

Mitigating the risk of assumptions and biases in assessments of mental capacity

A brief for policy makers and health and social care
professionals

Health and social care professionals routinely assess the capacity of people to make decisions about their lives, in accordance with the Mental Capacity Act 2005 (MCA). This briefing note outlines how the functional approach to assessing capacity in the MCA underdetermines decisions concerning mental capacity, and describes the risk that stereotypes and assumptions will affect outcomes. It advocates for the need for specific training for professionals using the MCA to enable them to recognise the role of value judgements in capacity assessments, and to enact strategies to mitigate the effects of stereotypes and assumptions.

Away from the status approach...

In some jurisdictions, the presence of a psychiatric or neurodivergent diagnosis is sufficient to authorise health and social care professionals to intervene in a person's life (for instance, administering treatment without consent) on the grounds of the risk the person is thought to pose to their own health or safety.¹ This is known as the "status" approach, according to which the presence of the diagnosis means that the person is not in a position to decide for themselves, and so there is no need to assess the person's decision-making ability.² This approach has been widely criticised because the mere presence of a diagnosis does not mean that a person is unable to make decisions concerning medical treatment or care for themselves.³ Further, there is no special sort of irrationality present in people experiencing mental health problems that is not also present, to an extent, in people without such experiences (see Segment 1 & 2).

...to a functional approach

The MCA rejects the notion that a diagnosis is sufficient to determine whether or not a person has the capacity to make decisions, and aims instead to assess the person's decision-making abilities.⁴ A person is considered to lack the capacity to make a decision about an aspect of their life or treatment at a particular time if they are unable to understand, retain, use or weigh information relevant to that decision, or communicate their choice, and this is judged to be the result of a mental impairment.⁵ A capacity assessment has three components: (1) a diagnostic component (which considers whether there is an impairment or disturbance), (2) a functional component (which considers whether the person is unable

to make a decision), and (3) a causative nexus (which considers whether the inability is there *because* of the identified impairment or disturbance).⁶

All practicable steps must be taken to help the person make their own decision before they can be deemed unable to decide; and if the person is found to lack capacity, any decisions taken on their behalf must result in the least restrictive option, and be in their best interests, as defined by the Act. A recent Amendment to the MCA affords updated safeguards designed to ensure that people who are found to lack the capacity to consent to their care arrangements are protected if those arrangements deprive them of their liberty.⁷

Capacity can be assessed in practice by using a semi-structured interview which provides the person with information relevant to the decision. One study shows there is a high level of agreement between practitioners administering these sorts of assessments.⁸ However, capacity decisions have been disputed, by the individuals whose capacity is in question, their families, and bodies with caring responsibility when there are disagreements between professionals, which are resolved in the Court of Protection, a specialist court created by the MCA⁹ (see Segment 3).

Segment 1: The continuity between “normal” and “abnormal” cognition

Some social practices embed the notion that there is a particular kind of severe irrationality associated with mental illness, which is reflected in some of the language of psychiatric classification and diagnosis. Researchers from project PERFECT (based in the University of Birmingham) investigated all kinds of beliefs and found that the irrationality present in people who attract psychiatric diagnoses is not different in kind from the irrationality present in the non-clinical population. All human agents routinely exhibit inconsistent preferences, make reasoning mistakes, and have beliefs that are either badly supported by evidence or resistant to counter-evidence.¹⁰ Recognising the continuity between so-called “normal” and “abnormal” cognition renders episodes of mental distress more understandable to those who do not experience them directly, and helps dispel the assumption that irrationality is an exclusive feature of mental illness.¹¹

Segment 2: Irrational beliefs can have some short-term psychological benefits.

Researchers from Project PERFECT found that, whilst irrational beliefs have costs as they may compromise understanding of the self and of reality, they can also have short-term benefits, and enhance motivation, increase sociability, or improve information retention and exchange in some contexts, whether or not they are accompanied by mental distress.¹² Project PERFECT emphasises how irrational beliefs in the clinical and non-clinical population can be at the same time false and useful, for instance, by supporting a unified and coherent sense of agency. This invites caution in how irrational beliefs are managed: challenging and confronting apparently irrational beliefs while they play a useful function is not always advisable.

