



# Significantly impaired decision making ability – How well is it recorded in practice?

## Background

In order to detain someone for treatment of a mental disorder under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') certain criteria need to be fulfilled. One criteria is that the individual has significantly impaired decision-making ability (abbreviated as SIDMA) due to the mental disorder. This concept is unique to Scottish mental health law.

SIDMA plays a role in using coercive power in the context of mental illness (or mental disorder, as stated in the Mental Health Act) including (but not limited to):

- the criteria for emergency detention in hospital (s36, up to 72 hours detention);
- the criteria for short term detention in hospital (s44, up to 28 days detention); and
- provisions regarding applications for compulsory treatment orders (CTOs) (s57 and s64).

For both emergency and short-term detentions, the doctor who assesses the person needs to believe that it is likely that they have SIDMA. For a CTO the person must be shown to have SIDMA.

Since the Mental Health Act was adopted, guidance for applying standards for SIDMA has been published. This includes the Training Manual for Approved Medical Practitioners (AMPs) (1) and the Code of Practice for the Mental Health Act (2).

The *Training Manual* associated with the new legislation explained the concept of SIDMA as follows:

*SIDMA occurs when a mental disorder affects the person's ability to believe, understand and retain information, and to make and communicate decisions. It is consequently a manifestation of a disorder of mind. SIDMA arises out of mental disorder alone; 'incapacity' can also arise from disease of the brain or impaired cognition, and can include physical disability. SIDMA is not the same as limited or poor communication, or disagreements with professional opinion. (Scottish Executive, 2005a, p.45; see also Scottish Executive 2005b, para. 1.22)*

A study that was done five years after the 2003 Act came into force (3) analysed recording of SIDMA on CTO applications. The authors found that impaired insight was the single most commonly reason given that the individual had SIDMA. This was the case in 58% of CTO applications. In 44% of cases, impaired insight was the only reason cited as evidence of SIDMA.

Other reasons for SIDMA included limited cognitive function (13%) and the presence of psychotic symptoms (24%) (3).

The authors of the 2010 study made a number of recommendations relating to SIDMA. They recommended that CTO applications should:

- indicate "the actual reasons for SIDMA";
- include an explanation of "how the individual's mental disorder ... affect[s] their ability to make decisions about treatment";
- not simply record the condition or disorder;
- include an explanation of how lack of insight affects the person's decision-making ability; and



- make it clear in what way does the mental illness affect the individual's ability to believe, understand and retain information, and to make and communicate decisions about treatment?" (p.242).

Ten years on from the study, which indicated that the guidance published relating to SIDMA may not have led to good practice in recording it, we wanted to:

- a) explore the grounds on which persons are currently deemed to have SIDMA;
- b) compare recording practices regarding SIDMA in 2019 with the practices reported in 2010; and
- c) critically evaluate the quality of current SIDMA-reporting by assessing how current practice conforms to guidance.

## What we did

We followed a similar approach to the study by Shek et al. (2010) and looked at 100 CTO forms to see how SIDMA was recorded. We randomly alternated forms to get one of the two applications that are either written by an Approved Medical Practitioner (AMP) or a GP. An AMP is often a consultant psychiatrist, approved under section 22 of the Mental Health Act for diagnosing and treating mental illness.

We developed a coding framework that categorised how SIDMA had been recorded on the form. One of the main reasons for SIDMA was lack of, or impaired, insight. We defined whether this was recorded based on whether the statement met one or more of four criteria:

- a) explicit use of the word 'insight' ('insight,' 'insightless,' 'insightlessness,' etc);
- b) the patient was described as not believing, accepting or agreeing that they have a mental health problem;
- c) the patient was described as failing to comprehend or understand their mental health problem;
- d) the patient was failing to recognise the value of treatment (4).

We also made a quality assessment of the information on the form, which we did based on

standards described in the Mental Welfare Commission for Scotland's ('the Commission's') report from 2017 on SIDMA relating to eating disorders (5). We considered SIDMA to be complete if there was a description of three conditions:

- a) specific symptoms of a mental illness;
- b) component(s) of the overall decision-making process was impaired (e.g. understanding, retaining, weighing and balancing information and coming to a decision); and
- c) there was a link between these first two elements, as required under the "because of" clause in the statutory requirement.

We also calculated the readability of each of the SIDMA fields, using the Flesch Reading Ease (FRE) (6) score to assess how accessible the form is for patients and those who support them. We did this because participation is a key principle of the Mental Health Act.

