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Reconceptualizing involuntary outpatient psychiatric treatment: From “Capacity” to “Capability”

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RECONCEPTUALIZING
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*From “Capacity” to
“Capability”*

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ABSTRACT: Justifying involuntary psychiatric treatment on the basis of a judgment that a person lacks capacity is controversial because there are questions about the meaning and utility of the concept in this context. There are complexities to using capacity in this way, which are further amplified in the community outpatient setting compared with acute inpatient care. A richer account of capacity, its meanings, and practical applications in context, is required. This qualitative study sought to build inductively a model of capacity in the context of involuntary outpatient psychiatric treatment, based on 38 interviews with stakeholders from New South Wales, Australia. The emergent model incorporates multiple “capacities”: to manage illness, for self-care, and to maintain social roles. It identifies core values that correspond with the “capabilities approach,” elaborating the justifications and processes of involuntary outpatient psychiatric treatment. This proposed model of “capability” may have a range of benefits to sound and ethical practice and scrutiny of systems of involuntary outpatient treatment.

KEYWORDS: qualitative research, community mental health care, capabilities, ethics, mental health law

JUSTIFYING INVOLUNTARY psychiatric treatment on the basis of a judgment that a person lacks capacity is usually expressed in terms of a person’s ability to make a decision about his or her health and treatment. Typically, this relates to the ability to refuse treatment. Exactly what “capacity” means, however, and how one determines when another individual lacks capacity, or lacks sufficient capacity, in this context is particularly controversial, with the United Nations Committee on the Rights of Persons with Disabilities (2014) insisting that involuntary treatment be abandoned altogether and capacity tests avoided.

Capacity is a concept that has multiple meanings and applications across different disciplines and settings, including in the context of mental illness and treatment (Australian Law Reform Commission, 2014; Banner, 2012; Okai et al., 2007; Owen, David, et al., 2009; Owen, Freyenhagen, Richardson et al., 2009). In clinical and legal domains, capacity is often used synonymously with the term “competence” and approaches to both

concepts focus on a person's time and task-specific decision-making ability and related processes of decision making (Banner, 2012; Doorn, 2011). A common approach to assessing decision-making capacity in psychiatric and other health care settings is a predominantly cognitive-based functional test of the capacity of a person to provide valid consent to treatment or refusal of treatment. Criteria used in this method seek to determine whether a person's mental impairment makes him or her unable to understand information about their health and treatment, to retain and use that information to make and justify a decision, and to communicate a choice about treatment (Doorn, 2011; Grisso & Appelbaum, 1995; Owen, David, et al., 2009; Owen, Freyenhagen, et al., 2009).

Philosophical critiques frequently interrogate the moral and political relevance of capacity determinations as a justification for coercive use of psychiatric power by the state to implement psychiatric treatment (Dawson & Kampf, 2006; Sullivan & Mullen, 2012; Szmukler & Dawson, 2011). In this regard, capacity is viewed through its interplay with principles of autonomy, beneficence, dignity, and equity—specifically, how capacity might frame bioethical and human rights approaches to involuntary psychiatric treatment and how it could protect or enhance relevant principles in practice (Australian Law Reform Commission, 2014; Doorn, 2011; Owen, David et al., 2009; Owen, Freyenhagen et al., 2009). In this context, contemporary capacity-based justifications for involuntary treatment are often contrasted with more traditional legal justifications based on risk of harm.

Recent proposals for reform in mental health law have echoed this philosophical shift, with increasing interest in capacity-based criteria for involuntary psychiatric treatment in place of the traditional risk-based systems (Burns, 2011; Fistein et al., 2009; Szmukler & Dawson, 2011). There are a number of arguments that would seem to justify this proposal. The first is that it would make mental health law consistent with other capacity-based approaches to health and welfare decision making. The second is that it would overcome many of the drawbacks of risk-based laws, which are often seen as discriminatory—stigmatiz-

ing people living with mental illness as dangerous and disrespecting their autonomy (Link, Castille, & Stuber, 2008; Ryan, Nielssen, Paton, & Large, 2010; Szmukler & Dawson, 2011). In practical terms, laws that take a capacity-based approach to involuntary treatment include either those where a functional test of decision-making ability is the primary feature, those that integrate capacity principles with primarily risk-based criteria (Fistein et al., 2009), or those which seek to merge capacity and risk criteria together (Szmukler & Dawson, 2011).

