible handwriting from the medical practitioner, thus could not be included in the interpretation of results.

It can be seen that a lack of insight into the mental disorder (and the treatment needs arising, therefore) is the single most common reason given in the reports for SIDMA. Examples of commonly occurring 'other' reasons noted in 20 cases in Table 1 include thinking being distorted by severe depression and learning disability leading to difficulty processing and retaining information.

Table 1 also reveals that the authors thought the majority of reasons given in free text of the reports for SIDMA were valid, although a substantial minority of free text reasons were not viewed sufficient justification for SIDMA. A trend towards increasingly doubtful or poor justification, and increasing number of reasons provided for SIDMA was evident in Table 2.



**Fig 1** Diagnoses.

**Discussion**

This study is the first systematic examination of the reasons behind impaired decision-making with regard to treatment needs for mental disorder for people detained under the Act in Scotland.

The sample consisted mostly of young to middle-aged individuals with a psychotic illness and older people with dementia. In those with dementia, limited cognitive function was the main reason documented for SIDMA. The youngest people in this study were two females aged 13

**Table 1** Main reason for significant impaired decision-making ability (SIDMA) (i.e. one reason only) in mental health reports

Valid justification?	n (%)			
	Lack of insight (n = 44)	Limited cognitive function (n = 9)	Psychotic symptoms (n = 10)	Other (n = 20)
Yes	29 (66)	8 (89)	3 (30)	5 (25)
Doubtful	11 (25)	1 (11)	6 (60)	7 (35)
No	4 (9)	0 (0)	1 (10)	8 (40)

**Table 2** More than one reason for significant impaired decision-making ability (SIDMA) (i.e. two to three reasons) per mental health report (n = 16)

Valid justification?	n (%)			
	Lack of insight (n = 13)	Limited cognitive function (n = 4)	Psychotic symptoms (n = 14)	Other (n = 6)
Yes	5 (38.5)	2 (50)	5 (35.7)	2 (33.3)
Doubtful	7 (53.8)	2 (50)	8 (57.1)	4 (66.7)
No	1 (7.7)	0 (0)	1 (7.1)	0 (0)

years of age with a diagnosis of anorexia nervosa, where one report had lack of insight as the main reason for SIDMA and the other report was illegible. The sample captured in this study represented a fairly good geographic and diagnostic spread of the patient population across Scotland (Fig. 1).

We found that the most common reasons for SIDMA were lack of insight (44%), limited cognitive function (9%) and/or presence of psychotic symptoms (10%) (Table 1). Lack of insight was commonly correlated with psychotic symptoms. Other reasons for SIDMA included presence of severe depressive symptoms or learning disability (20%). Limited cognitive function was the main reason for SIDMA in people with dementia. There was no clear evidence of cognitive impairment being the main reason for SIDMA in individuals with learning disability.

We also retrieved mental health reports made by GPs (14%). From these reports it was clear that most of them did not give good justification for their reasons for SIDMA, poor examples are given overleaf. Therefore it is evident that there is still a continuing need and role for psychiatrists to educate GPs with regard to good documentation and reasoning when completing the second mental health report, in particular the reasons for SIDMA.

Here, we give free text examples of what we considered to be good and less-than-good explanations for the common reasons pertaining to SIDMA.

### Lack of insight

None of the research scales estimating level of insight in mental disorder were used in any of the reports. Clinicians gave descriptive justifications linking lack of insight to SIDMA, for example:

'...does not consider himself to have a mental illness. He is insightful into his present difficulties and need for treatment. As he considers himself mentally well, he does not appreciate his need to remain in hospital and continue medication.'

