Submission to the Department of Justice, Equality and Law Reform on the Proposed Capacity and Guardianship Legislation.

Preliminary Submission Paper - June 2009

on the

Scheme of the Mental Capacity Bill, September 2008

Prepared by a Working Group of CPsychI Human Rights, Ethics & Law Committee

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Introduction

The College of Psychiatry of Ireland welcomes the proposed legislation concerning the protection of the mentally incapacitated.

This document sets out our concerns with the proposed legislation firstly, by general comments, then by comments on the Heads of Bill in each of the 4 Parts of the 'Scheme of Mental Capacity 2008, 5 September 2008' followed by a summary section. An appendix with vignettes (case samples) is provided to illustrate the application of our comments in day to day clinical cases.

The College Human Rights, Ethics & Law Committee welcomes an opportunity to meet with the Department to discuss our recommendations and comments as outlined in this submission.

General Comments

We have made comments on the Heads of Bill item by item, however this is problematic because the Heads of Bill is structured around legal processes not clinical care processes and pathways. The Heads of Bill therefore emphasises legal rather than clinical or welfare decision-making, and at every point places the legal system at the centre of patient care and welfare, which at times fails to address the issues that arise in practice. The Appendix to this paper comprises Vignettes (case studies) which describe some of the very common problems in day-to-day practice that need to be addressed by this legislation.

The Heads of Bill document is written mainly from the perspective of long-term incapacity (personal guardianship and enduring power of attorney), which in practice is less common and less urgent an issue than short-term incapacity in relation to medical emergencies or acute illnesses. Short-term incapacity situations are generally more fraught with risk and are often managed by more junior staff. An unintended consequence of this Bill could be to obstruct the urgent management of the most common clinical problems concerning incapacity and decision making regarding medical treatment.

Recommendations:-

- There exist informal pathways into clinical, financial and social care for the incapacitated. These three domains are separable. These existing pathways require a clear legal process, which is fit for the purpose of serving such pathways while ensuring protection for the vulnerable.
- A simple means of addressing this problem is for the proposed Bill to create a legal process for relevant others (including next of kin) to be empowered to give consent for urgent medical interventions in an emergency. This would require a definition of relevant others (and next of kin) and a definition of the circumstances under which a doctor treating a person who meets the criteria for incapacity may proceed with urgent treatment by completing a formal certification process in which defined persons must be consulted. This has the advantage that it emulates the existing informal practice in Ireland and elsewhere, adding formal legal protections while ensuring the minimum of delay. Where disagreements arise, a more elaborated procedure involving an urgent hearing before an appropriate decision maker could then take place. This procedure would also have the advantage of minimising the need for such emergency hearings.

- A similar process might be defined for the process of urgent welfare interventions by social workers for vulnerable adults so that a place of safety could be provided where the necessity is urgent.

- The definitions of incapacity, infirmity of mind or mental disorder must ensure compatibility between all the Acts employing such terms (e.g. Mental Health Act 2001, Disability Act 2004, Criminal Law (Insanity) Act 2006), because in practice individuals may require protection under different Acts at the same time or sequentially. This Act must provide for this and other Acts may have to be amended to take account of this[1].

- The legal process must define every stage of the pathway into Guardianship (and/or Enduring Power of Attorney) and where relevant the pathway to recovery. The legal process should define -
    - Who may apply for guardianship, when there would be no obligation to do so e.g. in relation to matters that are not immediately life threatening, and who must apply as a matter of duty of care.
    - The most common need for an intervention in medical practice concerns an intermediate state between elective interventions and emergency interventions for life-threatening illnesses. Typically where treatment or an intervention is urgently needed to relieve suffering or prevent further deterioration to a life threatening condition.

[1] Harry Kennedy A General Theory of Mental Disorder and Consolidated Mental Disability Legislation: Commentary on the Mental Capacity and Guardianship Bill 2008 *(2008) 14, 2 Medico-Legal Journal of Ireland.51-58*

  - Who may assess incapacity, and who must do so as part of a duty of care; we believe this should be reserved to medical practitioners and the medical role cannot be dispensed with even in emergencies if this Bill is to have meaningful protections against erroneous use.
  - Who may decide to make the guardianship order, and who must do so because of a duty of care – because of the volume of such matters routinely arising in medical practice, a simple process to sanction urgent decisions is needed – see the account below of how this is done under the Adults With Incapacity (Scotland) Act 2000.
  - Who may make decisions for the person and who must do so because of a duty of care?
  - How guardianship shall be reviewed & if appropriate, discharged when capacity has been recovered or when the benefit of substituted decision making or protection from exploitation is no longer required. We believe that in mental illness and intellectual disability cases 36 months may be too long an interval for regular review.

- The legal process must define the pathways into guardianship in order to allow substituted decision making for three types of decision –
  - Decisions regarding medical treatments – whether emergency, urgent or elective, including treatments for mental disorders not covered by the Mental Health Act 2001;
  - financial decisions and the management of financial affairs;
  - Social care decisions and the management of social care.

- The legal processes and pathways defined must be equally useful and accessible for the person with dementia, organic brain disorder, intellectual disability and mental illness, the acutely delirious or temporarily incapacitated.

- The definition of incapacity must accommodate temporary incapacity, fluctuating incapacity and enduring incapacity. Urgent procedures will be required for urgent medical treatment for those with both temporary and enduring incapacity.

The bill needs to include powers modelled on the Adults with Incapacity (Scotland) Act 2000, Part V.

- The Scottish Act gave a new legal obligation for the doctor primarily responsible for the care of an adult to assess the adult's capacity to reach a decision in connection with medical treatment. The treating doctor has authority 'to do what is reasonable, in relation to medical treatment, to safeguard or promote the physical or mental health of the adult' where the patient lacks capacity. The treating doctor must confer with relevant others (see below). This authority extends to others acting on behalf of the doctor (dentists etc).

The responsible doctor (e.g. a consultant in a hospital, who can delegate to team members or to a GP in the community) assesses capacity as defined in the Act. If incapacity is shown, then the doctor must –

- Discuss with relevant others (including next of kin)
- Sign a (statutory) certificate of incapacity for a specific purpose or event (e.g. 'treatment of renal failure') and
- The certificate must be issued by the doctor primarily responsible for the treatment, for a specific period of time (less than or equal to 1 year).

In a life-threatening emergency, where these processes cannot be completed, common law powers would still apply in Scotland.

- There is an over-riding authority which prevents the responsible doctor exercising an automatic authority to treat if
  - A Guardian or welfare attorney has already been appointed or
  - The patient is already subject to an Intervention Order

- If there is disagreement between the responsible doctor and a guardian or welfare attorney, then
  - An Independent Medical Opinion is obtained from a doctor appointed by the Mental Welfare Commission.
  - Any further disagreement goes to Court

The Scheme of Mental Capacity Bill 2008 (5th September 2008) is in four parts.

Part 1 deals with capacity, formal and informal decision making and covers issues, including definitions.

Part 2 deals with the establishment of an office of public guardian.

Part 3 deals with enduring powers of attorney.

Part 4 deals with private international law and contains a series of schedules.

Part 1: Capacity, Formal and Informal Decision Making

Head 1: Guiding Principles

We note the presumption of capacity, the principle of least restriction and respect for past and present wishes where ascertainable.

There is a need to state as a principle that there is an obligation to provide the means to restore capacity where possible and preserve dignity at all times. This refers to an advocacy and agency role for the personal guardian or donee of Enduring power of Attorney (EPOA).

There should be a clear statement of principle concerning the scope of the Bill/Act in respect of decisions concerning financial affairs, welfare and health. This should set a structure for the remaining Heads. We are concerned that decisions regarding welfare and health are subsumed jointly under Head 7. These two areas should be dealt with under separate Heads. In keeping with this, we note that Head 58 incorporates the Convention on the International Protection of Adults. This gives a very useful definition of "Adult with incapacity" and defines "protective measures" to include measures concerning the person, placement and property.

