

## **‘Mentally Incapacitated Adults and Decision Making’: implications of the Law Commission consultation paper for old age psychiatrists**

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Old age psychiatrists’ main concern with regard to incapacity is with patients with dementia. Dementia is predominantly a disorder of old age, probably affecting over half a million people in the UK, and it inevitably affects decision-making capacity. The 1983 Mental Health Act does not appear to have been framed with particular consideration for this group and it is vital that any new laws pay special attention to people with dementia.

Currently only a minority of people with dementia come under the care of psychiatrists, but psychiatrists are often involved where psychiatric diagnosis, investigation and management are called for and this involvement may increase dramatically if new drug treatments become available.

Most property and personal decision-making for this group is currently informal. In respect of psychiatric treatment, decisions are usually made by a psychiatrist. These decisions are, in the best practice, made in discussion with the patient, relatives and multidisciplinary team. Relatively minor decisions or urgent decisions are made by the psychiatrist in consultation with nurses and (where appropriate) the patient. If compulsion is necessary, the existing powers of the Mental Health Act are invoked. Psychiatrists are sometimes involved in the proceedings of the Court of Protection and in judging a patient’s competence to make a Power of Attorney and, inevitably, in Mental Health Act Proceedings.

### *Is reform needed?*

The Law Commission Paper discusses the target population as “people who suffer from such a degree of mental disorder or disability that they are incapable of taking decisions for themselves”. The proposals are to include people who have such severe communication problems that they are unable to make themselves understood. They identify four main groups in whom incapacity may arise: people with mental handicap, elderly people with mental infirmity, people with mental illness, and brain damaged and physi-

cally ill or handicapped people. All these groups are of interest to the College and the last three of major interest to the Section of Old Age Psychiatry.

The document reviews difficulties which may arise in a wide range of situations; for example, consent to medical treatment in those who cannot give valid consent, the problem of making significant life decisions for them, and the problem of having the power to intervene when there is suspicion of neglect or abuse (physical, sexual or even financial). It discusses the need to balance freedom and autonomy against protection from abuse and exploitation.

We are agreed that reform is needed and it is particularly important that it takes into account the needs of people with dementia, who are likely to form the largest group of permanently and (sometimes) severely incapacitated adults. From the point of view of an old age psychiatrist, it is important that changes in the law do not become so cumbersome that it is impossible to deal with every-day decisions relating to people who cannot give valid consent but who do not object to things occurring on a day to day basis.

### *What tests of capacity are useful?*

In practice all doctors decide on capacity to consent whenever patients are seen. It needs to be more widely recognised that everyday decisions involve capacity to consent and that this is an area where old age psychiatrists have special expertise. The old age psychiatrist is best placed to resolve difficult cases.

We believe that the function/understanding approach to capacity is to be preferred because it allows individuals to exercise their autonomy as far as possible. Doctors do not have a single medical test of capacity, as opposed to a legal test; decisions are complex and multi-factorial. Old age psychiatrists consider the question of understanding in broad terms in relation to a particular decision or class of decisions.

***What is the best general approach: to deal with different areas separately or incrementally, or to aim for a single unified system?***

It is unlikely that a single answer will be appropriate to all areas where incapacity affects decision-making. A broad overview is therefore needed and an incremental approach may be preferable. It is essential to retain flexibility as, in practice, problems change from day to day. People with acute confusional states will fall into the area of incapacity during their acute illnesses and this could lead to widespread problems. It is therefore advisable to devolve decision making down, as far as possible to where the everyday decisions are having to be made.

***What principles and values should reforms be based on and how are conflicts of principle and interest to be resolved?***

There are occasions when best interests outweigh substituted judgement, where health and safety of others are at risk and this needs to be recognised. The underlying philosophy needs to make allowance for the progressive loss of capacity that occurs in dementia. The principles of "best interests" and "substituted judgement" should both be considered. Substituted judgement alone could give rise to major problems – for example it is not uncommon for old people to get their relatives to promise not to "put them away" but this judgement may be based on false premises about the nature of residential and nursing care as well as a lack of knowledge of the degree of help they might need in future. In clinical practice such people if they develop dementia are generally placed in residential/nursing care only when other possibilities have been exhausted – and they often settle happily to a better quality of life than previously enjoyed. Other essential principles are those of the least restrictive alternative and the basic presumption of competence.