The problem of underdetermination

Within the process of assessing mental capacity under the MCA, the necessary decision-making abilities are open to interpretation. For instance, diagnostic tools do not conclusively establish what counts as ‘using or weighing information’.¹³ To illustrate this problem of underdetermination, consider this thought experiment from Natalie Banner:

“Say I were to tell a person standing at a set of traffic lights that a lorry was hurtling along the road ignoring red lights, and I have every reason to believe he understands my utterances. He then proceeds to step directly into the lorry’s oncoming path. Without being able to delve into his reasoning, I would judge that this person had failed to use or weigh the information I had given him, because he did not respond to that information in the way that he ought to (taken with the assumption that he had an interest in preserving his own life).”¹⁴

The point of this example is that an observer’s judgement of whether a person is “using or weighing” information depends on whether that information is perceived by the observer as being used in the right way, and is making the right kind of difference to an end choice – a judgement that is often arrived at by making assumptions about that person’s aims.

It has been emphasised in case law that a person cannot be considered to be unable to use or weigh information simply on the basis that they have applied their own values and chosen to attach no weight to that information in the decision-making process.¹⁵ But in other cases, patients who do this may still be found to lack capacity on account of being deemed to have failed to use or weigh information. In one case, a patient with a diagnosis of chronic depression and borderline personality disorder, gave a clear and rigorous articulation of her reasons for refusing to eat, an action which was endangering her life. A judge ruled that ‘It is... this very self-awareness and acute self-analysis which leads me to doubt whether, at the critical time, she could be said to have made a true choice in refusing to eat.’¹⁶ This led to compulsory treatment. The ability of individuals with anorexia to articulate clear and insightful reasons for their choices has not prevented them from being found to lack capacity to refuse treatment.¹⁷

This is not to suggest that assessment outcomes are wrong in these cases, but that the outcomes depend on whether the observer thinks information is making the *right* sort of difference to the person’s decision, which depends on what the observer thinks is valuable. As such, the observer’s values, which themselves are factors beyond the procedural criteria, influence the end result.¹⁸ Whilst there is a Code of Practice for the MCA, and relevant professional bodies have codes of ethics to guide practice, these offer guiding principles, rather than definitive answers to individual cases in which observers may come to different opinions on account of prioritising different values.¹⁹

The risk of stereotypes and assumptions

Multiple studies show that human decision making is susceptible to the influence of irrelevant factors and preconceptions, which can lead to suboptimal reasoning, especially in conditions of uncertainty, and where there is room for interpretation.²⁰ Of particular interest are implicit social biases. Researchers have described these as “fast, automatic and difficult to control processes that encode stereotypes and evaluative content, and influence how we think and behave”.²¹ Multiple studies show that people with psychiatric diagnoses are associated with concepts such as dangerousness, incompetence, unpredictability or helplessness, more strongly than other people, as well as showing that people harbour negative implicit biases toward those with intellectual disabilities.²² In a further study, participants who read written descriptions of individuals which differ *only* for whether the person is described as having a learning disability, perceive those with such a description as less emotionally stable than those without it.²³ Research shows people harbour negative

implicit biases against members of other marginalised groups (for example, people of colour, women, and those with physical disabilities).²⁴

These associations can become activated and affect our interactions with a person with the diagnosis (or social attributes), *regardless* of whether we have any reason to believe they will exhibit any of these behaviours or characteristics. Research shows that people are more likely to notice, remember, and place importance on information about an individual that is consistent with social stereotypes than information that is inconsistent, and that this occurs in assessments of skills and abilities.²⁵ For instance, in an experiment in which participants aim to hire the best candidate for the role of police chief, men rate particular qualifications as more relevant to the job when they are had by male candidates as opposed to when they are had by female candidates.²⁶

Implicit biases have been shown to affect medical professionals,²⁷ including medical students with no direct experience of people with mental health problems,²⁸ and also arise in educational and legal settings.²⁹ For example, research into mental healthcare professionals from a organisation specialising in providing psychosocial care, recovery-based supported accommodation, and outreach for people affected by mental illness, showed that those found to have higher levels of negative implicit bias report they would be less certain to help a person with a mental illness.³⁰ A further study comprising 407 professional clinicians and 275 clinical psychology graduates, showed that those with negative implicit biases are more likely to overdiagnose.³¹ Stereotyping can lead to stigma and unwarranted assumptions, and people with lived experience of mental health problems describe the stigma arising from stereotyping encountered in everyday life as worse than the mental illness and distress itself.³² For some, the effect is compounded: people who are members of more than one marginalised group experience discrimination in relation to multiple dimensions of their identity.