There are, however, a number of complexities and contentions associated with the use of capacity to justify and operationalize involuntary treatment. The current cognitive approach to the criteria for capacity testing relies on an assumption that it is “an objectively measurable phenomenon” (Banner, 2012, p. 1040; United Nations Committee on the Rights of Persons with Disabilities, 2014). The reality is that all definitions and applications of capacity involve intrinsically normative judgments and inevitably reflect the influence of context and values (Doorn, 2011; Radden, 2003; Szmukler & Dawson, 2011). Moreover, it is argued that the concept of capacity can be difficult to conceptualize and to put into practice, and at times may be misunderstood or misapplied (Select Committee on the Mental Capacity Act 2005, 2014; Williamson, 2011). Indeed, a recent review of the Mental Capacity Act 2005 (England and Wales) identified these issues were part of the poor implementation of the act so far: “It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases it is because professionals struggle to understand how to apply the principle in practice” (Select Committee on the Mental Capacity Act 2005, 2014, p. 8). It is also suggested that changing from risk to capacity-based approaches to decision making will change the types and rates of use of involuntary treatment (Milne, O'Brien, & McKenna, 2009; Dawson, 2006), and that this, in turn, may affect other social systems (Dawson, 2006).

All these critiques are amplified in the context of community-based mental health care. Unlike acute and severe disturbances of mental state requiring

involuntary inpatient hospital admission, people may have variable levels of capacity over longer periods of time requiring very different levels of care (Szmukler & Dawson, 2011). Recognizing the dynamic and context-sensitive nature of capacity is therefore critical to the long-term care of people living with mental illness. This is because conceptualization and application of capacity are pertinent to how the law and clinicians should respond to severe and enduring mental illness in the community setting. Furthermore, inappropriate attribution of incapacity to a capable person, or vice versa, may undermine their care, dignity, and rights (Radden, 2002).

We require an account of capacity in a community mental health care setting that is richer and more contextualized than extant medicolegal and theoretical constructs (Doorn, 2011; Owen, Freyenhagen, et al., 2009; Szmukler & Dawson, 2011). Most data about capacity relates to the setting of severe and psychotic mental illness. Moreover, decisions about capacity in ambulatory psychiatric care are more complex than acute inpatient care, where the critical issue is usually dangerousness or risk of harm. Capacity may be understood and applied in different ways by different professionals, which in turn affects patients and carers. We, therefore, require data that help to provide a better understanding of capacity in the setting of severe and persistent mental illness and its ongoing management in the community. In light of this imperative, this qualitative study aimed to derive a comprehensive model of capacity in involuntary outpatient treatment that is credible and meaningful among patients, caregivers, clinicians, and legal decision makers, and better reflects the ways that capacity is constructed in clinical practice, policy and law. The inductive nature of qualitative research, where no prior assumptions are made about findings and where analysis is open to emergent issues, is well-suited to examining real world constructions of complex concepts such as capacity and experiences of complex processes, such as involuntary psychiatric treatment in the community setting.

METHODS

This qualitative study was conducted in New South Wales (NSW), Australia, and referred to involuntary outpatient “community treatment orders” (CTOs) under the Mental Health Act 2007 (NSW). The preliminary findings of the study were submitted as a report to the funding body and published online; however, this paper provides a more substantive and extended descriptive and philosophical account of the research findings and develops a normative alternative to the current conceptualization of capacity. Like other Australian and many international jurisdictions, NSW involuntary treatment law currently provides that unconsented psychiatric treatment cannot be delivered unless, owing to a mental illness (as defined in the act), a person requires protection from serious harm to self or others and that involuntary treatment represents the least restrictive route to safe and effective care. Recent reforms have added capacity considerations to the principles that are to be put in to practice in the care and treatment of people under the Act. Decisions on CTO applications are made by an independent Mental Health Review Tribunal (MHRT), based on applications from a clinician, a mental health facility director, and/or a primary carer of a person.

This study examined clinical and legal CTO decision making and patient and carer lived experiences. It aimed to inductively build a model of “capacity” in the context of CTOs (as well as models of “risk” and people’s lived experiences, which are reported elsewhere; Light et al., 2014; Light et al., 2015) and to identify potential improvements to CTO processes. The research questions were formulated as: How do mental health professionals, patients, caregivers, and legal decision makers conceptualize “capacity” in the context of decisions about involuntary psychiatric treatment in the community setting? and Can a comprehensive model of “capacity” that is consensually valid across participant groups be formulated?

