Some legal aspects of mental capacity

Tom Arie

This is the second in a series of 14 articles edited by Eileen Burns, Neil Penn, and Graham Mulley

This article discusses some practical matters which arise when competence to make decisions is in question. Consent, testamentary capacity, powers of attorney, the Court of Protection, "living wills," and research on people with dementia are briefly considered.

Doctors and other health workers are often asked for an opinion on the capacity of an older person to make a decision or give a signature. These decisions can be difficult, for there are "grey areas" and there may often be uncertainty. The principles for assessing testamentary capacity will often be helpful; they clarify other similar questions of competence.

Testamentary capacity

Testamentary capacity requires that the subject should understand the nature of the act being undertaken—that a will is being made and what a will is. The person should have a reasonable awareness of the nature and extent of the assets to be distributed and should be aware of who might reasonably have a claim to be considered as beneficiaries of the will. Judgment must not be clouded by delusions or other significant mental illness.

PRACTICAL POINTS

Though the person must know that he or she is making a will, and what a will is, it is not essential to know the exact value, say, of a house that will form part of the estate. However, not to know that there is a house would normally be a significant deficiency.

A person is not bound to leave his or her money to anyone in particular, but a will would clearly be invalid

if the person making it had forgotten that he or she was married, or the existence of some or all of the children.

It is usually acceptable for judgment to be influenced by likes or dislikes, but not by psychotic ideas.

DETERMINING TESTAMENTARY CAPACITY

When a doctor or other health worker is asked for an opinion on mental capacity, the basis for the opinion—whether negative or positive—must always be clearly recorded. The facts may later be challenged.

Careful and searching questions must be asked: it is not enough to record a conclusion. Simple standard tests of cognitive function are usually desirable.

Many people who are grossly mentally impaired may long preserve a deceptively reassuring social facade.

A person who is in hospital on account of mental disorder should never sign any document without the knowledge of the doctor in charge. This rule (which should be universal in psychiatric units) should be included in ward information booklets given to patients and relatives. This applies also to mentally incapacitated people in nursing homes or similar settings.

Consent to treatment

When obtaining consent to treatment, the doctor's overriding concern must always be to do what is in the patient's best interests. Every attempt should be made to ensure that the patient understands the nature of the treatment and its risks and benefits—this may require the use of large print and clear wording on forms and patience on the part of whoever is explaining.

Forgetfulness may sometimes have little bearing on ability to understand. Older people have the same rights to self determination as those who are younger.

Power of attorney

Power of attorney is a legal document whereby one person (the grantor) enables another person of his or her choice (the attorney) to act on his or her behalf. The attorney can then act as if he or she were the grantor.

To give a valid power of attorney the grantor must pass essentially the same tests as those for testamentary capacity. The power may be limited to specific acts (for example, selling the house) or it may be "general," covering all financial matters.

In English law an ordinary power of attorney—made when the grantor is mentally well—automatically ceases to be valid if he or she becomes mentally incompetent.

Enduring power of attorney

Since an ordinary power of attorney lapses if the grantor becomes mentally incompetent, many countries have introduced the enduring power of attorney. This provides that, should the grantor become mentally incapable, the power continues to have effect.

England and Wales introduced enduring power of attorney in 1985; in Scotland an ordinary power of attorney signed after January 1991 remains valid even if the grantor loses capacity, unless the original document specifies otherwise. Before the enduring power of attorney was instituted, it was necessary to make over the affairs of a person who became mentally incompetent to

"Portrait of Rembrandt's Mother" by Hermensz Rembrandt van Rijn (1606-69). By permission of the Earl of Pembroke, Wilton House

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Practical points—consent to treatment

- Questions of treatment should always be discussed with the relatives of a mentally incapacitated person, but their relationship does not give legal authority to make decisions on the patient's behalf
- When there are uncertainties about the patient's competence, it is wise to consult other colleagues who know the patient, or to get independent opinions from those who don't. It may be appropriate to obtain the opinion of a psychiatrist or psychogeriatrician on the patient's mental state
- Confusion may be transient, and mild dementia may not be incompatible with ability to give informed consent
- A patient's lack of objection is often taken as consent ("the not unwilling patient"), but even this has been challenged

the Court of Protection (see below). This could be costly and time consuming.

Like an ordinary power of attorney, an enduring power of attorney is restricted to financial matters: it does not cover decisions on medical treatment or non-financial personal arrangements. It can refer to specific acts or can be "general."