As discussed above, assessments of mental capacity according to the MCA are not wholly determined by procedural criteria, and so there is the possibility for stereotypes and assumptions to influence outcomes. This risk exists at the level of (a) deciding how to communicate information relevant to a treatment decision before assessing capacity; (b) interpreting the assessment criteria (such as the ability to use or weigh information); and (c) deciding what counts as being in the best interests of the individual if it is found that the person lacks the capacity to make a decision. Stereotyping occurs when concepts relating to illness and diagnosis are made salient, and so removing the opportunity to think about these concepts when they are not immediately relevant to an assessment is one way to mitigate the influence of stereotypes. However, the risk is likely to be exacerbated given that the diagnostic aspect of the assessment proceeds the functional aspect, and therefore, stereotypes relating to diagnostic categories have been primed, making them more likely to affect judgements in the subsequent functional aspect of the assessment, such as the judgement of whether the individual is using or weighing information.

A recent report by NICE found that various stakeholders experienced assumptions being made about an individuals' capacity, particularly those with intellectual disabilities, dementia, or who were in long term residential care.³³ What it means to take "all practicable steps" to provide a patient with information relevant to a decision is also open

to interpretation, and will involve different approaches for different patients. For instance, those with intellectual disabilities selectively attend to visual information, and research shows that using picture books enables these patients to better participate in decisions about their treatment and lives, but such methods are not used universally.³⁴ The NICE report cautions that “people may not be receiving care they would have chosen had they been supported and given the opportunity to express their preferences”.³⁵

Segment 3: Different interpretations of evidence of (in)capacity

One case that reached the Court of Protection in 2016 concerned the capacity of a young woman “Z” with a diagnosis of learning disability and autism spectrum disorder, regarding the decisions of where to live, what care to receive, and what contact to have with others.³⁶ In a divergence from the conclusion of an independent expert, the judge concluded that Z had capacity, saying: “Having read the [expert] reports several times, with care, I was left unsure that I had received a complete or rounded picture of what Z was saying; some of Z’s specific responses were included to illustrate the expert opinion that she lacked capacity, but on my reading of them could just as easily have shown merely naivety, immaturity, diffidence, or embarrassment. That naivety, immaturity, diffidence or embarrassment may well not translate into (or necessarily evidence) a lack of capacity. It was, in the circumstances, particularly valuable to have the chance to hear from Z myself, and form an assessment of her, assisted by Dr. Rippon’s expertise, when Z herself gave evidence in court at the hearing”.³⁷

A case study: Do values play a part in establishing mental incapacity standards?

This section explores research by Jillian Craigie and Ailsa Davies into two conditions which both involve control-deficits, to which it was argued that the MCA is applied differentially.

The MCA doesn’t explicitly refer to the notion of control, but an analysis of case law in England and Wales shows it has been interpreted in a way that allows control problems to be taken into account.³⁸ Research has suggested that anorexia involves a compromised ability to control behaviours relating to eating.³⁹ An analysis of case law reveals that impaired control is often a central justification for findings of incapacity in anorexia in relation to treatment decisions.⁴⁰

Even though the MCA doesn’t refer to substance dependence, Lady Hale has made clear that a person who is substance dependent “will be impaired or disturbed” in the sense relevant for incapacity.⁴¹ Indeed, abnormal mental function is closely tied to a diagnosis of alcohol dependency and so it seems the latter can be the basis for mental incapacity.⁴² However, researchers found no evidence that alcohol dependency is accepted as grounds for mental incapacity in relation to treatment decisions about the condition; and only little evidence of the issue being considered at all.⁴³ Indeed, one expert gave evidence that “however chronic the alcoholism, an alcoholic always had a choice whether to drink.”⁴⁴

One case, *A NHS Foundation Trust v Ms X*, found the same individual, Ms X, lacked capacity as regards decisions relating to her anorexia, but had capacity as regards her alcoholism. Commenting on the ruling, the researchers say “It is puzzling... that the main countervailing reason cited by the Court was the calorific content of alcohol. The experts and Court were firmly of the opinion that Ms X’s fear of weight gain resulted in a mental incapacity in relation to her anorexia. The fact that this same consideration played a role in her decisions about drinking does not therefore seem like good evidence that she retained sufficient control—understood as an ability to weigh—in relation to her drinking.”⁴⁵

