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**Health, Social Services  
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# Seeking consent:

## Working with prisoners and detainees

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## 1. INTRODUCTION

1.1 Guidance on “Good Practice in Consent” was issued to health and social care professionals working in HSS Boards, Trusts, LHSC Groups and Special Agencies in March 2003. The guidance consists of:

- Reference Guide to Consent for Examination, Treatment or Care. This gives a background to the law on consent for health and social care professionals and gives references to legal cases; and
- Good Practice in Consent, Consent for Examination, Treatment or Care: A Handbook for the HPSS. This has 9 parts:

### Part 1

- Good practice in consent: implementation guide for health care professionals. This contains a Model Policy for Consent for Examination or Treatment for HSS Trusts, Boards, Local health and Social Care (LHSC) Groups and Special Agencies, a patient information leaflet “Consent – it’s up to you” and model consent forms.

### Parts 2, 3, 4

- Seeking consent: working with children, working with older people, and working with people with learning disabilities. These booklets give guidance to health and social care professionals on good practice in consent when they are working with children, older people and people with learning disabilities.

### Parts 5, 6, 7, 8, 9

- Consent – what you have right to expect- guides for adults, children and young people, parents, people with learning disabilities and relatives and carers. These are information

leaflets on consent for patients/clients on what they should expect when being examined, treated or cared for.

- 1.2 This booklet is part of the “Seeking Consent” series and focuses on the particular issues which may arise when seeking consent from people in prison. It should be read in conjunction with the other guidance. It is designed primarily for the use of prison health care staff, but non-health care staff may also find it helpful, particularly where a prisoner’s health needs and the demands of discipline interact. It may also be helpful for people providing healthcare to prisoners or detainees outside a prison setting.
- 1.3 If your work involves providing healthcare to people in prison, you need to make sure you have your patient’s consent to do what you are doing, if they are able to give it. This respect for people’s rights to determine what happens to their own bodies is a fundamental part of good practice. It is also a legal requirement. The fact that a patient is also a prisoner does not affect his/her right to determine whether or not to accept treatment where they have the mental capacity to make such a decision.
- 1.4 Your role as a professional providing healthcare in relation to patients who are in prison is solely to evaluate, protect or improve their physical and mental health (UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1982).
- 1.5 Difficult situations can arise for healthcare staff in prisons where serious mental health problems, doubts around patients’ capacity to give or withhold consent, and behaviour likely to result in serious harm to self or to others can all come together. Particular issues covered by this guidance include:
  - the right of a competent adult patient to refuse treatment
  - the assessment of ‘competence’ (also known as ‘capacity’)
  - the circumstances in which patients who lack capacity can receive treatment

- the position of young people
- dealing with violent or threatening behaviour, where patients may also have associated health problems
- Self-harm and food refusal

1.6 The guidance in this booklet is based on the current common law. Where patients are detained in hospital under the *Mental Health (Northern Ireland) Order 1986*, different provisions will apply. However, the provisions the Order which relate to compulsory treatment in hospitals do not apply in prisons. Where a patient has a serious mental disorder which requires detention and treatment under the *Mental Health (Northern Ireland) Order 1986*, it is important that the patient is transferred out of prison to an appropriate hospital as soon as possible.

### 2. PROVIDING CARE FOR COMPETENT ADULT PRISONERS

- 2.1 Before you provide treatment for a patient, you should ensure that you have their consent to do so. For a patient's consent to be valid, the person must:
- have the capacity (be 'competent') to take that particular decision
  - be acting voluntarily (not under duress from anyone)
  - be provided with enough information to enable them to make the decision
- 2.2 The law presumes that an adult (person aged 18 and over) has the capacity to take his/her own healthcare decisions unless the opposite is proved. It is important not to underestimate the capacity of a patient with a learning disability or other cognitive impairment to understand. Many people with learning disabilities have the capacity to consent if time is spent explaining to the individual the issue in plain language, using visual aids and signing if necessary. Further guidance is set out in the Department's booklet *Seeking consent: Working with people with learning disabilities*.
- 2.3 Seeking consent should usually be seen as a *process*, not a one-off event. People who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point if they still have the capacity (are 'competent') to do so. Similarly, they can change their minds and consent to an intervention which they have earlier refused. It is important to let each person know this, so that they feel able to tell you if they change their mind.
- 2.4 Legally, it makes no difference whether people sign a form to indicate their consent, or whether they give consent orally or even

non-verbally (for example by holding out an arm for blood pressure to be taken). A consent form is only a record, not proof that genuine consent has been given. It is good practice to seek written consent if treatment is complex, or involves significant risk or side effects. If the person has the capacity to consent to treatment for which consent is usual but cannot write or is physically unable to sign a form, a record that the person has given oral or non-verbal consent should be made in their medical records (IMR).

