

# But when can I go home?<sup>†</sup>

## COMMENTARY ON... RESIDENCE CAPACITY

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### SUMMARY

Assessment of mental capacity is, or should be, a regular part of daily clinical practice in general hospitals. It is both particularly important and potentially complex in relation to an older person with dementia wishing to return home despite concern over perceived risk. Case law provides some guidance, but an ethical duty remains for clinicians to develop and hone their professional judgement in this increasingly important area of practice.

### DECLARATION OF INTEREST

None

of the corresponding demerits of hospital in that regard, and only by the third edition (BMA 2010: pp. 214–216) is there a solitary scenario, but still not a chapter, on capacity in relation to discharge.

It is hard to imagine inability to communicate a decision being the sole cause of residence incapacity where communication has been sufficient to permit an otherwise satisfactory interview with the patient. The assessment of mental capacity is legally required to be functional (i.e. task- and context-specific) rather than status-based (i.e. resting solely on diagnosis), but is nonetheless conditional on the presence of mental and/or communication disorder. Both adequate communication and the presence of mental disorder would thus seem necessary prerequisites to a meaningful consideration of residence capacity in everyday practice.

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Assessment of mental capacity may at times appear couched in terms of complying with relevant legislation as much as securing overall benefit in line with a patient's wishes and values. The principle of proportionality can be seen as central to a human rights-based approach (Curtice 2011) in terms of actions carried out on behalf of 'incapacitated' or incapacitous individuals, but (understandable) concern about the gravity of potential outcomes and consequences appears to loom over the perceived complexity of the associated decision-making process. This risk of conflation seems particularly marked in the case of residence capacity for people with dementia.

### Communication

Assessment of residence capacity, whether recognised as such or not, occurs on a daily basis in any general hospital, but is relatively under-represented in the mental capacity literature. There is, for instance, little specific in the three editions of the generally excellent *Assessment of Mental Capacity* from the British Medical Association (BMA) and the Law Society. In the first edition (BMA 1995: p. 98) there is emphasis on trenchant generic advice that 'the doctor must guard against allowing a personal view of what is in the person's best interests to influence an assessment of capacity'. The second edition (BMA 2004: pp. 17–19) discusses ensuring a suitable environment for assessment, with welcome focus on the benefits of conducting this at home, but makes no mention

### Information

Such increased dependence on the remaining information-processing elements (understanding, retaining and using/weighing in the balance) thus imposes on information itself at least the level of emphasis suggested (Hughes 2015, this issue). There may well be a case for standards of information provision to both the patient/adult and any assessing professional. Arguably, these might at least include not only those options considered by the multidisciplinary team, but also any associated advice or recommendation.

### Home

A previously independent person with dementia may essentially be having to choose between the hitherto unfamiliar, and in some ways almost abstract, possibilities of home care or a care home. How far the notion of 'all practicable steps' in assisting assessment can be taken in relation to trial discharge to the individual's home remains an unanswered question. One possible approach to this, and to the question of how much information to provide, would be to include actual visits home, perhaps as part of an occupational therapy assessment, and to at least one care home.

The importance of home, particularly towards the end of life, does not lessen with the progression

<sup>†</sup>See pp. 307–312, this issue.

of dementia. The case law quoted by Hughes *et al* feels persuasive even though extrapolated. Its tone differs markedly from the prevailing assumption that a finding of incapacity will elicit a paternalistic response. Several of the article's authors have elsewhere (Poole 2014) argued powerfully for proper emphasis on best interests in conjunction with the assessment of residence capacity, but the risks portrayed probably reflect current clinical reality. The general point of seeking to 'explicitly place the person's will and preferences at the centre of determinations of best interests' (Kelly 2015) retains its importance in relation to residence decisions.

### How much capacity?

The relative lack of clear-cut clinical guidance for such an important life change is disconcerting, and more particular legal standards are clearly required (Emmett 2013). Hughes *et al* give due consideration to the significance of securing appropriate questions to guide assessment, but they do not tackle head on the problematic issue of how high to set the incapacity bar. The assessment of mental capacity is a core skill for all doctors, with old age psychiatrists perhaps best utilised in helping general hospital colleagues with the most difficult instances of assessing residence capacity.

### Best interests

Whether assessment of capacity/incapacity is better guided by objectivity or empathy may seem an odd question, given the need to avoid conflation of the assessment process and likely outcome or consequences, but it might nonetheless have some relevance. The patient must jump an essentially 'cognitive' hurdle of indeterminate height and their appreciation of the information being considered seems inevitably linked to premorbid personality. For the assessor, the question cannot be 'What would I do in this situation?', but rather 'What is this person really trying to tell me?'

Conflicting value judgements appear most likely in the weighing up of information, when different options are given varying levels of emphasis. If the treating team's considered view of a person with dementia's best interests, offered as a recommendation, is admission to a care home this is likely to become the default option should autonomy be denied. The questions suggested by

Hughes *et al* to guide the assessment of residence capacity appear eminently sensible and helpful, but also seem potentially quite 'high level' for someone with significant cognitive impairment. It is important that an institutionalising response does not follow automatically upon a finding of residence incapacity, but the assessment is unlikely to have taken place at all unless there was disagreement. Neither uncomprehending acceptance of multidisciplinary advice nor even grudging professional acceptance of a patient's wishes is likely to have triggered professional doubt and consequent challenge to the legal presumption of capacity.

### The future

Assessment of mental capacity, not least in relation to residence, is often presented as an essentially legalistic 'one-off' process, but ongoing professional judgement is presumably appropriate on a clinical basis. Return of residence capacity is unlikely to happen often, but slow recovery from delirium, prolonged abstinence from alcohol or, somewhat ironically, skilled management in a care home environment, might all contribute to this. Population demographics, lost bed-days and human rights all demand that assessment of residence capacity be an area of active continuing professional development as well as a regularly exercised clinical skill.

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