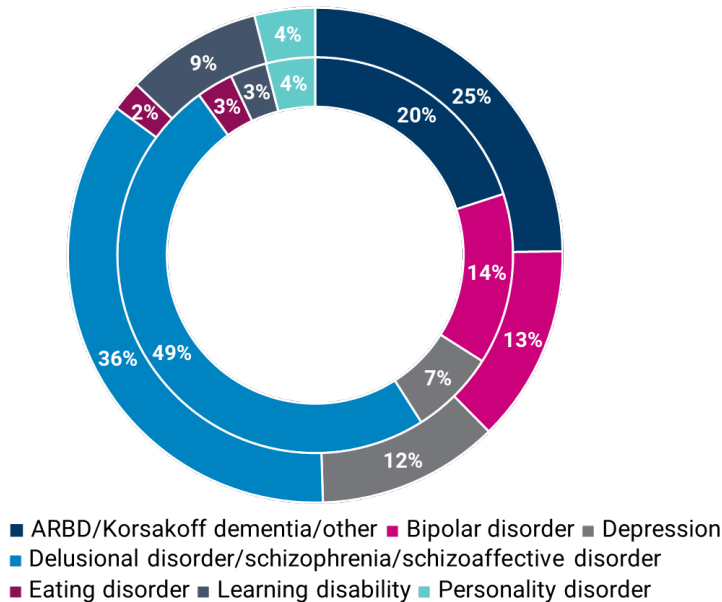
## What we found

The majority of the 100 forms were completed by an AMP (87%), with a minority completed by GPs (13%).

The average age of the group we looked at was 50 years and 53% of these individuals were male. The most common main diagnoses were delusional disorder, schizophrenia or schizoaffective disorder (36%), and alcohol-related brain damage (ARBD), Korsakoff dementia or other (25%). A comparison of the main diagnoses we found (outer circle) with the study by Shek et al. (3) (inner circle) is presented in Figure 1.



**Figure 1. Main diagnosis of individuals (Shek et al. inner circle; current study outer circle)**



## Reasons for SIDMA

In their 2010 study, Shek et al. reported four reasons for SIDMA:

- lack of insight;
- confusion/cognitive impairment;
- psychotic symptoms; and
- other reasons (including severe depression and learning disability).

We found a similar percentage of forms where psychotic symptoms was given as a reason for SIDMA (21%) as Shek et al. (2010) did (24%). We found more forms that reported lack of insight (76%) than the study in 2010 (58%). Sixty two of the forms we looked at gave more than one reason for SIDMA, compared to only 16 in the previous study.

We identified five forms where no evidence of SIDMA was given, compared to Shek et al. who found none.

## Quality assessment

Most of the forms (93%) said that a symptom contributed to the individual having SIDMA. Only 18 of these forms (18%) also explained the specific part of the decision-making process that was impaired as a result of that symptom. Only 12 forms out of 100 made a clear link between the specific symptom of the disorder and the

specifically affected part of the decision making process. This was the minimum standard we identified in guidance developed by the Commission.

## Supported decision making

We only found four examples of supported decision making being recorded (please note this is not a statutory requirement but we wanted to see whether and to what extent practitioners mentioned this in their thinking about recording SIDMA). We interpreted supported decision making in the broadest possible sense. This included making changes to the environment, providing advocacy, or considering alternative ways for the individual to express themselves. The main technique appeared to be revisiting the subject; one form noted that the information had been simplified, but did not explain how that had been done.

## Readability

The median FRE score was 45, which is significantly below the recommended target of 60 (7). Only 21% of forms had a FRE score of 60 or above. The lowest scoring forms did not have a lot of medical terminology and poor readability generally did not result from using jargon. Instead forms that had low reading score had very long and grammatically difficult sentences.

## Examples of SIDMA recording

While there were only five forms where no evidence of SIDMA was given, this is a very important finding. As an example, in one of these CTO applications the SIDMA field was completed with only one sentence: "Mr X is unable to make decisions about his care and treatment." This form made a statement about Mr X's inability to make decisions, but did not give any evidence for that statement.

We saw another group of forms (n=12) where SIDMA was entirely based on an unexplained and unsupported claim of impaired insight. These were particularly problematic because of a combination of:

- the claim about impaired insight was the only justification for SIDMA;



- no explanation was provided as to what was meant by impaired insight; and
- no causal or explanatory link was offered to indicate the impact of the impaired insight upon the person's decision-making abilities.

Another group included cases (just over half of all forms) where there was evidence of SIDMA but no link between the condition and the person's decision-making inability was made. The amount of information included varied on the forms we looked at. In some cases the information was very minimal; one read in total: "Psychosis; no insight into illness." In other cases, considerably more information about the patient was provided. But in none of these cases did the form specify the consequences of the aspects of how the individual presented which affected their ability to make decisions.

It is important to stress that the picture was not uniformly bleak. As noted, 12% of the CTOs satisfied the standard we had adopted for assessing recordings of SIDMA. See Box 1 for examples.

#### **Box 1. Examples of good descriptions of SIDMA**

*Ms X, by reason of her intellectual disability, is unable to comprehend any complex information including the care and treatment that is provided or the rationale for it. I am therefore of the opinion that Ms X's ability to make informed decisions about the provision of medical treatment is significantly impaired.*

*X's insight into his mental illness is variable with there being times that he does not accept he is mentally unwell. He remains very thought disordered which prevents him from understanding information about his illness and the need for treatment, and so his decision making regarding his medical treatment is significantly impaired.*

## **What this means**

SIDMA is a concept unique to Scots Law, which demonstrated a distinctive strategy in ongoing efforts to reform mental health legislation to reduce discrimination and incorporate greater respect for patient autonomy. The reliance on SIDMA in existing Scottish mental health legislation can be understood as a compromise in the ongoing debates about so called fusion law. This is an approach that would bring capacity based legislation such as the Adults with Incapacity (Scotland) Act 2000 and the Mental Health Act together in one framework.