We suggest that all or most of the following principles are already implicit in the published 'Scheme' and should be explicitly stated -

- There is an assumption of capacity but incapacity can be raised where there are reasonable grounds for doing so.
- Right to limit the degree of intervention in keeping with the degree of incapacity i.e. the least restrictive, least intrusive intervention necessary.
- Obligation to provide the means to restore capacity where possible and preserve dignity at all times.
- Obligation to act in the best interests of the person's health, dignity and well being.
- Respect for valid function-specific advance directives
- Consult with family/next of kin/carers.
- Continue to involve the patient in all subsequent decision making
- Continue to inform the person of the decisions, the reasons for the decisions and their consequences.
- Explain what is being done and why at all times, so as to involve the incapacitated person in the decision making process, to as great a degree as possible.
- Recognise that there is an inter-relationship between the urgency of the situation, the necessity of decision and action, and the complexity of the issues. The less urgent the situation, the more time can be devoted to the restoration of capacity and to a full analysis of the complexities of the situation and involvement of carers and others.

Head 2: Definition of Capacity

We note that criteria for lack of capacity have been added since the earlier Bill. However this is not a definition of 'mental incapacity' because there is no requirement for evidence regarding any abnormality or impairment of the mind or brain. This could lead to misuse of the powers conferred under this Bill, so that those with unconventional behaviour, those who make unwise decisions or are in some way non-conforming, could fulfil the definition as presently drafted. We note that the Convention on the International Protection of Adults agreed at The Hague 13th January 2000, incorporated by Head 58 and given in Schedule 5 does include such a definitional requirement for "an impairment or insufficiency of his or her personal faculties".

We strongly recommend the approach taken in the Scottish Act. Within the present Head this could be accomplished in Head 2(2) by including some or all of the words (underlined below) "for the purposes of this head a person lacks the capacity to make a decision if her or she is unable

"By reason of an impairment or insufficiency of his or her personal faculties[2] / unsoundness of mind[3] / mental disorder[4]/mental disability/abnormality of mind…"

This is necessary to avoid including those who are merely socially deviant or personality disordered[5]. We believe it is necessary also to comply with Article 5 of the European Convention on Human Rights Act 2005 and related case law.

Absence of a diagnostic step will leave open the mistaken, fraudulent or inappropriate use of the powers conferred by the Bill. An elderly person, a physically ill person or an institutionalised person with a history of some mental disability who has since recovered might all fall victim to such misuse. However Head 58 says that Schedule 4 "gives effect in the State to the Convention on the International Protection of Adults agreed at the Hague on 13th January 2000 – which for ease of reference is set out in Schedule 5 – in so far as this Act does not otherwise do so…Schedule 4 Part 1, paragraph 4 "Adults with Incapacity" means a person who – (a) as a result of an impairment or insufficiency of his or her personal faculties, cannot protect his or her interests, and (b) has reached 18 [Article 2].

It is merely confusing to have an incomplete definition in Head 2 and a full definition which includes a diagnostic threshold ("as a result of impairment or insufficiency of his or her personal faculties") in Schedules 4 and 5, incorporated via Head 58.

Concerning drafting, each of the criterion clauses should be linked by an 'or', to make clear that any one of them would be sufficient.

[2] As per Head 58 and Schedules 4 & 5

[3] As per Article 5.1(e) ECHR and related case law and Council of Europe Recommendation Rec(2004)10.

[4] See both the Mental Health Act 2001 Sections 3 & 8(2), and Criminal Law (Insanity) Act 2006 Section 1 ands COE Rec(2004)10 Article 2(1).

[5] See Mental Health Act 2001 section 8(2) and COE Rec(2004)10 Article 2(2)

We have doubts regarding Head 2(4) "the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him or her from being regarded as having the capacity to make a decision". This may work if the person is consistent because of their personality and disposition, but in a moderately impaired person it could lead to random and inconsistent decision making which is the product of mental incapacity and would in our view invalidate the decisions made under some circumstances.

Head 2(2) (a) to (d) should also be supplemented by an additional element "inability to believe the information given"(see Appendix, Vignette xvi).

A more general concern arises regarding the compatibility or inter-relatedness of this definition of incapacity and the definitions of mental disorder in other Acts [12](See Appendix, Vignette ii). This legislation should make explicit how the process and powers of personal guardians and attorneys overlap with or interconnect with related, existing legislation so that these are not mutually exclusive and are mutually supportive of the vulnerable / incapacitated person, to facilitate protection, recovery and access to services.-

- Control of Clinical Trials Act 1987
- Mental Health Act 2001
- European Convention on Human Rights Act 2003
- Education for Persons with Special Educational Needs Act 2004
- Disability Act 2005
- Criminal Law (Insanity) Act 2006

We strongly suggest that this Bill should be formally linked to the above Acts, and the above Acts amended to consolidate this link.

Models for this type of consolidated legislation can be found in legislation for England and Wales.

- The model used in England & Wales can be characterised as 'framework' so that each decision must be considered not just on a case by case basis but on an instance by instance basis. This would give rise to inconsistency and unpredictability if not arbitrariness. It would not be in the best interests of those with enduring mental incapacities.
- The Scottish model can be characterised as 'formwork'. Although this may not sit so neatly with legal theory, it does accord better with the clinical and scientific realities of most types of mental incapacity (see the Vignettes in Appendix for examples). It also ensures greater consistency and permits greater transparency in decision making. The most practical solution is a hybrid of status (formwork) and functional

[12] Harry Kennedy A General Theory of Mental Disorder and Consolidated Mental Disability Legislation: Commentary on the Mental Capacity and Guardianship Bill 2008 *(2008) 14, 2 Medico-Legal Journal of Ireland.51-58*

capacity (framework) which recognises the reality of enduring and global incapacities for many while respecting the need to make best use of the capacities a person may still have. We believe this is compatible with the definition in the Convention on the International Protection of Adults agreed at The Hague, 13th January, 2000 incorporated into this Bill at Head 58 and Schedules 4 and 5.

Section 28(4) of the Mental Health Act 2001 notes that on discharge, the consultant psychiatrist responsible for the care and treatment of the patient "shall cause copies of the (discharge) order…where appropriate (to) the relevant Health Board and housing authority". This should now be extended to include a means of initiating guardianship prior to rather than at the time of discharge, in appropriate cases. This might usefully be considered e.g. in respect of those for whom there have been two or more admissions under the Mental Health Act 2001 within the previous five years.

Similarly, the *Third Interim Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons, November 1978 'The Treatment and Care of Persons Suffering From Mental Disorder Who Appear Before the Courts on Criminal Charges'*, generally known as the Henchy Committee published a draft Criminal Justice (Mental Illness) Bill. This included amongst its Heads a provision so that when a person charged before the District or Circuit Courts is found to be suffering from mental disorder, the Court could send a report to the Registrar of Wards of Court if the court considered it desirable in his interest. This would be of great benefit if incorporated into or added to the Criminal Law (Insanity) Act 2006 for those found unfit to stand trial or not guilty by reason of insanity. The system of making this application at the beginning of a period of detention rather than prior to or at the time of discharge has much to recommend it in appropriate cases, under both the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2001. In many such cases, a mental health social worker might be the most appropriate personal guardian, appointed by the office of public guardian, solely or jointly with a lay guardian.