The researchers argue that the divergent findings regarding the MCA’s application in the context of alcohol dependence and anorexia are due to evaluative factors shaping the interpretation and

implementation of incapacity assessments. Failures of control in substance dependence are seen as moral failures, absent in anorexia. Consider Lord Donaldson's judgment in a case regarding the refusal of treatment in anorexia: "Anorexia is an illness that is not the fault of the sufferer. In this it is no different from pneumonia or appendicitis... It is an addictive illness although, unlike other addictions such as drug taking, the sufferer is not to be blamed for having allowed herself to become addicted."^{46,47}

Recognising the role of assumptions and values in decision making

The Committee of the Convention on the Rights of Persons with Disabilities (CRPD) proposes that there is no naturally occurring phenomenon of capacity, and that judgements of whether a person has or lacks it are always contingent on social and political contexts.⁴⁸ It presses instead for a framework in which supported decision making ensures care and treatment issues are determined by the individual. Others point out that such a framework still faces difficulties in guaranteeing authentic decisions and protecting those in vulnerable positions, but also urge researchers and practitioners to actively involve disabled people in the deliberation of policies and laws relating to them.⁴⁹

Following the approach of the CRPD Committee, there is increasing interest in recognising the role of assumptions and values in decision making, and the risk that stereotypes can affect decisions. For instance, the *Judging Values and Participation in Mental Capacity Law* project⁵⁰ holds that remedies should not focus on *disengaging* from values-based decision making inherent in the MCA framework, but rather, encourage *active engagement* and *reflection* of this framework as part of good practice under the MCA. This not only helps foster greater transparency about how different reasons contribute to the procedural and substantive aspects of capacity and best interests deliberations, but also encourages critical reflection amongst practitioners regarding their personal and professional values that inevitably impact on such decisions, and thereby better promote the voice and participation of the individual in decision-making under the MCA.⁵¹

There is no quick remedy to ensure that the kind of value-judgements that are made in decisions of capacity are unaffected by implicit bias or unfounded assumptions, but some interventions are likely to make a positive impact. Firstly, in order to mitigate the effects of biases and assumptions, it is necessary to acquire an understanding of implicit biases and how they can shape judgements of people with a psychiatric diagnosis.⁵² It is also important to realise that broad assumptions about the irrationality of people who experience mental health problems are largely unfounded. However, research suggests that one-off interventions which focus on individual employee's attitudes have been found lacking in their long-term effectiveness.⁵³

Researchers from project PERFECT have developed a novel training model in the form of a series of workshops which aimed to:

- (1) promote understanding, encouraging people to reflect on both the theoretical and social bases for the assumptions and biases that are made about people with mental health problems;
- (2) focus primarily on examples and case studies, in order to stimulate debate, and to draw out underlying themes and models;

- (3) in groups comprising mental health professionals and people with lived experience, give the opportunity to all to share personal experiences in a safe environment and express ideas creatively, as individuals or groups.⁵⁴

This workshop series incorporates two elements which are associated with longer-term positive behavioural changes: (i) ongoing participation (six sessions occurring over as many weeks); (ii) meaningful engagement between people with different experiences of marginalisation, working towards a shared goal on equal footing.⁵⁵

Working with relevant stakeholders, we propose a similar model could be adapted for training professionals who are involved in mental capacity decisions, and could complement training that health and social care professionals currently receive.⁵⁶ The training would integrate several components:

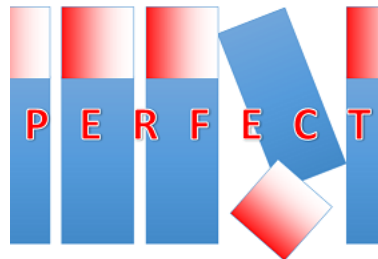
- Demonstrating that capacity assessments involve extra-procedural considerations, including value judgements.
- Exploring the concerns that may ground such value judgements (e.g. safeguarding, harm-reduction, or autonomy preservation) and reflecting on whether the concerns conflict and under what circumstances they might be valid or invalid.
- Discussing examples and case studies to show that extra-procedural considerations create the risk for biases and assumptions to affect decisions.
- Introducing a framework for monitoring and evaluating assessment practices in order to reduce the influence of biases and assumptions, tailored to specific practitioners.⁵⁷
 - This includes strategies to insulate the functional component of the assessment as much as possible from the influence of stereotypes relating to a particular diagnosis.
 - This reinforces the need to ensure that the wording of the Act (but not the current version of the Code of Practice) is followed, placing as it does the functional component of the assessment prior to the consideration of the diagnostic element.
 - This also reinforces the need for professionals to shield themselves as far as possible from diagnostic information during the functional assessment, in order to limit the activation of stereotypes associated with diagnostic concepts, and notions of illness and impairment more generally.

Such training could be delivered in the form of CPD days for practitioners, as well as in more agile formats, like online discussion-based training.⁵⁸

This briefing note has been prepared by Sophie Stammers and Lisa Bortolotti, researchers at the University of Birmingham, as part of Project PERFECT, see more at www.projectperfect.eu.



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Notes and References

¹ A note on descriptions in this brief: there are different frameworks for understanding the diagnoses and experiences described here, for instance: the medical model, which places emphasis on biological explanations and interventions; the Power Threat Meaning Framework, which locates understanding of distress in past trauma and social relationships; and the bio-psycho-social model, which emphasises a combination of interrelated factors. The authors of this note have included research and reports from a range of sources which assume different models, but they do not themselves take a position on which is correct, and instead encourage readers to adhere to the model they prefer, whilst observing how biases and assumptions arise in virtue of society's differential perceptions of individuals who are given psychiatric diagnoses or who are neurodivergent. Also see endnote 47.

² As discussed in Cairns, R., Maddock, C., et al. (2005). 'Reliability of Mental Capacity Assessments in Psychiatric In-Patients'. *British Journal of Psychiatry* 187 (4): 372–78., and for example in Saddichha, S. (2008). 'Who Decides on Treatment for Mental Illness?' *British Medical Journal* 337 (jul 22 3): a899–a899.; and Hewitt, J. (2010). 'Schizophrenia, Mental Capacity, and Rational Suicide'. *Theoretical Medicine and Bioethics* 31 (1): 63–77.; further examples in Craigie, J., and Bortolotti, L. (2015). 'Rationality, Diagnosis, and Patient Autonomy in Psychiatry'. *The Oxford Handbook of Psychiatric Ethics*. Edited by J. Z. Sadler, K. W. M. Fulford, and C. Werendly van Staden. Oxford: Oxford University Press., p. 395.

³ Department of Health (1999). 'Review of the Mental Health Act 1983 Report of the Expert Committee'. London: Department of Health; Szumkler, G. and Dawson, J.F. (2011). 'Reducing discrimination in mental health law— the "fusion" of incapacity and mental health legislation'. In *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects*, Edited by T. Kallert, J. Mezzich, and J. Monahan. Oxford: Wiley; Wildeman, S. (2013). 'Protecting rights and building capacities: Challenges of global mental health policy in light of the Convention on the Rights of Persons with Disabilities'. *Journal of Law, Medicine and Ethics* 41(1): 48–73., in Craigie and Bortolotti (2015) *op cit*.

⁴ Mental Capacity Act Code of Practice (2007). London: TSO. Section 4.2. Available online at <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>, in Banner, N. F. (2012). 'Unreasonable Reasons: Normative Judgements in the Assessment of Mental Capacity: Unreasonable Reasons'. *Journal of Evaluation in Clinical Practice* 18 (5): 1038–44.

⁵ Mental Capacity Act 2005, c 9. Section 3. Available online at: <http://www.legislation.gov.uk/ukpga/2005/9/contents> .

⁶ Ruck Keene, A., Butler-Cole, V., Allen, N., *et al.* (2014). “Mental Capacity Law Guidance Note: Capacity Assessments.” *ThirtyNine Essex*. Available online at: <http://www.39essex.com/docs/newsletters/capacityassessmentsguide31mar14.pdf> .

⁷ Mental Capacity (Amendment) Act 2019, c 18. Available online at: <http://www.legislation.gov.uk/ukpga/2019/18/contents/enacted> .