PARTICIPANTS AND RECRUITMENT

Participants were recruited using a theoretical, purposive method of sampling, and comprised four groups: patients currently or previously on

a CTO, relatives or carers of a person subject to a CTO, community mental health clinicians, and members of the legal body overseeing involuntary psychiatric treatment (the MHRT).

The investigators sought to build a maximum variation, rather than representative, sample in which as many different subgroups of different participant groups are included. This does not allow justification of claims to generalizability of study findings. Rather, it enabled the investigators to describe and understand a rich and varied range of experiences and perspectives and to build a comprehensive model of capacity in the context of involuntary psychiatric treatment in a community setting. In the patient and carer groups, the study aimed to recruit people with current or past experience CTOs, those ordered in different geographic locations, or those relating to people with different diagnoses of mental illness. The study also sought to include participants from different disciplines and professional histories in the clinician and MHRT member groups.

Recruitment involved a variety of methods. Clinicians were recruited through distribution of an invitation issued by NSW health service managers. Potential participants (clinicians) were also recruited using the “snowball” method, through which the study was recommended to subsequent participants through professional networks or relationships. In the case of patient and carer participants, an invitation was circulated through non-government organizations (Carers NSW, the Mental Health Coordinating Council, and NSW Consumer Advisory Group—Mental Health Inc.). This was further disseminated through their own networks and individual recommendations. Patient and carer participants received \$40 at interview toward costs of participation. In the case of MHRT participants, the invitation was circulated by the tribunal to all members. All consumer participants were clinically stable at the time of their participation and were judged to have sufficient capacity to freely participate in this research. Their expressions and views were valid irrespective of whether they were on a CTO or not.

After provision of a participant information statement, and an opportunity for questions about the project and the conduct of interviews,

written informed consent was obtained from each participant. The research was conducted with the approval of the following committees: University of Sydney Human Research Ethics Committee (patient and carer interviews—protocol number 12583; MHRT member interviews—protocol number 14421); Sydney Local Health Network Ethics Review Committee (protocol number X10-0338).

DATA COLLECTION AND ANALYSIS

The investigators conducted in-depth semi-structured interviews in a variety of sites. In the case of clinician participants, interviews were conducted in clinical sites. MHRT participants were interviewed either at the MHRT offices or, where appropriate, in their other workplaces. Interviews with patient and carer participants were held in offices of non-government organizations. Patient participants were not recruited from or interviewed in clinical settings because the investigators sought to maintain a clear distinction between their voluntary participation in the study and their involuntary treatment status.

In the conduct of the interviews, the investigators prompted the participants to speak about their unique understanding of CTO use by providing narrative accounts of their experience of CTO processes. In the case of clinicians or MHRT participants, this involved their reflection on specific examples of decisions around CTOs in their professional experience. In the case of patients and carers, this involved a process of constructing a personal narrative of their direct and indirect experiences of the use of CTOs. The interviews were audio-recorded, transcribed, and de-identified. The data were managed using the NVIVO9 computer program.

The analysis utilized grounded theory and inductive methods as described by Charmaz (2006), Corbin and Strauss (2008), and Thomas (2006). Using an a priori code of “capacity,” this involved an initial coding process to sort and begin an analytic account of the data, then the synthesis of the coding into more conceptually complete categories. As the iterative process of data collection and analysis progressed, data and codes within and between interviews were constantly compared

and memos written to analyze the nature of and relationships between codes and emerging categories. This facilitated the emergence of a number of themes, which formed the basis of the model of capacity. The investigators sought to confirm data saturation by triangulation of the data coded separately by two members of the team (M.R. and E.L.) and through discussion of the data among the investigators and stakeholder reference group members. Triangulation is an intrinsic aspect of qualitative research used to establish validity and completeness of an analysis and can involve use of different investigators and stakeholders (as this study did), data sources, study theories, and/or methods (Miles & Huberman, 1984; Rosen et al., 2012).

RESULTS

PARTICIPANTS

Five patients and six carers participated in interviews. Six were men and five women from metropolitan or regional/rural areas. Among either the patients or the relative of the carer were diagnoses of schizophrenia, depression, bipolar disorder, and anxiety. All of the CTOs under discussion were initiated from a hospital, although renewals of CTOs in a community setting were also discussed at interview. Six of the interviews related to CTOs currently in place, and the other CTOs had either lapsed or the status of the CTO was unknown to the interviewee. One issue of note was the difficulties in recruiting patients subject to CTOs through non-clinical pathways. In opting not to recruit through treating clinicians, the yield of suitable participants was lower than anticipated. Moreover, several suitable participants later withdrew or were unable to participate.