SIDMA includes an assessment of an individual's decision-making abilities to determine whether compulsion is justified. However, because the decision to treat someone under compulsion is based on the presence of SIDMA, it remains legal to treat someone who has capacity to refuse treatment for mental illness under the Mental Health Act (subject to certain safeguards).

Our work expanded on a study from 2010 which found that SIDMA was poorly recorded in CTO reports (3). We conclude that this is still the case. Only 12% of CTOs that we looked at fulfilled the minimum standard we used, based on guidance from the Commission (5). We found that doctors now seem to give more reasons for SIDMA than in 2010, but there is little difference in the content of their descriptions for SIDMA. This is despite the fact that SIDMA has been in effect for more than 15 years.

Those who are working on the review of mental health legislation in Scotland will need to consider how current provisions regarding SIDMA might be adjusted. Additional guidance on its own will probably not improve what we can see in this work, which is a lack of clear descriptions of the reasons why someone has SIDMA. An alternative would be to create new guidance together with better training and quality checking of CTO applications.

One possible reason why there seems to be poor practice in recording and describing SIDMA is that it is not defined in the law. If a legal definition was adopted, this could help structure training, patient assessments and the reporting of the assessment.



The Scottish experiment with SIDMA presents valuable lessons for other countries to think about mental health law reform strategies that retain provision for use of compulsion in mental health care and treatment while ensuring greater respect for patient autonomy and mitigating concerns about potential discrimination.

The Scottish Mental Health Law Review has been provided these findings through the Commission's participation in the Review.

The Commission also meets regularly with NHS Education for Scotland (NES) that runs the training programme for doctors who wish to become s22 approved AMPs and we will make these findings available to NES for consideration about how this might inform training development for the s22 course.

## Acknowledgements

This work was undertaken by Dr Miriam Brown, ST6 Learning Disability Psychiatrist while doing a traineeship with the Commission and was done in collaboration with Professor Wayne Martin and Dr Thomas Hartvigsson at the University of Essex. The work was coordinated by Dr Arun Chopra and Dr Lisa Schölin from the Commission and the wider project group, who contributed to the study design and the paper, were: Dr Donny Lyons, Dr Kathleen Taylor, Graham Morgan, and Callum MacLeod, all with the Commission.

## Why we wrote this Brief

The Commission has a statutory duty to promote best practice with the Mental Health. One way we do this is by presenting the key findings of our research and monitoring activity. This is presented in a summarised format here.

## References

1. Scottish Executive. Approved Medical Practitioners. Mental Health (Care and Treatment) (Scotland) Act, 2003 Training Manual [Internet]. 2005. Available from: <https://www.gov.scot/publications/approved-medical-practitioners-mental-health-care-treatment-scotland-act-2003-training-manual/pages/13/>
2. Scottish Executive. Mental Health (Care and Treatment) (Scotland) Act 2003. Code of Practice. Volume 2 - Civil Compulsory Powers [Internet]. 2005. Available from: <https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-2-civil-compulsory-powers-parts-5-6-7-20/>
3. Shek E, Lyons D, Taylor M. Understanding "significant impaired decision-making ability" with regard to treatment for mental disorder: An empirical analysis. *Psychiatrist*. 2010;34(6):239–42.
4. Gurbai S, Fitton E, Martin W. Insight Under Scrutiny in the Court of Protection: A Case Law Survey. *Front Psychiatry*. 2020;11(September).
5. Mental Welfare Commission for Scotland. "Significantly impaired decision making ability" in individuals with eating disorders - Good practice guide [Internet]. 2017. Available from: <https://www.mwccscot.org.uk/sites/default/files/2019-06/sidma.pdf>
6. Farr JN, Jenkins JJ, Paterson DG. Simplification of Flesch Reading Ease Formula. *J Appl Psychol* [Internet]. 1951 Oct [cited 2021 May 18];35(5):333–7. Available from: <https://psycnet.apa.org/record/1952-03973-001>
7. Lim YT, Bennett DM. Readability of statutory letters issued by Forensic Services in NHS Scotland. *Med Sci Law*. 2020;60(2):93–101.



Mental Welfare Commission for Scotland  
Thistle House,  
91 Haymarket Terrace,  
Edinburgh,  
EH12 5HE  
Tel: 0131 313 8777  
Fax: 0131 313 8778  
Freephone: 0800 389 6809  
[mwc.enquiries@nhs.scot](mailto:mwc.enquiries@nhs.scot)  
[www.mwcscot.org.uk](http://www.mwcscot.org.uk)