Here an explanation of how the illness impairs insight is offered, whereas another report simply states the 'Patient is lacking in insight'. This brief statement does not explain how and why the person having a lack of insight impairs their decision-making ability about medical treatment. It is highly likely that the mental health tribunal, when testing this latter compulsory treatment order application, would require additional oral evidence from the medical practitioner explaining the detail of the case. Also, research has indicated<sup>5</sup> that subtle impairments of neuropsychological function are often linked to impaired awareness of illness (poor insight), and it is perhaps no surprise intellectual dysfunction was frequently identified by this study as a contributing factor to SIDMA.

### Impaired cognition

If the reason for SIDMA is that the individual has limited cognitive function, the mental health report should ideally detail how this impaired cognitive function affects their decision-making ability. Consider this example where the medical practitioner has mentioned cognitive impairment as a reason for SIDMA:

'has a significant degree of cognitive impairment and presents as disorientated. He lacks an understanding of his condition or

his need for hospital treatment, is unable to retain information to allow for informed choice, and hence his ability to make decisions about his care is significantly impaired'.

Here, the medical practitioner has given a good reason, explaining how the individual's cognitive impairment has an impact on his ability to make decisions about medical treatment, thus having SIDMA.

Another well-documented example justifying cognitive impairment is as follows:

'presents a fluctuating mental state... His level therefore of fluctuating confusion makes it likely that his decision making processes are impaired. He has difficulty retaining information for a sufficient time that would allow him to make informed decisions regarding his care'.

A less well-documented reason for SIDMA was: 'has severe impairment in his decision making abilities regarding medical treatment and care needs'. Here, the medical practitioner has not explained how any impairment affects the person's decision-making abilities. They had merely stated the criterion without explaining why it is satisfied.

### Presence of psychosis

If the main reason for SIDMA is presence of psychosis, how do these psychotic symptoms affect the individual's decision-making ability? Consider this example where the medical practitioner has stated the presence of delusions for justifying SIDMA: 'He adamantly rejects the notion that he is unwell... He is deluded regarding treatment, believing that I am trying to kill him rather than treat his psychosis'. In this statement, the medical practitioner has stated that the patient's delusions impair his decision-making ability about treatment as he firmly believes the psychiatrist is trying to kill him. Hence the patient has poor judgement about treatment because his delusions mean that he cannot interact appropriately with the psychiatrist.

Another well-documented statement justifying the presence of psychosis for SIDMA was:

'at present displays a significant disordered thought process with delusional beliefs... When trying to talk to her she appears unable to focus on a subject being quite incoherent in her thinking and flighty in her thoughts'.

Less well-documented reports included: 'I have observed [X's] behaviour over some months and her thoughts are impaired'. In this report there is lack of clarity about how the individual's impaired thinking has an impact on SIDMA.

### Other reasons for SIDMA (severe depressive symptoms and learning disability)

In the following example, the psychiatrist has described the patient's symptoms and how this has an impact on her decision-making ability with regard to medical treatment.

'...She demonstrated numerous cognitive distortions which are typically found in severe depressive illness. She views the future as hopeless and views all interventions as being futile. As such, she is unable to appraise information provided to her with respect to the provision of medical treatment'.

The psychiatrist in the following report has stated that it's the individual's learning disability that limits her ability to understand the assessment and treatments and nothing

more. There are no details of which particular aspects of the person's learning disability affects SIDMA:

'ability to understand the purpose of her assessment and treatment and make decisions about what is proposed for her assessment and treatment is limited by her learning disability'.

### Implications and recommendations

It is necessary for the medical practitioner to justify clearly how the SIDMA criterion is met, rather than simply reiterating that SIDMA exists. Points to consider are:

- what are the actual reasons for SIDMA?
- how does the individual's mental disorder (defined in the Act as mental illness, personality disorder and learning disability, however caused or manifest) affect their ability to make decisions about medical treatment?
- in what way does the mental disorder affect the individual's ability to believe, understand and retain information, and to make and communicate decisions about treatment?