- 2.5 People with the capacity to take a particular decision are entitled to refuse any treatment being offered, even if this will clearly be detrimental to their health. No competent adult (defined as a person aged 18 or over) can be treated against his or her will.
- 2.6 Competent adults can refuse any treatment. The only circumstance in which this would not apply is where treatment is being provided for mental disorder, under certain articles of the *Mental Health (Northern Ireland) Order 1986*. However, these powers can only be used where a patient is detained in hospital, and prison health care centres are not regarded as 'hospitals' for this purpose. Compulsory treatment under the *Mental Health (Northern Ireland) Order 1986* can therefore only be provided after the patient has been transferred to an appropriate HPSS hospital, under a relevant article of the Order.

## Does the person have capacity?

- 2.7 If you have any doubts as to whether your patient has the capacity to take a particular healthcare decision, you or an appropriate colleague should assess the capacity of the person to take the decision in question. This assessment and the conclusions drawn from it should be recorded in the prisoner's medical records. More detailed advice about assessing capacity is given at Annex 1.
- 2.8 For people to have the capacity to take a particular decision, they must be able to:
  - understand and retain:

- information material to the decision
  - especially as to the consequences of having or not having the intervention in question: and
  - use and weigh this information in the decision-making process
- 2.9 Some people may therefore have capacity to consent to some interventions but not to others. A prisoner with a moderate learning disability, for example, would probably have the capacity to make many straightforward decisions about their own care (such as having a tooth extracted) but might lack capacity to take very complex decisions. It should not be assumed that people can take no decisions for themselves, just because they have been unable to take a particular decision in the past. A person's capacity may also fluctuate: they may be able to take a particular decision one day even if they had not been able to take it the day before.
- 2.10 At times, where a prisoner is highly disturbed or violent, it may simply not be possible to make a reasoned assessment of their capacity. In such cases, where you have some reason to believe that they may lack capacity, you may have no choice but to assume incapacity until such time as the patient is calm enough for you to make a more in-depth judgment. It is important to remember, however, that you are professionally accountable for such decisions and should be able to justify at a later date on what evidence you based both your assumption of incapacity and any subsequent treatment.

## **What information do people need?**

- 2.11 People need enough information before they can decide whether to consent to, or refuse, treatment. In particular, they need information about:
- the benefits and the risks of the proposed treatment
  - what the treatment will involve
  - what the implications of not having the treatment are
  - what alternatives there may be



- what the practical effects on their lives of having, or not having, the treatment will be.
- 2.12 It is important that this information is provided in a form that the particular person can understand. This may involve using interpreters, where the person's first language is not English, and offering information in a variety of forms depending on the person's needs and abilities. It may also involve the use of independent advocates. Staff should be mindful that it will usually be inappropriate to use relatives in the role of interpreter, and professional interpreters should be sought.

### **Is the person's decision made voluntary?**

- 2.13 It is very important to ensure that the person's decision is truly their own. Clearly, you and your colleagues have a role to play in discussing the options and providing appropriate reassurance, but you should take care that prisoners do not feel forced into making healthcare decisions because of pressure (perceived or real) from others. It is never acceptable to attempt to coerce a patient, for example by implying that a decision to give or withhold consent to treatment could affect their privileges or remission of sentence.

### **Consent to participate in clinical trials**

- 2.14 People in prison should only be invited to participate in clinical trials for their own health or benefit. All clinical trials should have ethical consent. Participation in any trial should not involve anything that could be considered or interpreted as reward or coercion. People should have ready access to independent information to allow them to decide if they will participate in a trial.