Questions also arise and must be clarified concerning the respective roles of the consultant responsible for the care and treatment of a person detained under the Mental Health Act 2001 or Criminal Law (Insanity) Act 2006 and the Mental Health Tribunal or Mental Health (Criminal) Review Board, and the Inspectorate of Mental Health Services on the one hand and personal guardians or donees of enduring power of attorney on the other. We recommend that a personal guardian or donee of enduring power of attorney should be formally empowered to initiate an application under the Mental Health Act where it appears that this might be appropriate, but we the powers of guardians and donees of EPA should be suspended specifically in respect of the various decisions concerning mental health treatment including the decisions in relation to detention and treatment for which the responsible consultant psychiatrist, Mental Health Tribunal or Mental Health Review Board are normally responsible in respect of a patient detained under either the Mental Health Act 2001 or Criminal Law (Insanity) Act 2006, for the duration of that detention or leave under section 26 of the Mental Health Act or section 14 of

the Criminal Law (Insanity) Act 2006 and conditional discharge under section 13 of the Criminal Law (Insanity) Act.

Head 3: Best Interests
Best interests should include the restoration of health and mental capacity in so far as possible and the preservation of dignity at all times. The omission of this is in our view an error of principle. We have mentioned this also in respect of Head 1, and we suggest that some responsibility for advocating or acting as agent to secure the above should rest with the personal guardian or donee of Enduring Power of Attorney (EPOA).

Head 4: Jurisdiction
It is needlessly complex to provide for jurisdiction both in the circuit court and the high court. The reference to rateable valuation as a basis for determining jurisdiction is in our view a fundamentally mistaken approach. It is not based on equality of access to justice or equality of access to health and social care and as such is in conflict with Government Policy[13]. This appears to be a left-over from 19th century legislation in which the primary preoccupation was with property.

In order to ensure proper representation and equality of access to these protections, the process including legal representation and appointment of a legal guardian should be paid for from a legal aid fund. The cost of Wardship at present excludes the great majority who might benefit from such protections. We strongly suggest that the costs of the HSE arising from the initiation of Guardianship proceedings or arising from any legal challenges to the legal process should be covered entirely by the Attorney General's fund or some similar fund. Such costs arising from the Mental Health Act 2001 have proved to be a substantial drain on HSE funds. It is fundamentally incorrect that such costs should be taken from monies voted for the provision of healthcare.

We note also the long delays in having hearings listed in the Circuit Court in respect of applications under the Mental Health Act 2001 S19 & S21(2)(d)(ii). This suggests that the Circuit Court would be unable to respond to the need for urgent interventions in many cases where medical treatment is required.

[13] Quality and Fairness: a health service for you. Department of Health and Children

Head 5: Powers of Court
There should be an introductory part in Head 5 specifying at the outset what the powers of the court are i.e. to make declarations regarding capacity, to make decisions and to appoint personal guardians. It should be made explicit who may apply, how an application may be made, whether an urgent application can be sought (see Head 9). Most jurisdictions have separated out management of financial affairs from welfare, social need, healthcare and advocacy issues. It would be helpful to define administrators and court processes for the former acting on behalf of "wards". It would be useful to have part or full guardians appointed acting on behalf of individuals in other areas. Healthcare decisions should have a specific subsection (see below).

Head 6: Power to Make Decisions and Appoint Personal Guardians
From a clinical perspective, the most difficult question likely to present is who amongst the relatives should be appointed personal guardian. In other jurisdictions this is dealt with by means of a list of priorities or by a rule e.g. "the spouse or oldest first degree relative" with relevant exclusions.

The Convention on the International Protection of Adults Schedule 4, 5(2) says that where a protective measure has already been in place for a child under age 18, the Schedule shall apply once he or she has reached 18. This should be explicitly repeated within the Bill itself. An automatic review should however be held.

Head 6 (7) should add "or no longer wishes to act as guardian".

Head 7: Powers of Personal Welfare
This confers wide ranging powers on a personal guardian concerning both social welfare -where a person should live and with whom, whom the person should see and not see, what training and rehabilitation the person should get, the person's diet and dress, inspection of the person's personal papers and 7(g) "giving or refusing consent to the carrying out or continuation of a treatment by a person providing healthcare for the person who lacks capacity". See also Head 48(3) which contains similar powers for the donees of enduring power of attorney.

Items 7(a) to 7(f) seem to have been drafted with a view to providing for persons with intellectual disability or dementia.

Item 7(g) which concerns consent to treatment may be too much to delegate to a personal guardian if the personal guardian is to be a lay person, even having regard to the exclusions covered by Head 11. It should at the very least be dealt with under a separate Head.

We recommend a separate head to deal with consent for medical treatment, or a proviso similar to that in Head 8 (4) - The court may, notwithstanding that it has appointed a personal guardian, confer on the Public Guardian the custody, control and management of such property of the person in respect of whom the personal guardian has been appointed, if the court considers in all the

circumstances of the case that the Public Guardian is the most appropriate to exercise that power in respect of that property.)

It could read that power to make decisions regarding consent to medical treatment be conferred on the treating doctor if it is considered that he/she is the most appropriate to exercise that power in respect of that healthcare decision. Where the treatment is elective, a system for obtaining independent second opinions would be helpful.

The power to make decisions regarding medical treatments should be drafted to resemble as closely as possible part 4 of the Mental Health Act 2001, with ready access to reviews by independent second opinion doctors.

We have already commented on the need, as a matter of principle, to establish that this Bill/Act deals with substituted decision making in respect of the three domains of financial affairs, welfare (social care) and health, for those who lack mental capacity to make such decisions. We suggest that whether for guardianship or enduring power of attorney, there should be distinct means of exercising the three types of decision making power.

Head 8: Powers, Property and Affairs
Wide ranging powers are conferred which once again may be vested in a lay person.

Head 9: Persons Who Can Make Application
There is a power to make applications without notice (urgent applications) or with the permission of the court on notice to the person to whom the application relates. The courts may then appoint a suitable person to act in the name of or on behalf of or to represent the person to whom the proceedings relate. Rules of court will define the manner and form in which proceedings are to be commenced. It is envisaged that the application could be disposed of without a hearing and proceedings might occur in the absence of the person to whom the proceedings relate.

- Who may apply?

We recommend next of kin (to be defined), a medical social worker or mental health social worker, senior or specialist nurse, or approved officer as defined in Mental Health Act 2001.

- Assessment of capacity to be made by a registered medical practitioner?

We suggest that the doctor carrying out the assessment should test the person's decision making capacity relevant to the immediate decision, using a legally approved form which provides a structure for the professional judgement based on legal definitions.

- Temporary treatment order to be made by whom?

E.g. the treating clinician or an independent professional.

- Speedy review to be carried out by a guardianship review board.

Head 10: Persons Who Can Be Appointed Personal Guardians

As mentioned above, there needs to be a system for defining how personal guardians are to be chosen from amongst the family and friends. Where a family member or friend is appointed jointly with a professional, there needs to be a system for deciding this.

The implication is that the personal guardian might be reimbursed from the property of the person concerned. We suggest that Head 10 should specify reasonable vouched expenses and remuneration.

Head 11: Restrictions on the Powers of Personal Guardians

We note that the personal guardian may not direct a change of medical attendant (11(2)(b)) nor may a personal guardian refuse consent to the carrying out or continuation of life sustaining treatment (Head 11(5)). This does not however cover the need to refer to new medical specialists or to initiate new treatments. A power must be vested somewhere to enable such medical assessments and interventions in good time or urgently as required.

Health care decisions should have a specific pathway/subsection for substituted decision making. Some statement will be required to deal with common dilemmas such as religious beliefs regarding blood transfusions, consent to psychiatric treatments such as ECT, termination of pregnancy, sterilisation, hormonal treatment, admission to approved centres (as defined in the Mental Health Act 2001), medication while in an approved centre – see below.