⁸ Cairns, *et al.* (2005). *op cit.*

⁹ Ruck Keene, A., and Kane, N. B. (2019). ‘Taking Capacity Seriously? Ten Years of Mental Capacity Disputes before England’s Court of Protection’. *International Journal of Law and Psychiatry* 62 (January): 56–76.

¹⁰ E.g. Stein, E. (1996). *Without Good Reason*. New York: Oxford University Press; Garb, H. (1998). *Studying the Clinician*. Washington, DC: American Psychological Association; in Craigie and Bortolotti (2015) *op cit.* p. 390-1.

¹¹ See Association for Child and Adolescent Mental Health. ‘In conversation... Philosophy of mind’. Podcast featuring Lisa Bortolotti, Sophie Stammers and Kathy Puddifoot. Available online at: <https://www.acamh.org/blog/philosophy-of-mind/>; and Bortolotti, L. (2019). ‘Irrational Beliefs’. University of Birmingham research video, 21 March. For scholarly outputs of Project PERFECT, most research is available open access here: <https://www.birmingham.ac.uk/generic/perfect/research/index.aspx>

¹² Bortolotti, L. (2020). *The Epistemic Innocence of Irrational Beliefs*. Oxford University Press.

¹³ Banner, N. F. (2012). ‘Unreasonable Reasons: Normative Judgements in the Assessment of Mental Capacity: Unreasonable Reasons’. *Journal of Evaluation in Clinical Practice* 18 (5): 1038–44., p. 1040).

¹⁴ Banner (2012) *ibid.*

¹⁵ Kings College Hospital NHS Foundation Trust v C & Anor (2015) EWCOP 80.

¹⁶ B v Croydon Health Authority (1995) 1 All ER 683 at 689., in Banner (2012), *op cit.*

¹⁷ Tan, J., Hope, T. (2008). ‘Treatment refusal in anorexia: a challenge to current concepts of capacity’. In *Empirical Ethics in Psychiatry*. Edited by G. Widdershoven, T. Hope and J. McMillan, pp. 187–211. Oxford: Oxford University Press; Tan, J., Stewart, A., *et al.* (2006). ‘Competence to make treatment decisions in anorexia nervosa: thinking processes and values’. *Philosophy, Psychiatry & Psychology* 13 (4), 267–282; Tan, J., Hope, T. *et al.* (2003). ‘Competence to refuse treatment in anorexia nervosa’. *International Journal of Law & Psychiatry* 26(6), 697–707; in Banner (2012), *op cit.*

¹⁸ Banner, N. F., and Szmukler, G. (2013). ““Radical Interpretation” and the Assessment of Decision-Making Capacity’. *Journal of Applied Philosophy* 30 (4): 379–94.

¹⁹ Mental Capacity Act Code of Practice (2007), *op cit.* (n.b. following the recent Amendment to the MCA, an updated code of practice is due to be published soon), and for example, for social workers: British Association of Social Workers (2014) *The Code of Ethics for Social Work*. Available online at www.basw.co.uk/codeofethics.

²⁰ For example see Gilovich, T. *et al.* (Eds.) (2002). *Heuristics and biases: The psychology of intuitive judgment*, Cambridge: Cambridge University Press; Tversky, A., and Kahneman, D. (1974). ‘Judgment under Uncertainty: Heuristics and Biases’. *Science* 185:4157, 1124-1131; Nickerson, R. (1998). ‘Confirmation Bias: A Ubiquitous Phenomenon in Many Guises.’ *Review of General Psychology* 2:2, 175–220.

²¹ Holroyd, J., Puddifoot, K. (2019). ‘Implicit Bias and Prejudice’. In M. Fricker, P.J. Graham, D. Henderson, *et al.* (Eds.) *Routledge Handbook of Social Epistemology*. Routledge, Chapter 30.

²² Rüsçh, N., Corrigan, P. W., et al. (2011). 'Automatic stereotyping against people with schizophrenia, schizoaffective and affective disorders'. *Psychiatry Research* 18, 34–39; Teachman, B. A., Wilson, J. G., et al. (2006). 'Implicit and explicit stigma of mental illness in diagnosed and healthy samples'. *Journal of Social and Clinical Psychology* 25, 75–95; see Puddifoot K. (forthcoming). 'Disclosure of Mental Health: Philosophical and Psychological Perspectives'. *Philosophy, Psychology and Psychiatry* for an overview. On intellectual disabilities, see Wilson, M. C., Scior, K. (2015) 'Implicit Attitudes towards People with Intellectual Disabilities: Their Relationship with Explicit Attitudes, Social Distance, Emotions and Contact'. *PLoS ONE* 10(9): e0137902. See also Taylor, B. (2017). *Decision Making, Assessment and Risk in Social Work*, London: Sage, chapter 5, for discussion of biases relevant to assessments made in social work.

