The College of Psychiatry of Ireland
Coláiste Síciatrachta na hÉireann

Press Statement - 03 July 2009

The College of Psychiatry of Ireland Disappointed at the Delay in Publishing the Mental Capacity Bill

The College of Psychiatry of Ireland has issued a submission paper to the Department of Justice, Equality and Law Reform outlining recommendations to be considered for the proposed new Capacity & Guardianship Legislation currently being drafted. In the same week it was announced by the Minster for Justice Mr Dermot Ahern that the publication of the new Mental Capacity Bill which will replace the 1871 Lunacy Regulations Ireland Act would be delayed until the end of the year at the earliest.

The College welcomes the proposed legislation concerning the protection of the mentally incapacitated but is disappointed that its publication is being deferred continuing to leave vulnerable people unprotected in terms of clinical, financial and welfare decision making.

The College has concerns about the Heads of Bill as outlined in the Scheme of Mental Capacity Bill, September 2008 which are structured around legal processes and not clinical care processes and pathways. Consultant Psychiatrist and one of the lead authors of the paper **Prof Harry Kennedy** in explaining the purpose for preparing the submission document said ***"The Bill (The Scheme of Mental Capacity Bill 2008) as it stands emphasises legal rather than clinical or welfare decision-making, and at every point seems to place the legal system at the centre of patient care and welfare. In many ways issues of capacity that arise in day-to-day cases and clinical practice are not dealt with".***

Outlining another concern addressed by the College submission paper Prof Kennedy goes on to say that ***"It (The Bill 2008) is written mainly from the perspective of long-term incapacity (involving personal guardianship and enduring power of attorney), which in practice is less common and less urgent an issue than short-term incapacity. This Bill could unintentionally obstruct the urgent management of the most common clinical problems concerning incapacity and decision making regarding medical treatment"***

Prof Kennedy points out that in reality **three areas of decision making can be distinguished with regard to person – 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 long term enduring incapacity. The bill should also be capable of providing for emergency intervention in life threatening situations, urgent interventions to relieve suffering or preserve dignity and for elective interventions.

The College submission paper notes that The Mental Capacity Bill should be fully integrated 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. The paper also provides examples of every day common clinical cases to illustrate the short comings of the Bill and/or highlight the concerns raised in their paper.

Ends

For further information or a copy of the CPsychI submission paper on the Proposed Capacity & Guardianship Legislation please contact:

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Please see attached for common clinical cases.

Case Examples – The real life stories

▪ **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.

There is a family history of 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.

Comment: 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?

▪ **A 75 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 €5,250 which his son is going to use for a holiday.

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

▪ **A 60 year old retired solicitor** 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.

Comment: 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.

▪ **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 Siochána 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. It is believed 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.

▪ **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: 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.