The overlapping roles between personal guardians or attorneys appointed under this Act and the consultant responsible for the care and treatment of a person detained under the Mental Health Act 2001 or Criminal Law (Insanity) Act 2006 will have to be clarified (see note above). The current system whereby the powers of the High Court in respect of Wards of Court are held to prevent the use of the Mental Health Act 2001 (due to the non-repealing of sections 241, 276, 283 and 284 of the Mental Treatment Act 1945 in the Schedule to the Mental Health Act 2001) is unsatisfactory – wards of court are deprived of the protections of the Mental Health Act 2001 concerning independent review of detention under Part 3 of the Act of 2001, concerning consent to treatment under Part 4 of the Mental Health Act and many other protections conferred by the Mental Health Act of 2001.

What is required is a compatibility clause allowing both Acts to apply within defined domains – while detained under the Mental Health Act 2001 or Criminal Law (Insanity) Act 2006, all treatments for mental disorder should come within the provisions of the Mental Health Act 2001 Part 4, while treatments for other health problems, as well as welfare and financial affairs, are dealt with under the Mental Capacity and Guardianship Act, with additional use of the Disability Act 2005 where appropriate.

Definitions of restraint are given and limited to acts done with an authority expressly conferred by the court. This again raises the problem of compatibility with the Mental Health Act 2001, in particular section 69 and the rules made under section 69(2). Head 11(9) refers to the necessity not to exceed article

5(1) of the European Convention on Human Rights (ECHR). It is important to note that this conveys a right to liberty and security with a number of exceptions, the most relevant of which is "the lawful detention of persons for the prevention of spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants". We would recommend that Section 5(1) of the ECHR in relation to drug addicts, alcoholics and vagrants has no place in modern legislation as it reflects the zeitgeist of 1951 when the Convention was drafted.

It should be specified that patients who lack capacity may be detained under the Mental Health Act provided they meet the criteria given in that Act – and likewise for the Criminal Law (Insanity) Act 2006

Head 12: Interim Orders
We suggest this should be re-titled emergency situations. A mechanism should be developed that does not require going to the high court if it is an urgent medical/psychiatric situation. It should be specified that patients who lack capacity may be detained under the Mental Health Act if they meet the definition of mental disorder under that Act.

It is envisaged that an interim order would be made by a court. It is unlikely that this would address the needs of emergency situations in general hospitals. This Head needs substantial detail concerning who may apply, what evidence should be required and what limits might be imposed on the duration and scope of such orders. See the account above with regard to the working of the Scottish Act 2000.

Head 13: Expert Reports
Medical, social and health care or financial experts are apparently put on an equal footing. This implies that medical expert evidence concerning impairment or insufficiency of personal faculties or unsoundness of mind and incapacity are not to be regarded as essential.

Head 14: Decisions on Capacity to be Subject to Review at Regular Intervals
Reviews are proposed to occur at least every 36 months. This may not be sufficiently frequent. The Applicant defined at Head 9 may apply for a review at any time, but the person who is the subject of guardianship or enduring power of attorney should also be able to apply for review in their own right.

Head 14(2) appears to assume that at least some 'declarations' will in effect be declarations of general or global incapacity.

Head 15: Schemes to Provide Persons with Legal Representation where Required
This should be provided under all circumstances, at the state's expense.

An important issue arises regarding the capacity to instruct a legal representative and to initiate legal proceedings. The potential for harm due to legal representation in the absence of capacity to instruct is considerable. We believe a specific power should be vested in all judges and in the Guardianship board to empower a guardian to act as the maker of substituted decisions in respect of such affairs (See Appendix, Vignette xviii)

Head 16: Informal Decision Making
This may also be intended to cover the situation of emergency medical treatment. Much more detail is required. No threshold is set, either lower threshold or an upper threshold. Head 16 should specify what situations must be referred to court.

Head 17: Limitations to Head 16
"Nothing in Head 16 shall be taken to authorise a person to do any act which would require the court to make an order under this Act". …Nothing in this Head prevents a person pending a decision concerning any relevant issue by a court exercising its powers under this Act from a) providing life sustaining treatment or b) doing any act which he or she reasonably believes to be necessary to prevent a serious deterioration in a person's condition." This clarifies that Head 16 is intended to provide for emergency medical treatment. However much more detail is required to allow for the most common situations in which an incapacitated person requires urgent treatment to relieve suffering, to restore dignity or to prevent deterioration

Head 18: Payment for Necessary Goods and Services
Noted. This legislates for existing common law custom and precedent.

Head 19: Wills
Noted.

Head 20: Consent and Capacity in Specific Contexts
Noted.

Head 21: Matters Confined to Jurisdiction of the High Courts
This should come earlier in the document.

Non-therapeutic sterilisation, withdrawal of artificial life sustaining treatment or organ donation are matters reserved to the High Court. See above re the need to amend the law concerning the Mental Health Act 2001, repeals of the Mental Treatment Act 1945 and wardship.

Head 22: Application of this Part
Applies to persons who have reached the age of majority. Noted.

Head 23: Lunacy Regulation to Cease
See above with regard to repeals of the Mental Treatment Act 1945.

Head 24: Appeals
We would suggest that a system should be devised so that the only route of appeal from a decision of the High Court of Care and Protection should not be to the Supreme Court.

Head 25: Fees
Noted.

Head 26: Costs
Noted.
The consequences for the HSE should be costed and provided for, before commencement. We suggest that the responsibility for defending challenges to the legal processes should rest with the office of the Attorney General and not with the HSE or clinicians. Funds voted for healthcare should not be diverted to legal costs.

Head 27: Offences
Noted.

Part 2: Public Guardian

Head 28: Establishment of Office of Public Guardian
Noted.

Head 29: Appointment of Public Guardian
It appears that this post will be vested in a Circuit Court judge or High Court Judge.

Head 30: Terms and Conditions of Office
Noted.

Head 31: Staff of Office of Public Guardian
Noted.

Head 32: Objectives and Functions
Noted.

Head 32(2) (k) "to nominate for appointment, when requested to do so by a court, a personal guardian of a person in circumstances where there is no other person willing or able to act, or to act as personal guardian."

This does not go far enough. There should be a power to nominate even when there are persons willing or able, if they are for some reason considered to be possibly unsuitable.

Head 32(5) refers to fees that may be charged by the Public Guardian. This appears to us to be a return to the emphasis on financial matters that adversely characterises the wardship procedures. It leads to the exclusion of those who have minimal or insufficient estates.

Head 32(60) refers to the appointment and functions of special and general visitors to report back to the Public Guardian.

Head 33: Expenses
Noted. This appears to conflict with Head 32(5).

Head 34: Accounts and Audit
Noted.

Head 35: Accountability of Public Guardian to Committee of Public Accounts
Noted.

Head 36: Accountability to Other Oireachtas Committees
Noted.

Head 37: Various Reports of Public Guardian
Noted.

Head 38: Special and General Visitors
A special visitor must be a registered medical practitioner and have special knowledge of and experience in cases where there is a lack of capacity to make a decision. A general visitor need not have a medical qualification but should have such qualifications and experience that makes him or her suitable for appointment as a general visitor. We suggest that more could be made explicit in the Bill concerning the qualifications appropriate for a general visitor by taking a functional approach e.g. "appropriate to the matter in hand", thus, legal qualifications and experience might be relevant in some situations, social work qualifications and experience would be relevant in others.

Head 39: Codes of Practice
Subject to Head 40 the public guardian shall as soon as practicable prepare and issue one or more codes of practice concerning the following:

(a) The guidance of persons including health care professionals assessing whether a person has capacity in relation to any matter.

(b) The guidance of persons including health care professionals acting in connection with the care or treatment of another person under Head 16 (informal decisions).

The experience to date of challenges to the Mental Health Act 2001 has shown that clearly stated operational procedures and definitions are needed to avoid frequent, time consuming and costly High Court hearings for clarification. These should be approved by the office of the Attorney General, who should then be responsible for defending legal challenges to them.