The grantor can require the enduring power of attorney to take effect at once and continue despite subsequent incapacity; or to take effect only if the grantor should become incompetent.

The enduring power of attorney must be made on a prescribed form; this form is available from stationers. The form must be signed by the grantor, the attorney, and a witness (who does not need to be a professional person, though doctors are quite often asked to be witnesses). If competence is in question, it may be sensible to ask a psychiatrist (or psychogeriatrician) to be a witness. Like a will, an enduring power of attorney can be made without the help of a solicitor. But it is in practice wise to ask a solicitor to ensure that the form has been correctly completed.

The grantor may appoint one or more attorneys to act either jointly or "severally" (that is, each may act alone). Having two attorneys is a good idea since one or other may be unavailable (or no longer alive) when they come to be needed; and having two to act jointly gives "checks and balances," if these are felt to be necessary. Generally, people choose their spouse and a child or close relative or solicitor as their attorneys.

If the attorney believes that the grantor has become mentally incapable, the enduring power of attorney must be registered with the Court of Protection (there is

a fee). The grantor and certain stipulated close relatives must then be informed and have the right to object. The Court of Protection can terminate the enduring power of attorney if, for instance, the appointed attorney has become mentally incapable or is found to be dishonest. The Court of Protection does not routinely supervise the attorney after an enduring power of attorney has been registered—but it may do so if it feels it necessary.

The attorney has limited powers to benefit himself or herself from the grantor's assets—for example, if the attorney is a child to whom the grantor has been in the habit of giving an annual gift exempt from inheritance tax may continue to take that sum, on the basis that the grantor would have wished to continue to give it.

The Court of Protection

The Court of Protection exists to supervise the management of the affairs of those (known as "patients" of the court) who are mentally incapable of doing so themselves. The Court's powers relate only to financial matters. The court can write a will for an incapacitated person, either when no will exists, or to supersede an existing will which is no longer appropriate.

Referral to the Court of Protection should be considered:

- When it is believed (by a relative, friend, doctor, social worker, or other key person) that the patient is not capable of managing his or her affairs because of mental incapacity, and when bank accounts and property are not held in joint names with another person—and when there is no enduring power of attorney;
- When the patient's financial state justifies it: for those with limited assets (say, a total estate of less than £5000) the court can issue a short procedure order (this can be useful in arranging payment, for instance, of nursing home fees); for small matters, like drawing of a state pension, arrangements can usually be made with the social security authorities without recourse to the Court of Protection;
- When there is dispute, among the family perhaps, as to who should handle the patient's financial affairs; if there are no relatives; or if it is thought that someone may be dealing dishonestly with the patient's affairs.

Usually the nearest relative applies to the court, but anyone with a legitimate interest may apply. Personal referral is possible, but it is usually done through a solicitor. A Citizens' Advice Bureau may give helpful advice.

The doctor's role in referrals to the Court of Protection is to complete a medical certificate stating that the patient is incapable of managing his or her affairs by virtue of a mental disorder, the nature of which must be described. A fee can be charged.

THE COURT'S PROCEDURES

The court charges a commencement fee, an annual administration fee (which varies with the patient's income), and a fee for any major transaction which the court may authorise (such as selling a house). Fees may run to hundreds of pounds, or more, in some cases.

The court will require details of the patient's assets and financial commitments and will make an enquiry into all circumstances. If assets are small the court issues a short procedure order, usually within weeks.

For those with larger assets, the court appoints a "receiver." This misleading term means an "administrator" who is appointed to manage the patient's affairs under the supervision of the court. Usually this is a close relative or a solicitor or accountant. In Scotland a curator bonis is appointed on application to the Court of Session.

The receiver is authorised to draw on the patient's money for clothing and personal needs up to an agreed maximum. Receivers must ensure that the patient receives all social security entitlements, that any

Practical points—enduring power of attorney

- It has been established in the courts that the mere existence of a degree of dementia does not preclude the making of an enduring power of attorney, provided the necessary criteria can still be reasonably met
- An enduring power of attorney should always be considered in the early stages of a dementing, or potentially dementing, illness
- It may be sensible for entirely well people to make an enduring power of attorney, just as it is sensible to make a will—a road traffic accident may happen tomorrow. The enduring power of attorney may never need to be used, but it gives the reassurance that, should incapacity occur, one's affairs will be managed by someone whom one has chosen.

property is kept in good order, that buildings are insured, and tax affairs dealt with. They can apply to use capital to pay for nursing home or similar care or to maintain the patient at home. They can also apply for special authority to make loans and investments on the patient's behalf or to buy a piece of special equipment or furniture for the patient's benefit.