²³ Lisle, K. and Wade, T. J (2013). 'Does the Presence of a Learning Disability Elicit a Stigmatization?'. *British Journal of Education, Society & Behavioural Science* 4(2): 211–225.

²⁴ Holroyd, J., Puddifoot, K. (2019). *op cit*.

²⁵ See Puddifoot, K. (forthcoming) *op cit.*, for an overview.

²⁶ Uhlmann, E. L., and Cohen, G. L. (2005). 'Constructed Criteria: Redefining Merit to Justify Discrimination.'. *Psychological Science* 16(6): 474–480.

²⁷ See Puddifoot, K. (2019). 'Stereotyping Patients.'. *Journal of Social Philosophy* 50 (1): 69–90.

²⁸ Kopera, M., Suszek, H., et al. (2015). 'Evaluating explicit and implicit stigma of mental illness in mental health professionals and medical students'. *Community Mental Health Journal* 51(5): 628–634, in Puddifoot (forthcoming) *op cit*.

²⁹ See Stammers, S. (2019). 'Improving knowledge acquisition and dissemination through technical interventions on cognitive biases'. *Educational Theory* 68 (6): 675–692; and Stammers, S. and Bunn, S., (2015) 'Unintentional Bias in Court'. POSTnotes POST-PN-0512, for overviews respectively.

³⁰ Brener, L., Rose, G., et al. (2013). 'Implicit attitudes, emotions, and helping intentions of mental health workers toward their clients'. *Journal of Nervous and Mental Disease* 201 (6): 460–3, in Puddifoot (forthcoming) *op cit*.

³¹ Peris, T. S., Teachman, B. A., et al. (2008). 'Implicit and explicit stigma of mental illness: Links to clinical care'. *Journal of Nervous and Mental Disease* 196 (10), 752–760., in Puddifoot (forthcoming) *op cit*.

³² Thornicroft G. (2017). *Shunned: Discrimination against People with Mental Illness*. Oxford; New York: Oxford University Press.

³³ National Institute for Health and Care Excellence (2020). 'Decision making and mental capacity.' In development [GID-QS10127], Available online at: <https://www.nice.org.uk/guidance/indevelopment/gid-qs10127>

³⁴ Mengoni, S.E., Gates, B., et al. (2016). 'Wordless intervention for people with epilepsy and learning disabilities (WIELD)', *British Medical Journal Open* 6 (11)., in Hollins, S., Carpenter, B., et al. (2017). 'Using Wordless Books to Support Clinical Consultations'. *The Journal of Mental Health Training, Education and Practice* 12 (4): 260–71.

³⁵ National Institute for Health and Care Excellence (2020). *op cit*.

³⁶ See overview and other cases in Ruck Keene et al. (2019) *op cit*.

³⁷ *WBC v Z*, para 41, in Ruck Keene et al. (2019) *op cit.*, p. 65.

³⁸ Craigie, J. and Davies, A. (2019). 'Problems of Control: Alcohol Dependence, Anorexia Nervosa, and the Flexible Interpretation of Mental Incapacity Tests'. *Medical Law Review* 27(2): 215–241., p. 220.

³⁹ E.g. Tan, J. *et al.*, (2006). 'Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values.' *Philosophy, Psychiatry and Psychology* 13(4): 267–282; Szmukler, G., Tantam, D. (1984). 'Anorexia Nervosa: Starvation Dependence.' *British Journal of Medical Psychology* 57(4): 303–310; in Craigie and Davies (2019) *op cit.*, p. 223.

⁴⁰ For example, in cases *Re W, A LA v E* and *B v Croydon HA*; in Craigie and Davies (2019) *op cit.*

⁴¹ Hale, B. (2010). *Mental Health Law* (5th edition), Thomson Reuters 63; in Craigie and Davies (2019) *op cit.* p., p. 220).