Some basis for an operational code of practice should be grounded in an improved definition of incapacity "by reason of an impairment or insufficiency of his or her personal faculties" or "by reason of unsoundness of mind", or "mental disorder" (see comment on Head 3 above) and the definition given in the Convention on the International Protection of Adults agreed at the Hague on 13th January 2000 at Schedules 4 & 5.

Head 40: Publication of Codes of Practices
Noted.
It remains our view that as much detail as possible should be given in the Act, with the Code of Practice elaborating details that follow directly and clearly from the Act.

Head 41: Transitional Provisions
Noted.

Head 42: Further Transitional Provisions
Noted.

Head 43: Interpretation
Noted.
Provided that in this Part and in Part 1 a reference to "court" is a reference to the High Court of Care and Protection or the Circuit Court of Care and Protection, as the case may be, unless the contrary is indicated.

Part 3: Enduring Powers of Attorney

Head 44: Interpretation of this Part
The same caveats regarding consent to healthcare decisions apply to *"personal welfare" including the matters mentioned in Head 7.*

Head 45: This Act to Apply to Enduring Powers
Noted.

Head 46: Characteristics of Enduring Power
We note the requirement at 46(2) (d)(iii) that a Registered Medical Practitioner should certify that in his or her opinion at the time the document was executed the donor had the capacity, with the assistance of such explanations as may have been given to the donor, to understand the effect of creating the power.

46(4) lists exclusions for the Attorney referring specifically to the owners of nursing homes or mental health facilities in which the donor resides.

It might be helpful to be more explicit regarding the exclusions that might apply to the Registered Medical Practitioner referred to in 46(2) (d)(iii). This person should also be excluded if there is any question of conflict of interest.

46(8) is confusingly worded and could be read as implying that the Attorney must have been convicted of an offence against the person of the donor (!).

Head 47: Scope of Authority of Attorney under Enduring Power – Property and Affairs of Donor
Noted.

Head 48: Scope of Authority of Attorney under Enduring Power – Personal Welfare Decisions
In general, healthcare decisions should not be seen as a routine part of the powers included under personal welfare decisions. We recommend a specific mechanism defined under a separate Head for dealing with medical decisions.

It should be clarified that treatment of mental illness, once admitted to an approved centre, needs to be provided in accordance with the normal procedures of the Mental Health Act 2001 where the person comes within the definition of mental disorder defined in the Mental Health Act 2001. The role of the personal guardian or donee of Enduring Power Of Attorney should then be limited to the same as that of anyone in the role of next of kin.

Personal Welfare decisions may require different expertise than that required for management of financial affairs. In general the powers to make these decisions should be conferred on those with social and healthcare background in the absence of a suitable family member. Note that in Head 54 (2) the court may (b) give directions with respect to (iv) a personal welfare decision made or about to be made by the attorney.

48(2)(b) leaves it to the Attorney to reasonably believe that what he or she decides is in the best interest of the donor. This highlights the limited scope of the definition of best interests given in Head 3.

48(3) states “a personal welfare decision includes a decision on healthcare”.

See also Head 7. In the event of a disagreement between the treating doctor/clinician and the Attorney, a means will have to be clarified whereby such a disagreement could be appealed or decided by access to the office of the public guardian and the special and general visitors.

Head 32(2)(c) and (d) allows the office of public guardian to supervise donees appointed under an enduring power of attorney, to supervise personal guardians appointed by a court and (e) allows the office of public guardian to direct a special or general visitor to visit a donee of an enduring power of attorney, a personal guardian appointed by a court or personal guardian appointed under paragraph k (nominated by the public guardian).

It is not sufficiently clear how the office of public guardian can be accessed by a concerned professional. It may be that this is intended to be covered under Head 39 Codes of Practice but it is not dealt with in any of the paragraphs listed.

Head 48(4) limits the extent of 48(3)

Head 48(5) Limits of Power of an Attorney to authorise an act that is intended to restrain the donor

Once again this emphasises the importance of the need to make the definition of incapacity (Head 2(2)) conditional in the first instance on the presence of "an impairment or insufficiency of his or her personal faculties". This is particularly emphasised by the reference in Head 48 (7) to deprivation of liberty within the meaning of Article 5(1) of the European Human Rights Convention. These powers should only apply to a person of unsound mind who is also mentally incapacitated. See also Council of Europe COE Rec(2004)10. The need for a system of compatibility with the Mental Health Act 2001 and Criminal Law (Insanity) Act 2006 is also obvious.

Head 49: Coming into Force and Survival of Enduring Power

The interim arrangements referred to in Head 49(2) should be much more clearly and explicitly defined. Clear time limits should be stated and similar time limits should be set for the office of public guardian to respond. A system for interim authorisation by the office of public guardian or approved visitors and general visitors should be required wherever possible e.g. other than in life threatening emergencies. Unless a statutory time limit is set e.g. within twenty one days (as for example in respect of Mental Health Tribunals under the Mental Health Act 2001), we fear that interim arrangements would be left indefinitely, without benefit of formal review and authorisation.

Head 50: Function of Court prior to Registration

Greater clarity and explicit definition in Head 49 might eliminate the need for much of this and should make clear the grounds on which the court "has reason to believe that the donor of an enduring power may lack…capacity". Medical evidence should be required.

The reference to acting when the person "shortly may lack capacity" is puzzling and difficult to make sense of. Is this really necessary?

Head 51: Application for Registration

As before, we are anxious that this process should not be expensive or onerous. It should be accessible and equitable. We are also anxious that the process for activating should be speedy and readily accessible i.e. speedy and economical.

Head 52: Registration

We note the procedure for notice of objection. We are concerned however that those who might wish to object may not be aware that a process is underway. Some mechanism should enable a list of appropriate persons to be notified of an application for registration. These might include

- Attending or treating doctors and other clinicians.
- Nursing home staff.
- Close relatives (to be defined).

We note that Head 52(4) requires the public guardian to apply to court to determine any matter regarding objections under sub heading 3. We are

concerned that this might lead to a prolonged interim period and once again some timely economical mechanism should be in place for making interim (urgent) decisions.

Head 52(5)(a) the term "immaterial respect" is likely to be open to extensive challenge. It would be helpful to be much more explicit.

Head 53: Effect and Proof of Registration
Noted.

Head 54: Functions of Court with Respect to a Registered Power
The power to revoke is noted. This is described very fully. Additional regulations would also be helpful.

As a general issue, it is not sufficient that there should be an elective power to revoke. It should be made clear that Head 14 concerning review at regular intervals (36 months) should apply here also. Failure to make this explicit may cause confusion or may lead to the view that regular review does not apply to enduring power of attorney.

Head 55: Protection of Attorney and Third Person where Registered Power Invalid or not Enforced
Noted.

Head 56: Application to Joint and Several Attorneys
Noted.

Head 57: Legal Effect of Existing Enduring Powers of Attorney be preserved
Noted.

Part 4 - Private International Law

Head 58: Private International Law: International Protection of Adults

Schedule 4
This gives effect in the State to the Convention on the International Protection of Adults agreed at The Hague on the 13th January 2000 (Schedule 5).

Schedule 1: Appointment to Position of Public Guardian of Person Holding Judicial Office
Noted

Schedule 2: Notification Prior to Registration
There is a duty to give notice to the donor and a duty to give notice to other persons.

Sub paragraph 3(1) lists relatives but does not list professional advisors and carers including healthcare professionals. It also states that no more than three persons are entitled to receive notice with some exceptions.

Schedule 3: Joint and Several Attorneys
Noted.

Schedule 4: International Protection of Adults
Part 1 Preliminary

"ADULTS with incapacity": "adult" means a person who – (a) as a result of an impairment or insufficiency of his or her personal faculties, cannot protect his or her interests, and (b) has reached eighteen [article 2].
We presume a typographical error has resulted in the dropping of the words "with incapacity" following "adult" in the above definition.