Twelve MHRT members participated in the interviews. Of these five were women and seven were men. Four were psychiatrists, four were lawyers, and four were from social work, nursing, psychology, and mental health service administration fields. Fifteen clinicians participated in interviews; three psychiatrists, eight nurses, two social workers, one psychologist, and one occupational therapist (four men and eleven women).

The various clinicians had worked in inpatient and community mental health settings and their clinical loads included general adult mental health, youth mental health, older person's mental health, and Aboriginal mental health. Participants worked in regional and metropolitan settings.

PERSPECTIVES ON CAPACITY

Analysis of participant accounts of "capacity" revealed a range of practical and conceptual themes. It also found significant overlaps in how groups of participants think about "capacity," although each group emphasized different aspects of it. This may have been because ideas about what gives life meaning are broadly shared and derive from sedimented values and norms (Nussbaum & Sen, 1993). Alternatively, this may have reflected the influence of hegemonic *institutional* norms. This necessitated our acknowledgement that many participants may have been speaking of socially constructed and nomothetic notions of the good life. Clinicians and MHRT member views were often based on legal and medical constructions relating to the ability to make decisions about health and treatment. They often raised epistemic concerns about how to conceptualize capacity, and were mindful of the different discourses around the phenomenon, including in their own ways of thinking. Many patients and caregivers shared these perspectives, but overall were more likely to emphasize capacities to manage illness and how severe mental illness often impaired capacity to pursue life goals and partake a social role. As the analysis progressed, these discourses on capacity were systematically integrated to derive a model of capacity in the context of outpatient involuntary psychiatric treatment.

The model of capacity identified three domains: "manage illness," "self-care," and "maintain social roles."

Manage illness. The capacity to manage one's mental illness was a key feature of perspectives on capacity among all participant groups. It incorporated the ability to recognize the features of illness, including early signs of recurrence; acknowledge the effect of illness on thought, emotion, and behavior; engage and negotiate with a clinical service and domains of treatment (including awareness of

potential benefits and harms from psychotropic treatments); and participate in a “recovery”-based model of care.

Clinicians described this capacity in both conceptual and practical terms. Conceptual capacity—akin to the medicolegal construct usually used to assess competence in various domains—related to a person’s ability to conceptualize and articulate choices about their illness management. Central to this were capabilities such as cognitive function, judgment or insight into consequences of various choices.

And there’s a difference when they’re actually able to cope, to have a life, to deal with their children, to deal with their partners, to go to work, all those things are signposts that things are getting better, and they can reflect, ‘I couldn’t do that then, but I can now.’ (Clinician participant)

Practical capacity concerned how a person might deal with the daily demands of living in the community and included negotiating to have one’s needs met within complex systems such as health and social services—making and communicating choices, and sustaining social supports. Some clinicians saw the utility of CTOs in prioritizing the needs of patients when illness may have adversely affected their ability to access or engage with treatment services.

when somebody is on a community treatment order, the system expects you to keep working with them... they have the safeguard of getting a certain priority—you’re not going to discharge them because you’ve got too many clients, that sort of priority. So it’s an obligation from the mental health service’s point of view. (Clinician participant)

MHRT member participants had similar perspectives on capacity to manage illness, including the themes of dealing with the intrinsic limitations of severe mental illness (frequently focused on legalistic questions of mental capacity to decide about treatment and of what is often called “lack of insight”) and of those presented by the mental health system (and in which CTOs acted as a form of advocacy for patient need).

The capacity to manage mental illness was a prominent theme among patient and carer perspectives on capacity. This included “knowing the illness”: recognizing signs of deterioration in

health, and learning the effect of certain treatments on symptoms; understanding the language and processes of mental health care including diagnoses, treatments, and health services, as well as involuntary treatment; and recognizing the need for knowledge and/or advocacy to participate in these health and medicolegal systems.