⁴² Craigie and Davies (2019) *op cit.*, p. 233.

⁴³ Searches were via the Westlaw database and consultation with experts in English mental health law. The focus was alcohol dependency rather than intoxication, or conditions that can arise from alcohol abuse, such as Korsakoff syndrome. Craigie and Davies (2019) *op cit.*

⁴⁴ *R v Stewart* [2009] EWCA Crim 593.) para 31., in Craigie and Davies (2019) *op cit.*, p. 232.

⁴⁵ Craigie and Davies (2019) *op cit.* p. 226.

⁴⁶ *Re W* (n 47) 73, Craigie and Davies (2019) *op cit.*, pp. 237-8.

⁴⁷ Although the case study section uses medical language, adopting the medical model is not necessary to the force of the point: that there is a differential application of the MCA that appears to track cultural notions of culpability for one's situation, regardless of whether the situations in question here are understood as the result of e.g. medical or social factors.

⁴⁸ UN Committee on the Rights of Persons with Disabilities (2014). Article 12: Equal recognition before the law, CRPD/C/GC/1.

⁴⁹ Series, L. (2015). 'Relationships, Autonomy and Legal Capacity: Mental Capacity and Support Paradigms'. *International Journal of Law and Psychiatry* 40 (May): 80–91; Ruck Keene, A. (2017). 'Is Mental Capacity in the Eye of the Beholder?' *Advances in Mental Health and Intellectual Disabilities* 11 (2): 30–39; Craigie, J., Bach, B., *et al.* (2019). 'Legal capacity, mental capacity and supported decision-making: Report from a panel event'. *International Journal of Law and Psychiatry* 62: 160–168.

⁵⁰ Kong, C., Coggon, J., Dunn, M., *et al.* (2019). 'Judging Values and Participation in Mental Capacity Law'. *Laws* 8 (1): 3.

⁵¹ Correspondence with Camillia Kong, 06/02/2020.

⁵² Holroyd, J. (2015). 'Implicit Bias, Awareness and Imperfect Cognitions'. *Consciousness and Cognition* 33 (May): 511–23; Holroyd, J., and Kelly, D. (2016). 'Implicit Bias, Character, and Control'. In *From Personality to Virtue Essays on the Philosophy of Character.*, Edited by A. Masala and J. Webber. Oxford University Press.

⁵³ Chang, E. H., Milkman, K. L., *et al.* (2019). 'The Mixed Effects of Online Diversity Training'. *Proceedings of the National Academy of Sciences* 116 (16): 7778–83.

⁵⁴ Resources for philosophy of mind and mental health workshop series available open access at <https://www.birmingham.ac.uk/generic/perfect/resources/philosophy-of-mind.aspx>; see also Bortolotti, L. and Stammers, S. article on *Mental Elf* regarding how groups like these might help to restore justice in mental health settings <https://www.nationalelfservice.net/mental-health/overcoming-injustice-in-mental-health-is-there-a-role-for-philosophy/>; further information on the background and motivations behind the project on the *Daily Nous*: <http://dailynous.com/2018/02/21/mental-health-philosophy-mind/>; a podcast about the workshop series made by the participants available here: <http://www.canstream.co.uk/camden/index.php?id=970>.

⁵⁵ As in the inter-group contact theory, e.g. Allport, G. W. (1985). *The Nature of Prejudice*. Nachdr. Reading, Mass.: Addison-Wesley; Hewstone, M., and Swart, H. (2011). 'Fifty-Odd Years of Inter-Group Contact: From Hypothesis to Integrated Theory'. *The British Journal of Social Psychology* 50 (3): 374–86. See the RE:CREATE Psychiatry's "dialogical approach" for a model of this in action in the sphere of mental health: <https://recreatepsychiatry.com>

⁵⁶ For instance, that provided to Best Interests Assessors.

⁵⁷ See Stafford, T., Holroyd, J., et al. (2018). 'Confronting Bias in Judging: A Framework for Addressing Psychological Biases in Decision Making'. Preprint. PsyArXiv; Kong et al. (2019) *op cit*.

⁵⁸ For example, see We Communities: <http://www.wecomunities.org/tweet-chats/chat-details/370>; see also Stammers, S., Pulvermacher, R. (under review). 'The value of doing philosophy in mental health contexts'.