***Are advance directives useful?***

Advance directives will probably only ever apply to a minority of people. They may need to be interpreted by a guardian, tribunal, or occasionally a Court. Mechanisms would have to be devised for the rare cases where an advance directive was in conflict with a doctor's ethical duties. Advance directives cannot be absolute for ethical and moral reasons; also because people change over time. They should instead be a factor which is taken into account but is not binding, and a concerned person should be able

to apply to set aside an advance directive where appropriate by some formal mechanism. The idea that a substitute decision maker could be nominated in advance is, however, basically a good one, which allows the preservation of personal autonomy as far as possible, but it should be possible to challenge, and if necessary displace, a substitute decision-maker whose actions are mischievous.

***Are statutory decision making procedures without judicial review acceptable in some areas?***

There should be a possibility of judicial review but the vast majority of cases, where consent cannot be informed, should be dealt with on the ground by the team of people closely involved in the day-to-day care of an incapable person. It is essential for services, in order to succeed in their strategy of early easy referral and helpful intervention, not to be stigmatised or stigmatising, as having many of their patients under the aegis of bureaucratic and interfering procedures similar to the former Lunacy Board of Control. Where the relevant parties are unable to agree, it is necessary to move up a hierarchy of decision-making levels. The next level might be an extended guardianship order; then a mental health review tribunal and ultimately (if all else fails) judicial review. We feel that it is not workable, nor in the best interests of those concerned, to decide matters on an adversarial basis and would regard the Mental Health Act Tribunals as offering a useful model.

***How to deal with crisis intervention – particularly how to balance protection from harm and abuse with respect for an individual's rights?***

In an immediate crisis flexibility must remain for doctors to make a decision on behalf of an incapable patient according to their conscience and good medical practice. This will occur only in exceptional circumstances, when freedom to act must be preserved.

In a crisis where time allows, e.g. the risk of abuse, other models may be appropriate. Should provisions here apply only to the mentally ill? If so, guardianship could be modified. However, elderly people may be vulnerable and at risk but not mentally ill and some form of emergency intervention order would allow action in these circumstances. (Most states in the USA have Elder Abuse Laws now). We believe there is a need to develop laws to protect vulnerable elderly people, particularly in the abusive situation, but the danger of infantilisation exists. This is not solely an area for psychiatrists.

*How to reform the existing provisions for guardianship under the Mental Health Act and the property management functions of the Court of Protection?*

We strongly support the review of guardianship. Individual Social Services Departments cannot be allowed to decide whether or not they choose to accept orders: perhaps a statutory responsibility could be placed on them to accept orders. This would extend guardianship geographically. A variable or incremental guardianship order might allow the option to deal with property or other matters, thereby combining it with the Court of Protection function so that it could cover social care and property. The issue of medical as opposed to psychiatric treatment is more difficult. Extending the order to cover this might be reasonable when the patient is actively objecting. If they are not objecting then such extension would not be necessary.

The option of allowing health authorities or health service staff to act as guardians is interesting and might repay further investigation.

*Are substitute decision making and advocacy mutually exclusive or can they somehow be combined?*

Advocacy is something which good psychiatrists have tried to practise on behalf of their patients for many years. It is appreciated that there may be a real or apparent conflict of interests. An independent advocacy service is supported but only if advocates are properly selected, trained and supervised. Some "advocates" appear to put forward their own views rather than the patient's, and one case has been reported where an advocate apparently persuaded a

patient to stop necessary treatment, leading to relapse of the patient's psychiatric condition. A mechanism would therefore be needed to displace advocates whose actions were mischievous.

Advocates and substitute decision making are *not* mutually exclusive. Instead advocates should represent the incapacitated patient's point of view within the substitute decision-making process, and more than one advocate may sometimes be required.

*Is there support for a new "institution"?*

If property functions are merged into guardianship then this will become the "new institution". We favour a Tribunal based system rather than an adversarial model. We favour modifying existing structures, not introducing a completely new one, e.g. as suggested by Scottish Action on Dementia. This latter would, however, have the advantage of setting up a separate structure which could then be separately funded and properly resourced.

It is important to cost and resource any new development properly. Generally speaking, the legal profession works on an "item of service" basis for fees. New laws which make new demands therefore attract new fees. Psychiatrists are generally salaried employees of the health service, and are not usually paid on an item of service basis. New laws make new demands on limited time and consideration needs to be given as to how great these new demands will be and how they will be met without asking consultant psychiatrists to take on extra commitments in a timetable already over-crowded by health service reform, the care planning procedure, medical audit and the adjustment of medical staffing brought about by *Achieving a Balance*. Ideally new demands would be reflected in increased staffing. If this were not possible then an item of service fee would at least enable the extra work to be quantified.