Because it [the medication] takes about two or three weeks to work ...it really takes a long time. And I’m glad I take the tablets, I don’t want to take the injection, because with the tablets I know I’ve got it every day, I know it’s in my system. (Patient participant)

He said, “I respond to my old medication, so that’s what I think I need.” So he’s very, very smart. And there was some medication they wanted to put him on, and he refused, he said ‘I don’t want that.’ And he does research himself, so he’s read the Mental Health Act and everything. So he knows what works for him. (Carer participant)

Being able to communicate about the illness was an integral part of this capacity, particularly to engage with clinicians about treatment and/or in involuntary treatment processes. The concept of “recovery,” as against other forms of improvement, was also evident in many consumer and carer perspectives on managing illness. The tenets of the “recovery approach”—including hope, secure base, self, supportive relationships, empowerment and inclusion, coping strategies, and meaning—may have influenced some participants, whereas others may have seen this in simple terms of optimism or hope. Patient participants spoke about aspirational goals of recovery from illness as well as short-term and longer term goals for symptom control or restoring vocational roles.

I think I’m going to learn to live with it, and live with it well, because I’m 42 and I’m quite healthy for my age, and I’m not silly, I reckon I can go back to work in a couple of years when I get stronger, and that’s my goal...it made me realize that hey you know, I can get rid of this illness; or not get rid of it, but I can stop the voices. And that was the main thing, the voices was the main thing. (Patient participant)

Self-care. Being able to care for one’s self emerged in the capacity discourses of all participant groups, referring to a person’s ability to maintain physical well-being and healthy lifestyle choices, and to establish and maintain a suitable personal environment as well as a network of

professional and interpersonal caregivers. Patient and carer participant accounts highlighted that being able to cope with the effects of illness, to meet interpersonal and health needs, and to live independently in the community were importance aspects of self-care. Severe mental illness could disrupt this capacity, either through the problems of disorganization, apathy, amotivation, or avolition or through the disruptive effects of psychosis.

So the simple thing like going to buy food, it's just everything you know. If he's so disturbed by the voices, he'll just have to lay down on the bed and stay there, he just can't do anything. (Carer participant)

MHRT member accounts included similar quality-of-life themes and explained how the absence of capacity for self-care emerged as the propensity for neglect (for example, of personal care or living conditions), which was a concept that frequently featured in deliberations on questions of involuntary community treatment.

Some case managers are very close to their clients, and they go and visit the client, with their permission of course, just to ensure that they are taking their medication....But you will have a sense of how the client is living in the home environment, so whether the place is looked after, whether the client's done the washing, see whether there are dishes in the sink, and talk to the neighbors, they will give you an indication as to whether or not they have received any complaints; take a walk with them down the street to the café that they go to, you get a sense of their surroundings as well, moving away from the home to a place outside. So those sorts of things come into play [in CTO decision-making]. (MHRT member participant)

Clinicians also regarded the impairment of the capacity to prioritize and maintain self-care as a significant concern in considerations of treating severe mental illness. In addition to attending to instrumental needs, some clinicians also saw that an aspiration of treatment was to facilitate the pleasurable or hedonic experience of participating in different aspects of life. One clinician participant regarded the consumer's perspective of what happiness they sought from life as an important focus of care: "I think first of all I'd want to know what the client considers important to their happiness and well-being, and that's different for everyone."

Maintain social roles. Participant perspectives on capacity also depicted the capability to maintain social roles. This included being able to establish and maintain interpersonal, vocational, and educational functioning; to meet obligations to others in the community; and to maintain harmonious and nurturing relationships with family, friends, and acquaintances.

Throughout their interviews, patient and carer participants spoke about the disabling effects of severe illness on a person's ability to pursue life goals and engage in a social role. These goal-focused capacities included establishing and maintaining relationships, which provided scope for support and interpersonal networks; seeking and maintaining financial independence; participating in education and employment; and fulfilling obligations to others (whether it be interpersonal, financial, or community relationships). Many such goals related to personal achievements and milestones, or more generally to being able to survive and flourish in the community.

I go to work and get sick and then I come back and then I'm not able to function as well as I could and I lose my job. (Patient participant)

A carer participant highlighted how the effects of severe mental illness meant that, for some people, programs to support people's social participation—such as peer support or employment programs—were still out of reach:

I know from speaking to other people, other parents, that they feel the same as I do about their son. You've got to be pretty high functioning to go and join most of these groups, and most of them aren't. So the resources are there ... but they're not meeting the needs of everyone, it's only a small functioning group that are using them. (Carer participant)

MHRT member and clinician accounts also explored how illness frequently disrupted a person's practical capacity and ability to maintain a social role. Practical capacity involved being able to apply skills in dealing with the complexities of the social system—comparable with the notions of "phronesis" (Kraut, 2014) and the capacity to partake in citizenship—and was part of some of the considerations about treatment aims.