### 3. ADULTS WITHOUT CAPACITY

#### General Points

- 3.1 Even where information is presented as simply and clearly as possible, some people will not be capable of taking some decisions. In the prison context, it may apply to some prisoners with mental health problems and to some with learning disabilities, although a mental health problem or a learning disability is not in itself proof of incapacity. It may also apply where a prisoner is under the influence of drugs or alcohol, though again this may be different in different cases.
- 3.2 If a person is *not* capable of giving or refusing consent, it is still possible for you lawfully to provide treatment and care, unless the patient has clearly refused that care in advance. However, any treatment or care provided must be in the person's "best interests" (see below).
- 3.3 No-one (not even a spouse or close relative) can give consent on behalf of adults who are not capable of giving consent for themselves. However, those close to the incapacitated person should ideally be involved in decision-making unless the person has made it clear that they don't want such involvement.

#### Advance Directives

- 3.4 Sometimes people may have expressed clear views in the past as to how they would like to be treated if in future they were to lose capacity. Such views may have been expressed orally or in writing as "advance directives" or "living wills". Advance directives may take two forms: they may explicitly refuse particular treatment (when they are sometimes known as advance directives or living

wills), or they may spell out the kind of care a person would wish to receive in certain circumstances.

- 3.5 If a person makes an advance *refusal* of certain kinds of treatment, then such a refusal is legally binding if at the time of making the decision the individual was competent, they understood in broad terms the implications of their decision, and the refusal is applicable to their current situation. Advance directives setting out the kind of care the person would like to receive are not legally binding, but are influential when deciding what treatment is in the person's best interests.

## Best interests

- 3.6 The courts have made clear that a person's "best interests" are not limited to what would benefit them medically. Other factors, such as the views and beliefs that they held before they lost capacity, their general well-being, their relationships with those close to them, and their spiritual and religious welfare, should all be taken into account. Moreover, people who lack capacity to consent to, or refuse, a particular treatment option may still express willingness or unwillingness to co-operate with what is being offered. Such preferences form an important part of deciding whether the proposed care or treatment is genuinely in the patient's best interests.

## Responsibility for decision-making

- 3.7 Decisions relating to a patient's capacity to give or withhold consent to treatment, and determining what is in the best interests of a person lacking capacity to consent are a matter for the responsible treating doctor (or nurse officer or healthcare officer if an emergency arises and a doctor is not available). This decision should be made in consultation with any other members of the healthcare team who are on duty at the time. Nurse officers and healthcare officers would be expected to take all action to preserve life or health within their sphere of competence while seeking to obtain advice and where relevant attendance of a suitably qualified person. In considering the patient's capacity and his/her best interests, the treating doctor should review all

relevant information about the patient's medical history as s/he can reasonably obtain in the time available. S/he should also seek the views of colleagues who know the patient well, such as probation officers, prison officers as well as other healthcare staff. If they are in any doubt as to the patient's capacity or best interests, you should obtain a second opinion from another doctor, prior to treatment, unless the urgency of the situation genuinely prevents this. In the case of patients with suspected mental health problems, the second opinion doctor should be a consultant psychiatrist appointed for the purpose of Part II of *Mental Health (Northern Ireland) Order 1986*.

- 3.8 It is very important that after any treatment given without consent, the patient's condition should be monitored, with a view to deciding what should happen next. It may be that after initial treatment, a prisoner who did not previously have capacity regains that capacity to give or withhold consent for continuing treatment. A doctor should go through the capacity assessment each time treatment of an unwilling prisoner is being considered, even if the prisoner has been assessed as having, or not having had, capacity in the recent past. Capacity may fluctuate, and different degrees of capacity are needed for more or less complex decisions.

## How and where care can best be provided

- 3.9 When considering what treatment would be in an incapacitated patient's best interests, it may be the case that the patient would be more beneficially treated in the HPSS, and a suitable transfer would be more appropriate.