Questions for the medical practitioner to consider when justifying SIDMA are:

- does the individual have lack of insight, and if so, how does it affect their decision-making ability?
- is the individual confused or is there evidence of cognitive impairment that affects the individual's decisions on medical treatment?
- is the individual able to understand, retain, make and communicate decisions about treatment, and if not, why not?
- does the presence of psychotic or severe depressive symptoms affect the individual in such a way that they cannot make decisions about treatment?
- if the individual has a learning disability, how does this affect their ability in making decisions about treatment? What aspect of the learning disability gives the individual SIDMA?

If the medical practitioner can give a good reason or answer to any of the above questions, that may be a valid justification for answering the SIDMA criterion.

### Future directions and study limitations

This is the first study to attempt to empirically describe a new concept in mental health law – that of significantly impaired decision-making ability. We have demonstrated, by analysing 100 consecutive medical reports to the mental health tribunal, that the most common clinical reasons for SIDMA are a lack of insight; learning disability or cognitive impairment; and the presence of psychotic symptoms. We have also argued that a detailed clinical explanation drawing a nexus between the symptoms and the SIDMA is helpful to all parties and arguably precludes extensive cross-examination at the mental health tribunal.

As a guide, we also recommend that doctors completing the mental health reports consider the five questions given above when justifying their reasons and explanations for SIDMA, and it would be useful to repeat this study in a year's time to see if there has been an improvement in the quality of reporting.

Mental Health Act (Section 22) training in Scotland involves two parts, the first part is a self-assessment, online multiple choice question exam on the National Health Service (NHS) website. The pass mark is 100% but unlimited attempts are allowed. Once this is achieved, the College then contacts the medical practitioner to participate in the second part, a training day where all practitioners receive a training manual on the Mental Health Act. A survey would be useful to see how frequently all approved medical practitioners refer to this training manual in particular when defining SIDMA. The results from this survey could better inform and shape future Mental Health Act training sessions.

Although our findings will be of particular interest in Scotland, all psychiatrists should take note of how the SIDMA criterion is being applied. The use of SIDMA as a criterion for compulsory treatment is controversial, and has been rejected by other jurisdictions, for example in England and Wales, as it is argued that there is no link between the clinical severity of a mental disorder and the individual's decision-making ability.<sup>6</sup> In our view, when documented well, it provides good evidence to justify taking away a person's right to make their own decisions about care and treatment.

Our study limitations include the small sample size, a lack of reference points for the new concept of SIDMA, and the subjective elements to our analysis of quality rather than using a pre-agreed 'quality checklist'. However, two of the authors independently corroborated each others quality judgements, and only where consensus was reached a quality judgement was assigned.

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### References

- 1 Scottish Executive. *Approved Medical Practitioners – Mental Health (Care & Treatment)(Scotland) Act 2003 Training Manual. Appendix 2 – Significantly Impaired Decision-Making Ability*. Scottish Executive, 2005.
- 2 Office of Public Section Information. *The Adults With Incapacity (Scotland) Act 2000*. OPSI, 2000 ([http://www.opsi.gov.uk/legislation/SCOTLAND/acts2000/asp\\_20000004\\_en\\_1](http://www.opsi.gov.uk/legislation/SCOTLAND/acts2000/asp_20000004_en_1)).
- 3 Office of Public Section Information. *Mental Health (Care and Treatment) (Scotland) Act 2003. Part 7 Compulsory Treatment Orders Chapter 1 section 57 (4) (b)*. OPSI, 2003 ([http://www.opsi.gov.uk/legislation/scotland/acts2003/asp\\_20030013\\_en\\_7#pt7](http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_7#pt7)).
- 4 Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G, et al. Prevalence and predictors of mental incapacity in psychiatric in-patients. *Bri J Psychiatry* 2005; **187**: 379–85.
- 5 Aleman A, Agrawal N, Morgan KD, David AS. Insight in psychosis and neuropsychological function. Meta-analysis. *Br J Psychiatry* 2006; **189**: 204–12.
- 6 Department of Health. *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill 2004*: 16. Department of Health, 2005.