This woman was a registered nurse, and very smart lady and she had a husband, she had children, before the illness debilitated her. So we want to get ... [her] involved with society, because she's very withdrawn. (Clinician participant)

Some participants also commented on the sometimes profoundly disabling effects of “negative symptoms” of illness, which might undermine other people’s perceptions of the credibility of a person’s plans for themselves or destabilize their fulfilment of expressed intentions to engage in life.

Look I don’t think you can order people to go to TAFE [technical and further education], one of the problems, particularly with schizophrenia for example, is you have people with prominent negative symptoms,... Their executive functioning skills and planning skills are so impaired, even if they know what would be a good thing for them, they just can’t quite organize it. (MHRT member participant)

As part of deliberations on such issues, some clinicians recognized the need for a patient to have the capacity to manage the adversity often brought into their lives by illness, particularly to manage losses such as the loss of agency, social role, or status.

DISCUSSION

This study sought to describe how patients, carers, clinicians, and MHRT members conceptualize “capacity” and to use this empirical data to derive a model of capacity in the context of involuntary psychiatric treatment in the community setting. The model of capacity described incorporates a person’s multiple capacities to manage illness, for self-care, and to maintain social roles. It is grounded in the participants’ lived experiences of many aspects of severe mental illness and of outpatient involuntary psychiatric treatment. It was noteworthy that many participants were aware of, and thoughtful about, the epistemic, ethical, policy, and practical issues associated with the conceptualization and application of capacity, including functional capacity testing and possible approaches to mental health law. What emerged in our findings, however, were broader concerns about the extant conceptualization and construction of capacity in this setting. As such, they offer a

number of opportunities to reappraise the practical application of “capacity” in this particular context, as well as helping to frame debate on relevant ethical and policy concerns. No qualitative work can make claims to generalizability; however, this research indicates dissonance between the traditional cognitive approach of “capacity” and the, arguably idiographic, expanded notion of capacity described by this group. Within the setting of involuntary psychiatric treatment in the community in NSW, the traditional cognitive-focused notion of capacity was an incomplete account of what all participants conceptualized.

DECISION MAKING ABOUT INVOLUNTARY OUTPATIENT PSYCHIATRIC TREATMENT

Capacity figures significantly in clinical and legal approaches to the treatment (voluntary and involuntary) of people living with severe and enduring mental illnesses. Our account of a “real-world” model of capacity, that is particular to involuntary psychiatric treatment in the community, improves our understanding of how people think about and apply this concept in practice. The model incorporates the wide range of perspectives held among different stakeholders, each of whom bring diverse and overlapping experiences to bear on their understandings of capacity. It also accommodates both points of agreement and divergence and as such provides a robust framework to improve applications of capacity in this setting. The model was developed by careful identification of points of overlap among participant groups and consideration of the origins of points of difference from epistemic and ontological perspectives. In doing so, it provides a possible mechanism for improving communication between patients, families, clinicians, and tribunal members about the rationale for and limits of involuntary treatment in community settings, including the articulation of treatment goals and plans that are implemented under involuntary orders. It could also increase the transparency and accountability of decisions about involuntary (and voluntary) treatment and the systems through which they are implemented. Indeed, by explicitly incorporating multiple domains of capacity, this model would make these processes more inclusive, dynamic, and context

specific. Each of the capacity domains would not have the same significance in every situation and with every patient. Rather, the weight attached to each capacity domain would depend on who it involves (e.g., the patient, the carer, the clinician, or legal decision maker) and the context (e.g., the clinical diagnoses, history, or setting).

Importantly, we believe the instrumental value of this model of capacity has potential in any jurisdiction, regardless of its specific legislative criteria for decisions about involuntary community treatment. Whether laws are predominately risk based (as was the setting of this empirical study) or use forms of functional decision-making capacity testing, this model is useful to improving communication between stakeholders, treatment planning, and the transparency of these processes. Research into decision making under mental health legislation shows that the complexity of such processes can lead to decision makers substituting their own criteria for the statutory criteria, based on an analysis of what lay behind the intentions of the law (Perkins, 2011). The results of this study help us to understand what is in the minds of decision makers and suggest that, even when mindful of statutory criteria, stakeholders are able to articulate and engage with other matters, including the health and social context in which such legal decisions are embedded (Carney & Beaupert, 2008). In addition, the model that we have proposed may also be useful in elaborating areas of the currently applied capacity testing criteria that are contested and complex (Banner, 2012; Doorn, 2011; Szmukler & Dawson, 2011), by depicting some of the values and context relevant to deliberations over involuntary outpatient psychiatric treatment.

