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(In)capacity legislation in practice

AIMS AND METHOD

Capacity legislation was implemented in Scotland in 2002 under the Adults with Incapacity (Scotland) Act 2000. This questionnaire study aimed to explore the knowledge, experience and opinions of the Act among consultant psychiatrists in Scotland ($n=373$; response rate 64%).

RESULTS

The majority of respondents had attended an induction programme: 74% were confident in their assessment of capacity and 54% felt confident in their use of the Act. Awareness of the principles and code of practice was good. The administration of the Act varied between areas.

CLINICAL IMPLICATIONS

Despite good knowledge of the Act, respondents reported they were largely self-taught and would welcome further training. Administration, uptake by other medical disciplines and discrepancies between principle and practice were raised; these concerns are relevant to amendments of this legislation and to other jurisdictions.

The right to make decisions affecting one's own life is a basic legal and ethical principle but this is only meaningful if the decision is appropriately informed, made without coercion and the individual has the 'capacity' to choose. Prior to the introduction of capacity legislation in Britain – the Adults with Incapacity (Scotland) Act 2000 and the Mental Capacity Act 2005 – the treatment of incapable adults was mainly governed by case law and for many lacked clarity. Studies suggest that the assessment of patients' decision-making ability was *ad hoc* with little agreement as to the necessary components (Ganzini *et al*, 2003) and psychiatrists were found to disagree in their interpretation of the competence criteria for consent to treatment (Shah & Mukherjee, 2003). Differences were also demonstrated in assessment of decision-making ability between lawyers and doctors, with the former more likely to find an individual competent (Schachter *et al*, 1999).

The Adults with Incapacity (Scotland) Act 2000 (AWIA) was passed by the Scottish Parliament on 29 March 2000. The legislation gives a statutory definition of incapacity and forms a framework for the management of property, financial affairs, personal welfare and medical treatment in adults who have impaired decision-making ability. Guardianship orders may grant power over personal welfare, property and/or financial affairs, and certificates of incapacity and accompanying 'treatment plans' authorise medical interventions. The legislation places an obligation on the doctor to take into account the present and past wishes of the adult concerned, in as far as they can be ascertained, and to encourage the use of the skills he or she has, and the development of new skills.

The principles of the AWIA state that any intervention should benefit the adult concerned, represent the least restrictive option and be consultative. These principles are similar to those of the Mental Capacity Act 2005, which was implemented in 2007.

Method

The questionnaire (available from the author) was devised based on a review of the literature, consultation with psychiatric colleagues and a feasibility and pilot study. It comprised four sections, examining demographic details, training in the AWIA, experience of using the Act and knowledge of the Act. There were open text boxes for additional comments.

The questionnaire was initially distributed as an adjunct to a routine Royal College of Psychiatrists Scottish Division mailing; a second mailing was sent to named consultant psychiatrists individually. It was not possible to contact non-responders because of the anonymous distribution method. The study was carried out in 2004. The delay to submission is attributable to the personal circumstances of the author; however, the literature indicates few developments in the interim.

Results

Demographic characteristics of the sample

In total, 240 completed questionnaires were returned over a 6-month period, a response rate of 64%. The gender ratio was 55% male to 45% female. The geographic spread of respondents corresponded to workforce numbers (Royal College of Psychiatrists, 2003). Half ($n=120$) of respondents were general adult psychiatrists, 24% ($n=57$) were old age psychiatrists and 10% ($n=24$) were psychiatrists in learning disability. This equates to an overall response rate of 85% in the old age psychiatry group and 86% in the psychiatry of learning disability group. Other specialties included substance misuse, psychotherapy, liaison psychiatry, rehabilitation and forensic psychiatry.

Training

The majority of respondents (71%; $n=171$) had been to an induction programme; local programmes were more commonly attended (68%; $n=117$) than national ones



(37%; $n=63$); 9 respondents had attended both. Respondents' views on these programmes varied: 57% ($n=97$) reported that the programme was helpful, 36% ($n=61$) reported that it was adequate and 6% ($n=11$) that it was unhelpful.

Knowledge of the legislation

The majority of respondents were aware of the legal presumption of competence (88%; $n=210$), the principles of the Act (75%; $n=180$) and whom there was an obligation to consult regarding any proposed intervention (70%; $n=166$). However, there was less certainty over the legal definition of incapacity, with 124 (52%) of respondents unclear or incorrect. The overall knowledge of the legislation was greater among consultants in old age psychiatry and the psychiatry of learning disability, with both groups scoring an average of 87% correct on all questions.

The Act in practice

Over half (54%; $n=128$) of respondents were confident in their application of the Act, 37% ($n=89$) were not and 9% ($n=23$) were unsure. Almost three-quarters of respondents (74%; $n=177$) felt confident in their assessment of capacity, 21% ($n=50$) did not feel confident and 6% ($n=11$) were unsure. Most respondents had experience of writing certificates of incapacity (68%; $n=162$), although 44% were not clear how to write a treatment plan. Guardianship procedures had been carried out by over half of respondents (58%; $n=138$) and 24% ($n=54$) had applied for intervention orders.

The administration of the AWIA varied between areas, with only 45% ($n=108$) of respondents reporting that there was a formal local system in place for the keeping, checking and collation of documentation (incapacity certificates, treatment plans, etc.).