This is extremely helpful and given the working of Head 58 this substantially amends the definition of incapacity given in Head 2(2). The reference to an impairment or insufficiency of his or her personal faculties answers the point raised earlier regarding the need for a medical diagnostic step in the test of incapacity. This should however be stated in Head 2 itself.

Paragraph 5(1) defines protective measures to include the determination of incapacity and the institution of protective regime. It helpfully distinguishes between having charge of the adult's person, their placement in a place where protection can be provided and administering, conserving and disposing of their property as well as authorising a specific intervention for protection.

Paragraph 5(2) helpfully notes that where a protective measure has been taken in relation to a person before he or she reaches eighteen, this schedule applies to the measure in so far as it has effect once he or she has reached eighteen.

Paragraph 23 "measures taken in relation to those under eighteen" further elaborates this matter

Part 5 Cooperation: refers to cross border placement. It would be helpful to extensively enlarge on this, concerning cross border placements under Mental Health Acts and Criminal Law (Insanity) Acts in addition to capacity matters.

Schedule 5: Text of Convention on the International Protection of Adults agreed at The Hague 13th January 2000

Article 10 of the Convention itself deals with cases of urgency and empowers the authorities of any contracting state in whose territory the adult or property belonging to the adult is present has jurisdiction to take any necessary measures of protection.

10.2 The measures taken under the proceeding paragraph with regard to an adult habitually resident in a contracting state shall lapse as soon as the authorities, which have jurisdiction, have taken the measures required by the situation.

SUMMARY OF COMMENTS

1. Although we have made comments on the draft Bill 'item by item' we believe the structure of the Bill should be revised to facilitate the existing naturalistic pathways into care and protection. It should be made clear that the Bill describes two pathways into protection, personal guardianship and enduring power of attorney (EPOA). These have the same functions – to provide substituted decision making for those who have become mentally incapacitated. These protections can be availed of whether the incapacity is temporary or more prolonged, and whether the incapacity is function-specific or more general.
   Three areas of decision making can be distinguished – welfare, financial affairs and decisions regarding the person (health matters). These three areas of decision making must be covered by the Bill, whether for some temporary incapacity or a more enduring incapacity. Because different considerations apply, these three domains should be dealt with under separate Heads or Parts. It may be that more than one personal guardian or donee of Enduring Power Of Attorney should be appointed, to act in consultation with each other but with responsibilities in different domains. This may be most relevant in respect of decisions regarding the person (health).

2. The Bill should be fully integrated (consolidated) with the existing and diverse Mental Health, Criminal Law (Insanity) and Disability legislation, so that naturalistic pathways through care and degrees of recovery can be facilitated without creating artificial barriers to progress.

3. The Bill must be fully worked out in operational detail, so that it can be operated without constant resort to the High Court for legal guidance or adjudication. We recommend the Scottish Act 2000 as a starting point and model. It should be the responsibility of the office of the Attorney General to approve procedures and codes of practice and to defend legal challenges to legal processes and interpretations.

4. One of the Principles should set out a right to appropriate treatment to restore capacity wherever possible.

5. The definition of incapacity should include a 'diagnostic' step to avoid the inappropriate use or abuse of the powers available under this Bill. This should simply take the form of words given in the Convention on the International Protection of Adults incorporated through Head 58 and Schedules 4 & 5 "as a result of an impairment or insufficiency of his or her personal faculties, cannot….". This would follow the example of the existing successfully implemented Acts in England & Wales and in Scotland.

6. Practical conflicts will arise unless the powers and domains of personal guardian / donee of Enduring Power Of Attorney are distinguished from the roles and powers of medical practitioners, consultant psychiatrists

responsible for the care and treatment of persons detained under the Mental Health Act 2001 or Criminal Law (Insanity) Act 2006, independent psychiatrists appointed to report to Mental Health Tribunals or to give second opinions regarding treatment and also from Mental Health Tribunals and the Mental Health Review Board.

7. The Bill should incorporate the provision in the Convention on the International Protection of Adults regarding the transition from Children's Legislation to Guardianship.

8. The Bill should provide protections that are equitable and accessible to all. The distinctions between the jurisdictions of the Circuit and High Courts based on rateable valuation have no place in modern legislation.

9. Heads 7 and 48(3) describe decision making powers concerning welfare, including healthcare decisions. These should be separated into welfare and health, with a detailed operational system to allow swift decisions to be made regarding urgent medical treatment as well as timely decisions regarding elective and continuing (long term) treatments. While Head 12 describes interim orders, a separate power is required concerning healthcare decisions, since special issues may arise that are distinct from issues regarding welfare (social care) or financial affairs.

10. Regular review should be at sufficient intervals to be meaningful.

11. Guardians or donees of Enduring Powers Of Attorney should be empowered to instruct legal representatives on behalf of those unable to give legal instructions.

12. All costs of legal challenges should be met out of a legal aid or Attorney General's fund and not out of HSE funds.

13. Concerning special and general visitors more should be said about qualifications for both, requiring qualifications appropriate to the issue or the case.
14. Powers to restrain should only apply to a person who is of unsound mind and is also mentally incapacitated.

15. Interim arrangements regarding EPOA or guardianship should be strictly time limited and should be reviewed by the Office of Public Guardian within that time limit, then either discharged or formalised.

Acknowledgments:
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APPENDIX

The Vignettes described below are intended to illustrate the recommendations and comments outlined in the College of Psychiatry of Ireland's Preliminary Submission Paper, June 2009 on the proposed Capacity & Guardianship Legislation. Theses cases are based on real situations and/or current patients in three areas of psychiatry – Psychiatry of Learning Disability, Psychiatry of Old Age and Liaison Psychiatry.

1. Psychiatry of Learning Disability

i. A 39 year old man has a **learning disability** and is functioning in the low mild range of ability. He has a history of epilepsy and also of unwanted sexual behaviours towards children but was never charged with any offence. Many years ago he was an inpatient in a Forensic Hospital and prescribed depot antiandrogen medication. He remains on this drug but it is unclear whether he has the capacity to consent to its administration.

Comment 1: This man is vulnerable to suggestion because of his learning disability. He would have difficulty understanding and retaining the information about the benefit and severe potential side effects of an anti-androgen (e.g. liver damage). Because of his suggestibility, he would also be vulnerable to unintended or implied duress. He requires the protection of this Act, and the Act needs to supply a process for independent review of treatment as in the Mental Health Act 2001 part 4.

Comment 2: Who should initiate an application and who should be empowered to give or withhold consent for the treatment with anti-androgen? Treatment in this community setting would not come within the Mental Health Act 2001 Part 4. Equivalent protections should be provided under this Act.

ii A 29 year old man with **severe autistic spectrum disorder** has been diagnosed with **Bipolar Affective Disorder**. He has had inpatient psychiatric treatment during episodes of hypomania and has on occasions been detained and treated under the Mental Health Act. He lives in a residential unit with four other men, which has high staffing ratios. The GP attends the service twice weekly and is available at other times if required. He is also reviewed at the psychiatric outpatient clinic locally.

The family history is positive for Bipolar Affective Disorder, his mother and two sisters both having the condition. His sisters have at times been non-adherent to their own recommended treatments and have had frequent relapses of their illnesses with adverse effects on their own lives. His family are aware of his diagnosis and treatment, but do not always agree with the recommended treatment. He functions in the low mild/moderate range of learning disability

and is not able to understand the full nature of his illness or his treatment. He is prescribed neuroleptic medication and also lithium therapy.