In promoting the benefits of an empirically derived model of capacity, it is important to distinguish it from conceptualizations of risk of harm as the moral justification for coercive psychiatric treatment. In this regard, it is noteworthy that all of the participants in this qualitative study spoke of the risks of harm faced and posed by people living in the community with a severe and persistent mental illness (Light et al., 2015). Yet they readily distinguished this from the disabilities or incapacities consequent upon such an illness.

CAPACITY OR “CAPABILITY”?

Our examination of the lived experiences and perspectives of involuntary psychiatric treatment in the community demonstrates how often and how differently the notion of capacity arises in health care decision making and why a richer understanding of the concept is necessary for sound and ethical practice.

What is, perhaps, most striking about our data is that the model of capacity that emerges is not defined solely in the type of cognitive terms that dominate traditional medicolegal constructions of capacity and accepted processes of substituted or proxy decision making. The model that emerges from our research describes a series of capabilities that extend the traditional cognitive-focused approaches of “capacity.” We believe that by privileging cognitive capability over others, the ‘capacity’ approach is only a partial account of what this group of participants conceptualize when deliberating questions in community mental health care. Its dimensions of interpersonal efficacy, self-respect, self-care, and engaging in a social role direct us toward a notion of the “telos” or purposes of psychiatric treatment and the notion of a basic ethic of the psychiatric project. This poses the question: What is it that we seek to achieve through psychiatric treatment? Implicit in the narratives of the participants was that the aspiration of coercive treatment should be to restore and scaffold fundamental capabilities to pursue a “good life,” however socially constructed and contextualized. This would seem to be a liberal egalitarian perspective, as described by John Rawls (1971). This invites our reconsideration of the goals of mental health care—specifically, whether treatment of psychiatric disorder serves as a means of redressing the imbalances brought about by “the natural lottery” (Daniels 1985). In other words, whether coercive psychiatric treatment should be instrumental in compensating for the effects of severe mental illness on a person’s ability to vie for social goods and to pursue a life’s journey.

Our results suggest there may be merit in reframing or extending the notion of capacity(s) in this context in terms of capability(s), as outlined by Martha Nussbaum. Nussbaum’s elaboration of

Rawls and of Amartya Sen's capabilities approach to welfare economics and human development (Sen, 1985) provides a conceptual framework to situate our emergent theory of the purpose of psychiatric treatment. Nussbaum describes ten capabilities that are necessary for one to live a life with dignity—using this to provide an account of the fundamental sociopolitical entitlements that are central to the liberal egalitarian conception of social justice: life; bodily health; bodily integrity; senses, imagination, and thought; emotions; practical reason; affiliation; other species; play; and control over one's environment (political and material) (Nussbaum, 2006). These seem to be universalist assumptions; they have broad empirical support from studies in diverse communities and cultures (Nussbaum & Sen, 1993) and it is difficult to envisage a historical or cultural setting where these were not instrumental goods. In her writing, Nussbaum describes the implications that the capability approach would have for the development of policies concerning disability (including people with "mental impairment" or "mental disability"), noting that public policy would need to facilitate and protect a person's access to the capabilities while leaving the individual concerned the choice about whether to exercise or realize those capabilities. Thus, where a person needs assistance a capabilities approach would mandate that this should be provided in such a way that invites the person to participate as much as possible in decision making and choices. This would seem to parallel the commonly held view that coercive psychiatric treatment, ultimately, aspires to enable the patient to exercise a right to negative liberty through realization of autonomous choice. Importantly, when using the terms "mental impairment" and "mental disability," Nussbaum explains that she is referring to the terrain occupied by both "cognitive" disabilities and "mental illnesses" (Nussbaum, 2006, p. 423). Further, she argues that the "lives of citizens with mental impairments, and of those who care for them, will continue to be unusually difficult lives. ...[T]he lives of either people with disabilities or their caregivers need not contain the stigma and insult and the inordinate burdens that they used to contain ubiquitously, and now often still contain" (Nussbaum, 2006, p.

222). As such, her thesis is that a "decent" society will organize public policy that is supportive and inclusive of such lives, avoids further marginalizing and stigmatizing, and gives people as much access to the capabilities as possible. This idea is particularly salient with regards to involuntary psychiatric treatment, where stigma remains a feature of the experience of severe and persistent mental illness and its treatment (Goffman, 1963; Link et al., 2008).