### 4. CHILDREN AND YOUNG PEOPLE

- 4.1 More detailed advice on the law on consent as it relates to children and young people (aged less than 18 years) is found in Chapter 3 of the *Reference Guide* (see para 1.1 for details).
- 4.2 In order to provide treatment for a child or young person, you need consent in the same way as you do for an adult. A person with 'parental responsibility' for a child or young person (see below) retains the right to give consent on his/her behalf until his/her 18th birthday. However, children and young people also acquire the right to consent for themselves as they get older. This means that in some circumstances, both the child/young person and a person with parental responsibility are in a position to give consent. Treatment will be lawful if at least one of these people gives consent, even if the other refuses. However, it will rarely be appropriate to give treatment to a child or young person who is able to give consent for themselves but is refusing it, even if their parents consent. If agreement cannot be reached and the consequences of the child's refusal are serious, ultimately a court can be asked to decide.
- 4.3 Young people aged 16 or 17 are entitled to consent to their own medical treatment, by virtue of section 4 of the *Age of Majority Act (Northern Ireland) 1969*. In the same way as adults, they are supposed to be competent to give consent, unless the opposite is demonstrated.
- 4.4 The courts have also held that children under 16 who have "sufficient understanding and intelligence to enable them to understand fully what is proposed" will have the capacity to consent to that intervention. This may mean that a child has capacity to consent to one intervention, but not to another, since

the degree of understanding and maturity necessary for such a decision will vary depending on what treatment is proposed.

4.5 People who may have parental responsibility include the following:

- the child's parents if married to each other at the time of conception or birth;
- for children born before 15 April 2002 the child's mother, but not father if they were not married at the time of the child's birth *unless* the father has acquired parental responsibility via a court order or a parental responsibility agreement, or the couple subsequently marry;
- for children born to unmarried parents on or after 15 April 2002, the child's parents if they jointly registered the child's birth, so that the father's name appears on the birth certificate. Otherwise the child's mother only, *unless* the father has acquired parental responsibility via a court order or a parental responsibility agreement or the couple subsequently marry;
- the child's legally appointed guardian;
- a person in whose favour the court has made a residence order concerning the child;
- a Health and Social Services Trust designated in a care order in respect of the child (this excludes children being looked after under Article 21 of the *Children (Northern Ireland) Order 1995* who are "accommodated" on a voluntary basis and for whom the Health and Social Services Trust does not have parental responsibility);
- a Health and Social Services Trust who holds an emergency protection order in respect of the child

It is important to note that detention in custody does not itself affect the ability of a parent to make consent to treatment decisions on behalf of the children.

4.6 Where contact with a person with parental responsibility establishes that they are not competent themselves to give or withhold consent on the child or young person's behalf, efforts should be made to contact anyone else who may also have parental responsibility.

### 5. RESTRAINT AND MANAGEMENT OF PRISONERS

- 5.1 Control and Restraints Manuals set out the requirements and procedures for dealing with prisoners when there are restraint and control implications alongside health needs. To achieve the best outcomes, it is important that health care and non-healthcare staff work together to address both areas of need. Interventions for the purposes of maintaining good order or discipline (ie control and restraint, segregation, mechanical restraint, and special accommodation) fall to both healthcare and non-healthcare staff and are governed by the provisions of standing orders.
- 5.2 In practice, many violent incidents happen without warning. It is often not known at the time whether or not there is a medical aspect to such incidents. The priority must always be to control the situation, and then to consider what may have contributed to it arising.

### 6. SELF-HARM AND FOOD REFUSAL

#### Self-harm: Consent to treatment aspects

- 6.1 Inmates Suicide and Awareness and Prevention Manual (IG5/96) sets out the procedures to follow in cases of self-harm. Capacity to consent to treatment must be assessed before any question of medically treating the person against their will is considered. If the patient is judged not to have capacity, and provided they have not made a valid and applicable advance directive, they may be treated in their best interests on the basis of having temporary incapacity.
- 6.2 Adults with capacity have the right to refuse life-sustaining treatment, both at the time it is offered, and – by making an advance directive – in the future. As stated in the introduction of this guidance, staff in prison healthcare centres do not have any powers to treat patients without their consent under the *Mental Health (Northern Ireland) Order 1986*. They cannot therefore administer compulsory treatment to patients with capacity to refuse treatment. Where a mentally disordered patient, with capacity to make such a decision, refuses treatment, this refusal should be respected either until they have been transferred to an HPSS psychiatric facility, or until you believe that the patient no longer has capacity to withhold consent (assuming that the patient did not in the meantime make a valid advance refusal of treatment).

#### Food refusal: Consent to treatment aspects

- 6.3 Standing Orders set out procedures to follow in cases of food refusal.