Open text comments

The main themes and common issues related to training, difficulty obtaining clear advice from official bodies, underuse of the legislation by other medical disciplines, ideological issues and administrative problems.

- Specialists outside of psychiatry often do not use the AWIA owing to lack of training. In some specialties, principally surgery, relatives are still asked to sign consent on behalf of the patient.
- General practitioners neglect the AWIA because there is no incentive or disincentive to do otherwise.
- The Mental Welfare Commission which has the responsibility of overseeing this legislation is insufficiently rigorous in its role.
- The keeping, checking and collation of records (certificates, treatment plans, etc.) are *ad hoc* in many areas.
- Legal advice is inconsistent and varies between geographical areas.

- Why is a guardianship order necessary if all parties are in agreement that a nursing home placement is the appropriate management plan and the patient is not dissenting?
- Local authorities are unable to respond to clinical demand in a timely manner, such that it often takes months to arrange multidisciplinary meetings.
- There is uncertainty about short-term memory impairment as to whether patients are 'incapable' simply because they cannot remember a decision made, or whether it can be acceptable if they have a clear understanding of the issues and make the same decision on repeated occasions.
- The resource implications have been overlooked.

Discussion

This study demonstrated the following key findings: the majority of respondents had attended an induction programme; 74% were confident in their assessment of capacity; 54% felt confident in their use of the Act; and a surprisingly good knowledge of the Act and its code of practice was demonstrated. Respondents voiced concerns that they were largely self-taught and would welcome further training. Their comments highlighted a number of practical and ideological shortfalls in the legislation and did so at a time well in advance of the findings of statutory bodies.

Respondents reported a lack of regulation of incapacity certificates, which also removes the opportunity to learn from feedback. This regulatory function falls to the Mental Welfare Commission for Scotland, which is concerned with safeguarding patients affected by either incapacity or mental health legislation. At the time of the inception of the AWIA there were no central monies available to fund the development of local administrative systems for incapacity certificates, and as a result these are perceived as *ad hoc*. Comments suggest that the Mental Welfare Commission could be more rigorous in ensuring standards. In particular, the regulation and uptake of the legislation in other medical specialties, especially orthopaedic surgery, was raised as a concern.

Most emotive for respondents were guardianship/intervention orders and in this they showed considerable prescience. The Mental Welfare Commission has subsequently issued guidance outlining the present legal position, which does not always sit easily with the principles of the Act. The European Court of Human Rights in its finding regarding *L. v. Bournewood* [2004] held that a mentally incapable man who was kept in hospital without clear legal authority was unlawfully detained (*HL v. UK* [2004]), and in *Muldoon* [2004] Sheriff Baird held that a guardianship order was necessary to fill a 'legal vacuum' whenever an incapable adult was moved to a new home, regardless of whether or not the person was 'compliant' with the move. This judicial line seems at odds with the principle of employing the 'least restrictive option'. There are also problems from a practical perspective; local authorities are unable to apply for financial guardianship, as the guardian must be a private individual such as a relative or a professional (e.g. a solicitor or accountant).



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Unless the adult is suitably affluent it is not economically worthwhile for solicitors to become involved and they decline to do so. The local authority may then find there is no one to 'hold' the guardianship, leaving the vulnerable adult at the mercy of their own incapacity.

Adherence to the principle of the 'least restrictive option' was also raised in relation to the definition of incapacity and the criterion to 'retain the memory of decisions'. It was argued that if a consistent decision, using sound reasoning and in keeping with an individual's life preferences, is made, then the ability to retain the memory of it is less relevant than the preference itself.

In summary, the medical profession has embraced the legislative changes inherent in the AWIA. Dr Michael Wilks, chairman of the British Medical Association ethics committee, stated:

'These responses are good news for patients, carers and doctors . . . the intention of the legislation is to promote patient choice, and to enable health professionals to support independent decision making by vulnerable adults.' (Wilks, 2004)

Consultant psychiatrists in Scotland appear to endorse these sentiments and demonstrated good knowledge of the AWIA. Their familiarity with this legislation compares favourably with their knowledge of the Human Rights Act 1998 (Passmore & Leung, 2003) and mental health law (Humphreys, 1998).

Limitations of the study

Limitations of this study include a selection bias because of the postal distribution; the study took place some time after the induction programmes with likely reductions in retention and recall of information; for pragmatic reasons the study could not be extended to other disciplines in medicine or to primary care clinicians and it was not possible to arrange a comparison group. None the

less, findings from this group are important irrespective of whether they differ from other doctors' experience of the legislation.

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Prevalence of parental mental illness in Australian families

AIMS AND METHOD

To provide multiple estimates of the numbers of Australian and Victorian families and children living in families where a parent has had a mental illness. We used the Australian Bureau of Statistics Victorian Mental Health Branch service usage and data collected from 701 community participants to triangulate prevalence information.

RESULTS

According to population estimates, 23.3% of all children in Australia have a parent with a non-substance mental illness, 20.4% of mental health service users have dependent children and 14.4% of the community study participants report having at least one parent with a mental illness.

CLINICAL IMPLICATIONS

The multiple prevalence estimates of the numbers of children in families with parental mental illness provide fundamental information for psychiatric policy, planning and programming.

Each year in Australia one in five adults is thought to experience a mental illness (Australian Bureau of

Statistics, 1997) and across the lifetime one in four will be affected by a mental disorder (World Health Organization,