Comment 1: This man lacks capacity to make decisions about his welfare, his financial affairs or his medical treatment including psychiatric treatment. At times when his bi-polar illness is in relapse, the inter-relationship between the Personal Guardian and the consultant responsible for his care and treatment under the Mental Health Act 2001 will have to be clarified. The role of the family in relation to a personal guardian will be complex – who should have the role? How may a personal guardian be challenged or displaced if refusing consent to necessary treatment?

iii. A 54-year-old man with **severe intellectual disability** lives in a sheltered residential setting. He developed **non-insulin dependant diabetes**. He cannot understand the consequences of the diabetes treatment or of refusing treatment. He accepts oral medication. However, he has an extreme fear of needles and refuses blood tests. Consequently it is very difficult to monitor his condition. The consultant physician who is treating his diabetes recommends a minimum of blood tests every 12 months.

Comment 1: acting in 'best interests' here ought to balance the person's expressed preference and the real long-term risks to health and ultimately to life. It may be negligent if he does not have the recommended monitoring. How could such a decision be challenged where there is a disagreement concerning best interests of the person? Would a decision by a personal guardian not to have this regular monitoring cover the possibility of such future action, against the personal guardian and/ or the treating physician?

Comment 2: Is it possible to take blood by restraining the patient and under what circumstances? Such a power is not explicit in the Mental Health Act but is sometimes required.

Comment 3: His next of kin (a cousin who sees him yearly) thinks his diabetes does not need to be treated. Whose wishes should be taken into account?

iv. A 50-year-old lady with **mild intellectual disability and deafness** has **no family members** and lives in an **institutional setting**. She also has recurrent episodes of severe anxiety, when she becomes difficult to manage. She has smoked for many years and now smokes 5-10 per day. She receives some cigarettes directly from staff (this is used to help with her general cooperation) and some indirectly by asking other people around the institution.

She develops a precancerous lesion in her mouth and is strongly advised not to smoke. She understands about cancer but has difficulty applying the knowledge to herself and also has problems communicating because of her deafness. She wants to continue smoking; she becomes aggressive if refused her cigarettes and poses a danger to others.

Comment 1: How can a decision about this aspect of the service user's welfare be arrived at to the satisfaction of all concerned? A personal guardian may make a decision with minimal consultation or consensus amongst the carers. How can such a matter be appealed to the Office of Public Guardian?

v. M was an 84 year old woman with **moderate intellectual disability**. She did not suffer from a mental illness and was verbal and able to express her wishes clearly. She developed a **bony swelling of her left lower leg**. She was referred to an orthopaedic consultant who recommended a biopsy of her leg, as the most likely diagnosis was a sarcoma. She refused this intervention. She deteriorated rapidly, her leg broke down in weeks, she developed delirium and she died within 2-3 months.

Comment 1: M could express her wishes but lacked the capacity to give valid consent. Were the clinicians correct to accept her refusal?

2. Psychiatry of Old Age

The following vignettes are examples of situations not covered by mental health legislation or Wardship.

vi. A Husband and wife, ages 76 and 72, both have a long history of **alcohol dependence** and both have **moderate dementia.** Both refused medical input. Recently both were found with dehydration and impaired consciousness and brought to hospital. After 3 days both left hospital against medical advice. They live in squalor and refuse community supports [home help, meals on wheels, day centre]. Neither has capacity to manage personal or financial affairs due to dementia. No Enduring Power Of Attorney is in place and an approach to Wardship was refused as they live in rented accommodation and have no assets. Neither person meets criteria for mental disorder as defined in Mental Health Act 2001.

Comment 1: Assuming incapacity can be shown, who may apply for personal guardianship and who should (must) apply? How can the likely objections of the couple in question be heard?

vii. A 76 year old lady with **moderate dementia** has taken to wandering and has had to be helped back to her house on numerous occasions by neighbours. She has put her electric kettle on the gas cooker and is unsafe in her kitchen. She has no insight into her difficulties and refuses all supports. The problem is loss of function regarding activities of daily living rather than behavioural disturbance so that she does not fall within the definition of severe dementia as defined in the Mental Health Act 2001. She has no assets and so does not come within the scope of Wardship as it exists at present.

Comment 1: Will this Act permit the appointment of a personal guardian to decide issues regarding her welfare (where she should live) and her person

(treatment for dementia)? Who may apply (next of kin, GP, social worker, neighbour?)

viii. An 80 year old man with **moderate dementia** presents via ambulance to the A&E department with a **fractured hip** following a fall. He does not have capacity to consent to treatment. He is agitated and resistive to examination.

Comment 1: This is not really an immediate life-threatening situation, therefore 'common law' powers do not really apply. Pain and suffering need treatment and require preliminary investigations before they can safely be commenced. The longer such investigation and treatment is delayed, the more likely it is that further complications will set in.

Comment 2: How may urgent physical examination and investigations, including blood tests and X-rays, be carried out? Can A&E staff apply simple manual restraint and take blood samples (essential prior to surgery) without his consent? What power would cover this?

ix. A 66 year old man has **severe dysphasia** (impaired ability to communicate) and hemiparesis following a stroke. No Enduring Power Of Attorney is in place and he has no assets. There is longstanding marital disharmony and his wife refuses to have him at home following rehabilitation.

Comment 1: Who may apply for guardianship? Who has the responsibility to do so? The HSE may be reluctant to engage in a costly process of litigation unless under a duty to do so.

x. A 77 year old man has **donated Enduring Power Of Attorney to his wife and son.** He now has a **dementia.** His wife and son are both extremely burdened and consequently verbally abuse the patient. On occasion his wife has also given him some of her medications to try and sedate him. He has ongoing agitation in the context of the highly emotional situation at home but does not meet criteria for mental disorder as defined in the Mental Health Act 2001. The family are not co-operative with medical advice and refuse respite care or admission. He has assets of €4,000 which his son is going to use for a holiday.

Comment 1: Who may apply for guardianship and who is under an obligation to apply under what are likely to be fraught circumstances?

3. Liaison Psychiatry

The following vignettes describe typical clinical scenarios relating to capacity in the general hospital.

xi. **A 78 year old woman** is **refusing to allow blood to be taken.** She was admitted 2 days ago for investigation of a **breast lump.** She is a widow who lives alone. She is usually visited once a week by her daughter who lives in Cork. The woman has never been in hospital before. Nurses report 'no concerns' apart from refusing phlebotomy (blood tests). Her score on a screening test for dementia is near normal (MMSE=28/30). She states her reason for refusal as 'I'm afraid of needles'.

Comment 1: The screening assessment (MMSE) indicates that this woman does not have any impairment of cognitive capacity and is likely to be fully capable. An expert assessment is necessary to establish this, since it would otherwise be easy to assume that an elderly, physically ill person refusing treatment is incapacitated.

xii. **A 59 year old man refuses transfer** from St. Jude's District General Hospital to St. Elsewhere's (regional centre of excellence) for management of **suspected laryngeal carcinoma.** He has presented to A+E with **stridor (difficulty breathing)** 2 weeks earlier, having refused the entreaties of his family to go to hospital until respiratory distress became acute. Laryngoscopy and CT scan indicate a probable laryngeal tumour occluding the airway. This means that there is a high immanent risk of complete occlusion leading to suffocation and death. A general surgeon advises immediate transfer to the specialist centre with an ENT department as on-call staffs at St Judes are not skilled in tracheotomy under these circumstances. The patient refuses saying "I'm happy here – talk to my wife – she'll tell you".

The patient's wife reports **a long history of alcohol dependence** syndrome and that he has always been stubborn; he has had memory difficulty apparent for 6 months; she couldn't go against him – he'd never forgive her. Psychiatric assessment indicates **alcohol related dementia,** with very poor short term memory and some loss of other faculties. He does not believe the advice regarding the seriousness and immanence of his situation and appears on assessment to be unable to believe this advice.