- 6.4 A patient who is currently competent may make an advance directive to cover him/herself for a time when he/she may have lost competence, as in 6.2 above.
- 6.5 If a competent patient has made an advance directive, whilst they remain competent their views should be monitored to ensure that the directive continues to reflect their wishes for their future treatment when they have lost competence. A competent patient may withdraw or amend any advance directive that person has previously made.
- 6.6 An exception to adherence to an advance directive occurs where food refusal is clearly related to a mental disorder, following which compulsory treatment under the *Mental Health (Northern Ireland) Order 1986* can take place – including administration of artificial nutrition and hydration. Such compulsory treatment of competent patients (or those who have lost competence, but who made advance directives whilst competent) can only take place in a hospital setting under the terms of the *Mental Health (Northern Ireland) Order 1986*.
- 6.7 Where a patient is refusing food, is judged to lack capacity, and has not made an advance directive, doctors must consider administering whatever treatment is in the patient's best interests. It would be appropriate in these circumstances to try and arrange for the patient to be transferred to an HPSS hospital both for treatment, and for further observation and assessment. If the patient has a serious mental disorder, there would also be the option of transferring them to a hospital for treatment under the *Mental Health (Northern Ireland) Order 1986*.

### 7. EXAMPLES

A number of examples are given to illustrate the general principles of consent. They are not intended to provide guidance on specific cases but to enable you to assess how the issue of consent may affect your work with people in prison. Consent **MUST** be assessed on an individual basis.

#### Example 1

An adult with insulin-dependent diabetes is protesting at his sentence, and is refusing to take his usual medication. The psychiatrist states that there are no signs of mental illness. Both you, as the duty medical officer, and the psychiatrist believe that the prisoner has the capacity to make decisions about his medication: he understands and acknowledges the effect that the absence of insulin will have on his health, but states that he holds by his decision to refuse it. You **cannot** force him to take his insulin. You can, however, assist him in accessing other legitimate means of protest and ensure that he knows he can change his mind and accept medication at any point.

#### Example 2

You have been called to see a patient with an established history of psychosis. The patient is refusing all treatment. In your judgment, the patient lacks capacity to accept or refuse treatment. You believe that medication will be in the patient's best interests as in the past when psychotic the patient has tried to mutilate himself. You may therefore lawfully give this treatment, if necessary restraining the patient to do so. However, you should consult with the psychiatrist on the patient's management as soon as you can and you must reassess the patient's capacity on each future occasion before giving repeat

medication. If on any occasion you believe that the patient now has the capacity to understand the implications of having or not having treatment, you must abide by their treatment choice. If you believe that the patient's condition is likely to deteriorate so that treatment without consent will again become necessary within this episode of psychosis, you must do all you can to arrange a transfer to hospital under the *Mental Health Order (Northern Ireland) Order 1986*.

### **Example 3**

You are faced with exactly the same scenario as in Example 2. However, on this occasion you are aware that the patient has signed a 'living will', explicitly refusing any medication for his medical disorder, should he lose capacity as a result of his condition. The law does not permit you to treat him against his will. He can only be treated without his consent if he is transferred to hospital under the *Mental Health (Northern Ireland) Order 1986*.

### **Example 4**

You, as duty medical officer, are called to the Special Supervision Unit to see a new inmate with a largely unknown medical history who became exceedingly violent on normal location. It has taken 8 officers using control and restraint techniques to move him to special accommodation where he is trying to break or attack anything within reach. It is not possible to have any kind of conversation with him.

It is quite feasible that the prisoner's violence and distress is at least partly a result of drug-use or an untreated mental illness. It is clearly impossible to make a reasoned assessment of his capacity to make healthcare decisions by exploring his verbal responses. You believe that his behaviour in attempting to strike non-existent objects and his apparent responses to hearing hallucinated voices are sufficient to justify your belief that it is highly likely that he currently lacks capacity to make any treatment decisions. You also believe that particular medication is in his best interests. You may therefore provide this treatment.

In order for you to treat him, it is necessary to hold him down physically.

After this initial treatment, you must take urgent action to find out more about his past medical history and to contact a psychiatrist for advice on possible mental illness. If you continue to believe that treatment without his consent is necessary, you must consider on each occasion whether he does or does not at that point have the capacity to make his own healthcare decisions. If at some future point, you determine that he *does* have the capacity to refuse any treatment, then you cannot provide it unless he consents. If he continues to be violent in these circumstances, it is for non-healthcare staff to take responsibility for making decisions about any restraint necessary for the purposes of good order or discipline. If the medical information you obtain about him and the opinion of the psychiatrist suggest that he has a severe mental illness which requires detention under the *Mental Health (Northern Ireland) Order 1986*, you should take steps to arrange an assessment for his appropriate transfer.