CAPABILITIES AND MENTAL HEALTH

The capabilities approach has been applied worldwide in numerous mental and public health projects, including work to devise new ways of measuring outcome in public and social health programs. In an ongoing project seeking to operationalize the capabilities approach to welfare economics, Anand et al. (2013) have developed a variety of ways in which capabilities can be measured, including applications to health outcomes measurement. In an adaption of this work, Lorgelly, Lorimer, Fenwick, and Briggs (2008) used the capability approach to develop an instrument for evaluating public health interventions. They posited that complex social and public health interventions have a diverse range of outcomes not captured by the quality-adjusted life-years framework commonly used in health economics, and found the capability approach offered a richer set of dimensions. Simon et al. also adapted Anand's work to develop a capabilities-based instrument that would enable a more comprehensive measurement of important mental health outcomes as part of their study of CTOs in England. Their initial evaluation seems to demonstrate the feasibility and validity of directly utilizing measures of human capabilities as an approach to measurement of outcome in psychiatric care. Each of the projects has sought to find instruments able to account for all of the outcomes of "interest/importance" in health care (Lorgelly et al., 2008), arguing that capabilities-based tools provide such a measure.

The capabilities approach has value and utility in mental health well beyond the assessment of health care interventions, providing the basis for rigorous reconceptualizations of key concepts in the field such as "social integration" and "recov-

ery.” Ware et al, for example, used it as a framework to address the continuing social exclusion of people living with mental illness, providing the basis for an approach to social integration which casts persons with psychiatric disabilities as social agents and envisions flourishing, rather than simple functioning, as an outcome (Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007). Similarly, Hopper (2007) uses the capabilities approach to inform a new approach to “recovery,” arguing that a capabilities-informed mental health program enables people to thrive, not just survive: by re-enfranchising agency, redressing material and symbolic disadvantage, and raising the bar on fundamental entitlements.

In our findings, participant perspectives of “capacity” and involuntary outpatient treatment were frequently concerned with impairments of capabilities arising from mental illness that precluded or compromised a dignified life. The model that we propose identifies core values that correspond with Nussbaum’s capabilities approach and other’s efforts to apply it in certain contexts. It enlightens our understanding of how the state’s intervention in the lives of some citizens—in this case involuntary outpatient treatment—might seek to protect or restore a person’s agency (in the health care system, in society): seeking to mitigate the effects of mental illness and enable a person’s capability to maintain well-being, to experience pleasure, pursue a life’s journey, maintain interpersonal supportive relationships, manage the adversity often brought into one’s life owing to illness (such as loss of agency, social role, or status), and civic participation seem to be the moral foundation of that intervention.

This proposed model of “capability” in the context of involuntary outpatient psychiatric treatment moves beyond current medicolegal constructs of task-specific assessment of competence in relation to treatment decisions and may have a range of benefits: improving communication between stakeholders, providing a more comprehensive framework for decision making about involuntary orders and specified treatment plans, and improving the transparency of those processes. Perhaps most important, we believe that this model may also increase scrutiny on the

justifications for and implementation of systems of involuntary outpatient treatment. What cannot be justified by this research is the use of the capabilities approach as criteria to determine when coercion or usurpation of negative rights is justified.

There is currently no clear consensus about the instrumental value of CTOs and what we seek to achieve by using them. These are not simply “medical” questions, but ethical ones, because the outcomes we privilege—whether traditional measures of efficacy and effectiveness such as avoiding hospital readmissions, reducing hospital stays, improving quality-adjusted life-years, or stabilizing people’s health to enable illness insight or treatment engagement, prioritizing community-based over hospital-based coercive treatment, prompting a health system response—reflect our ideas about what it is that “matters” and what it is we want our mental health care system to achieve (Light, 2014). Of course, this many not simply be a question of what we want from our mental health care system, but what goals we also want social and welfare systems to fulfil in this context. The answers to these questions should not be determined solely by health professionals or regulators, but through a broad public debate informed by a genuine understanding of the experiences of those who suffer severe mental illness and those who provide care for them or deliberate legally and clinically over their lives. The “capability” model, as a means of understanding both a moral justification of involuntary psychiatric treatment and the telos of psychiatric treatment, elaborates what the community values as important in the provision of healthcare for those living with severe and enduring mental illness.

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