Comment 1: The incapacity here is most clearly evident from the inability to believe the information given by medical advisers. The capacity to reason is further impaired by the poor short term memory and other cognitive deficits, even though he can retain information for short periods.

xiii. A 32 year old man refuses to stay in the Intensive Care Unit for observation. The patient had been **admitted unconscious**. He was found collapsed, in a pub toilet, with an empty bottle labelled methadone. An Opiate overdose is suspected – confirmed when he responds to an injection of naloxone (an opiate antagonist) by regaining consciousness. The patient refuses to give a urine sample or to allow his family to be contacted. He is advised that he requires 24 hours observation because naloxone (the antidote) is eliminated from the body much more quickly than methadone and he is likely to lapse into unconsciousness. The patient states he will not stay in the general hospital but would agree to go to the local psychiatric hospital. He goes outside A+E to have a cigarette with friends.

Comment 1: While conscious this man is competent and the assumption of capacity should stand.

xiv. A 52 year old woman, a **patient in the hepatology** (liver) ward, regularly **refuses blood tests and frequently refuses medications**. She was scheduled for a procedure to prevent dangerous bleeding from oesophageal varices, but has now changed her mind and is refusing oesophageal banding.

The patient was admitted 2 months ago with end-stage alcoholic liver failure with jaundice, haematemesis (vomiting blood) and ascites (free fluid in the abdomen due to liver failure). She has been on the transplant list for 5 months. There have been several transient **episodes of hepatic encephalopathy.** Her current treatment includes Aldactone (for fluid and electrolyte balance), Alprazolam (for sedation) and abdominal drainage. Recent Hepatology review recommended commencing Total Parenteral Nutrition and banding of the bleeding oesophageal varices. The patient initially agreed but changed her mind 3 days later as she became more confused – she has since varied her decision frequently.

Comment 1: Fluctuating capacity and delirium is common in this and similar illnesses. A personal guardian should be empowered to make decisions that are consistent and coherent.

xv. 18 year old woman refusing to eat hospital food, refusing to leave her bed or to allow physical examination. She was admitted 24 hours previously with abdominal pain, white cells elevated (indicating possible infection) but other blood tests were normal and physical exam revealed no abnormality except for 3 scars on her left wrist. Her boyfriend has stayed in her room since admission (despite nursing staff requests for him to leave) apart from occasional visits to the hospital shop to buy coke and crisps (which she nibbles at). The woman refuses psychiatric assessment or consent for her family to be contacted.

Comment 1: The process of assessing capacity itself needs consent or permission. There are grounds for suspecting impaired capacity in this case.

This woman is at risk of serious deterioration in her physical health unless she undergoes medical investigation and if necessary medical treatment. It must be emphasised that this is not covered by the Mental Health Act 2001. How is the process of assessment to be initiated, and by whom? If this were a simple question of initiating assessment with a view to detention and treatment under the Mental Health Act 2001, Part 2 of that Act contains a detailed process for the application for assessment, recommendation, making of an order and independent review by a second opinion and Mental Health Tribunal within 21 days of the making of the order. A comparable process should be clearly set out in this Bill.

xvi. **A 58 year old retired doctor** has **long-standing schizophrenia**, partially controlled by anti-psychotic medication. He **develops gangrene** of the left leg following an arterial embolus (a clot in a major blood vessel). He has been admitted to the surgical ward of a general hospital. He is advised by his consultant psychiatrist that the leg must be amputated as it cannot be saved and if left, septicaemia will set in and will be life-threatening. The patient is fully oriented in time, place and person, he is able to retain the information given, and he is able to understand it and can explain the benefits and consequences of having or refusing amputation.

However he decides to **refuse surgery and all forms of treatment** because he does not believe the advice applies to him. He explains that he believes the gangrene is a test sent by God and the devil and the outcome will be decided by some cosmic struggle. He has been assessed by a consultant psychiatrist and although he has delusions he does not currently come within the definition of mental disorder in the Mental Health Act 2001. He is accepting all prescribed anti-psychotic medication but has never improved more than his present state. Detention under the Mental Health Act would not confer a power to give treatments for non-psychiatric disorders without consent.

<u>Comment 1</u>: This is one of the most common dilemmas in the treatment of the psychoses. Although most mental capacities appear to be intact, the defect of reason that leads to delusions also leads to an inability to believe information relevant to some decision regarding treatment, welfare or financial affairs.

xvii: A 36 year old man has had **numerous admissions** to his local **psychiatric unit** over the last 18 years for the treatment of **schizophrenia,** both voluntarily and, in recent years, mostly under the Mental Health Act 2001. He is seldom willing to accept treatment or advice regarding his health. Although he responds quickly to anti-psychotics, becoming calm, cheerful and friendly to others on medication, with minimal residual delusions and hallucinations, his occupational therapy assessment shows enduring impairments of his ability to organise his routines and activities of daily living. He cannot consistently budget.

Psychiatric assessment shows that even at his best he never gains insight and does not believe that he has a mental illness or benefits from medication or that he would benefit from living in a high support hostel. When discharged from detention under the Mental Health Act he usually leaves hospital and discontinues medication. He then often chooses to live rough because he believes he must escape spies and persecutors. He is usually readmitted to the hospital in a very undernourished and unhygienic state due to self-neglect, with tormenting delusions and hallucinations. At times he is brought to hospital by An Garda Siochana because, when very disturbed, he creates disturbances at his parents home or in public places. This has alienated many of his former friends and neighbours.

Comment 1: This is a very common presentation in general adult psychiatry. We believe this person lacks mental capacity to make decisions about his welfare, medical treatment (including psychiatric treatment) and financial affairs, even when partially recovered from the more acute symptoms of schizophrenia and even when no longer coming within the (narrow) definition of mental disorder in the Mental Health Act 2001. This person would benefit from having a personal guardian.

Comment 2: Deciding whether the person is competent to donate Enduring Power Of Attorney (EPOA) requires very careful assessment in the context of guidance regarding this question. As described above, we believe this person would not have the capacity to make a valid donation of EPOA. Also, it should be made clear that donating EPOA is not the same as an advance directive. The appointment of an attorney who is opposed in principle to psychiatric treatment should be open to appeal or objection where it can be shown that such a person would act or has acted contrary to the best interests of the donor.

Xviii: M was detained under the Mental Health Act 2001. He has **severe and enduring mental illness with severe thought disorder** and can seldom express himself coherently. His thought processes are dominated by persecutory and grandiose delusions. He has on a number of occasions thrown petrol bombs at ambulances and Garda cars because they bear the confidential helpline number which includes the digits '666'. He consistently expresses the desire to stay in hospital and becomes more disturbed when the possibility of rehabilitation or recovery is raised with him.
His **solicitor mounted a legal challenge** to the legal form of M's detention, while accepting that all medical opinions were unanimous concerning the continued appropriateness of M's detention under the Mental Health Act. The Habeas Corpus application was considered and rejected in the **High Court.** Costs were not awarded to the solicitor. The solicitor appealed to the **Supreme Court** who also **rejected** the legal argument. M consistently expressed to staff his distress at these proceedings and the possibility that the proceedings might lead to his discharge. M's family were very distressed that the proceedings

should have been taken and agreed with M that it was better for him to remain in hospital.

Comment 1: M was at no time capable of understanding the legal issues involved, nor could he make consistent decisions in his own best interests. However he was consistent in expressing his distress at the proceedings and their possible consequences. M's solicitor appears to have assumed that because of M's incapacity, he should act as the substitute decision maker and the solicitor appears to have made the decision to proceed in the belief that this was in keeping with legal professional ethics applying the legal principle that liberty is always the prime principle. This however conflicts with the principles stated in the Mental Health Act itself and conflicts also with the expressed wishes of M (even though M is mentally functionally incapable) and the expressed wishes of M's family. The solicitor was not awarded costs when the High Court Action failed, but was awarded costs following the failed appeal to the Supreme Court. This raises the appearance of conflict of interest, even if the solicitor was acting in good faith.

Comment 2: A personal guardian empowered to act as the source of legal instructions to the solicitor would have ensured a more ethically consistent and un-conflicted decision making process regarding the initiation of the various legal challenges.