Living wills (advance directives)

Powers of attorney and the Court of Protection deal only with material assets. Living wills are concerned with decisions about treatment, especially at the end of life. A person in sound mind might stipulate that, should he or she become incapable of decisions and develop particular grievous illnesses, then certain treatments should, or should not, be given.

In the United Kingdom "living wills" have no legal force. But they have moral force in such issues as relief of pain, the vigour of treatment in terminal disease, or in resuscitation decisions. Views of relatives, close friends, or appointed attorneys carry moral force if they are based on evidence of what the likely wishes would have been when the patient was well.

Various drafts of advance directives are available, and an excellent book considers the subject in detail (see below).

Research

Questions of consent to research on severely demented people (as on children) remain problematic. Again, consent of close relatives is always desirable, but has no legal force. Ethics committees understandably find these issues difficult.

Practical points

- "Advance directives" have no formal place in English law, but are part of the current agenda of active debate. In the absence of precise legal provision, the doctor must, as in all things, be seen to act in good faith, taking into account any evidence of what the patient would have wished had he or she had the capacity validly to indicate this.
- The Alzheimer's Disease Society now has an agreement with Lawnet, a group of solicitors who offer a named person specialising in the type of advice carers need. There is a fee, but people referred by the Society may receive an initial half hour consultation free of charge.

Further information

The Public Trust Office (Protection Division, Stewart House, 24 Kingsway, London WC2B 6JX, tel 0171 269 7000) makes available a *Handbook for Receivers* and a booklet of *Guidance on Enduring Powers of Attorney*. Similarly, the Court of Session (Meldrum House, 15 Drumsheugh Gardens, Edinburgh EH3 JQG, tel 0131 220 1898) in Scotland provides a booklet of *Information for Families of Persons Subject to Curatorship*.

A detailed consideration of "living wills" is given in *Let Me Decide: The Health Care Directive that Speaks For You When You Can't* by W Molloy and V Mepham, published by Penguin in 1993.

The rise of counselling and the return of alienism

Simon Wessely

Current services for those with mental disorders show two trends. Psychiatric services are becoming concentrated on the care of those with "severe mental illness," largely (but unjustifiably) synonymous with chronic psychosis. The retreat of psychiatry from the care of those with non-psychotic mental disorders has helped the growth of counselling services for these patients. However, there is no evidence that non-directive counselling is effective for such disorders, in contrast to the evidence for the effectiveness of other treatments that are usually delivered by psychologists or community psychiatric nurses. By retreating from the concerns of general practice and general medicine, psychiatry is returning to the days of alienism: in Victorian terms, the care of "the mad." Possible consequences include increasing expectations of psychiatric services that cannot be met, a loss of skills within psychiatry, and increased demoralisation in the mental health services.

According to recent media stories, British psychiatrists are becoming concerned that scarce resources are being diverted away from the care of seriously mentally ill patients and instead are being given to unnecessary and inappropriate services such as counselling. One headline caught the flavour of the debate—"Worried well force aside the mentally ill." Advocates of counselling respond to such charges with vigour, pointing to the popularity of counselling and claiming that such services can prevent mental disorder and reduce the use of other hard pressed services.

At issue is a fundamental question about mental health services. How can we balance the competing, and often contradictory, requirements of need, demand, and effectiveness? Who really is in need? Who best is able to meet that need? Should patients always get what they want anyway?

These issues have been brought to attention by two changes. The first is the rise in the availability of counselling services; the second is the shift of psychiatry towards community care and the perceived hazards of that shift. These two developments are linked, and the increasing preoccupation of psychiatry solely with the care of patients with chronic psychosis has directly influenced the rise of counselling, without benefiting either the profession or most of those with mental disorder.

Counselling is popular, but is it effective?

The rise of counselling has attracted both attention and criticism. A recent editorial pointed to the general practice contract, the desire of general practitioners to reduce their workload, and the popularity of counselling as setting the stage for "an explosion of counselling."² Having joined the ranks of others who noted the lack of evidence for the efficacy of counselling,³⁻⁵ the authors concluded that "all counsellors in primary care should be properly trained, supervised, and supported,"² goals which have the energetic support of organisations such as the British Association for Counselling.⁶ However, it seems logical to consider issues of efficacy and effectiveness before those of support and training. A properly trained and supervised person who delivers an ineffective treatment is hardly a sign of progress.