### **8. FURTHER SOURCES OF GUIDANCE AND INFORMATION**

- 8.1 Details of the law on which this guidance is based are given in the Department of Health Social Services and Public Safety's Reference Guide to Consent for Examination, Treatment available at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)
- 8.2 General Medical Council, Seeking patients' consent: the ethical considerations (1998) GMC: London. ([www.gmc-uk.org](http://www.gmc-uk.org))

### FURTHER ADVICE ON CAPACITY

It is very easy for an assessment of capacity to be affected by apparently conflicting demands, such as the needs of other prisoners and staff, or by the attitude of the person carrying out the assessment. It is your professional responsibility to ensure that you make as objective a judgement as you can, based on the principle that the person should be assisted to make their own healthcare decisions if at all possible. Where the patient is exhibiting violent or anti-social behaviour but you have no reason to believe they lack capacity, you cannot provide treatment against their will. If restraint is necessary in these circumstances, it should be provided under the Control and Restraint Manual provisions and not under the guise of medical treatment.

The Courts have stated that for people to have the capacity to take a particular decision, they must be able to:

- comprehend and retain:
  - information material to the decision;
  - especially as to the consequences of having or not having the intervention in question; and
- use and weigh this information in the decision-making process.

Methods of assessing comprehension and ability to use information to make a choice include:

- exploring the patient's ability to paraphrase what has been said (repeating and rewording explanations as necessary);

- exploring whether the patient is able to compare alternatives, or to express any thoughts on possible consequences other than those which you have disclosed;
- exploring whether the patient applies the information to his or her own case.

When making an assessment of capacity, it is good practice to ensure you have as much information about the patient's medical history as you can reasonably obtain in the time available and access to an interpreter if appropriate. You should be mindful that it may not be appropriate to use relatives in the role of interpreter. You should also seek the views of colleagues who know the patient well, such as probation officers, and prison officers, as well as other healthcare staff.

Guidance issued by the British Medical Association and The Law Society in 2004, *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* suggests that, where capacity is affected by a mental health problem, it is good practice to express the diagnosis in terms of one of the accepted international classifications of mental disorders (WHO International Classification of Diseases or the American Psychiatric Association Diagnostic and Statistical Manual), and that account should be taken of the following factors when considering the extent to which mental state might be affecting a patient's capacity:

### Appearance and behaviour

- Agitation and over-activity may make it impossible to impart relevant information.
- Appearance and behaviour may also suggest mood disorder or cognitive abnormality.

### Speech

- Examples of difficulties in communication, or abnormality in thought processes, evident from speech include:
  - lack of speech in a depressed patient;

- tangentially linked, high speed utterances in a hypomanic patient;
- 'knights move' thinking in patients with schizophrenia.

## Mood

- Depression and hypomania may distort perception of the future.
- Liability of mood may result in patients being unable to stick with decisions once made.

## Thought

- Strongly held delusions or overvalued ideas may distort ability to make a decision.

## Perception

- Hallucinations may reinforce delusions.
- Content of auditory hallucinations may interfere with ability to think about relevant issues.
- Constant presence of auditory hallucinations may distract thinking.
- Hallucinations are less likely to cause lack of capacity if the patient knows that the hallucinations are not "real".

## Cognition

- Attention and concentration are necessary for effective thought.
- High levels of distraction (eg by hallucinations) can impair cognition.



## Memory

- Essential for logical manipulation of concepts.
- Short-term memory deficit can impair capacity.
- Long-term memory deficit (memory of remote events) is less likely to impair capacity.

## Intelligence

- Great care must be taken not to presume incapacity just because a person has learning difficulties. Examine the ability of the person specifically in relation to the decision in question.

## Orientation

- Impaired awareness of time, place and person can indicate severe brain dysfunction, which might inhibit capacity.

## Insight

- People can lack insight in one area of their lives, and retain it for others. The BMA advises that no medical report should ever read “has insight” or “has not insight” – the lack of evidence for the opinion makes such statements valueless.

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