Capacity Australia

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Hong Kong Psychogeriatric Association (www.hkpga.org)

Book of Proceedings

1st Annual International Capacity Conference "Capacity, Ethics and the Prevention of Abuse"

20th September 2014

Venue: The Federation of Medical Societies of Hong Kong
Lecture Hall, 4/F Duke of Windsor Social Service Building
15 Hennessy Road
Wanchai, Hong Kong

Welcome Message

On behalf of Capacity Australia, I would like to wish you a very warm welcome to the 1st Annual International Capacity Conference, with this year's opening theme being: "Capacity, Ethics and the Prevention of Abuse". In bringing together delegates and speakers from eight countries, from a variety of disciplines both health and legal, the Conference aims to promote a truly international, multidisciplinary and human rights-driven approach to capacity and decision making. We hope this exciting, world-first initiative will encourage awareness- raising amongst health care professionals regarding their responsibilities under human rights and health care law frameworks and to alleviate some of the "legal phobia" that prevails amongst health care professionals. We also hope to model collaborative efforts and a mutual exchange of knowledge with legal professionals who share equal responsibilities under these frameworks.

We would like to thank our administrative team from Capacity Australia, including Tulsi Levin de Graaff, Vanita Connery and Simonetta Frey for their tireless efforts over the last year. We give special thanks to the Hong Kong Psychogeriatric Association (particularly Professor Helen Chiu and Associate Professor Joshua Tsoh) and Dr Wai-Ming Wong and Dr Elsa Hui for their support, and thanks to Associate Professor Jin Narumuto, Associate Professor Yuka Kato and Dr. Yumiko Arai for joining us from Japan. We also thank our pharmaceutical sponsors Novartis, Lundbeck, Eisai and Astra Zeneca.

Enjoy, be energized and learn about the exciting initiatives around the world that are promoting autonomy in decision-making and working to address the all-too frequent occurrence of exploitation and abuse.
And, join us next year at the International Psychogeriatric Association (IPA) Congress, Berlin, Germany, 13-16 October 2015.
Kind Regards

Carmelle Peisah
President Capacity Australia

Programme

SATURDAY, 20TH SEPTEMBER 2014

1st Annual International Capacity Conference "Capacity, Ethics and the Prevention of Abuse"

Morning session

	Activity	Speaker	Topic
8.00 - 8.30	Registration		
8.30 - 8.45	Welcome and opening address	Professor Helen Chiu	
8.45 - 9.15	Keynote address	Ass/Prof Carmelle Peisah, Australia	Supported decision making: putting our actions where our mouths are in human rights
9.15 - 9.45	Plenary	Ass/Professor Joshua Tsoh, Hong Kong	Guardianship laws and surrogate decision-making practices in Hong Kong and selected Asia-Pacific Rim Nations: A comparison and the ways forward
9.45 - 10.15	Plenary	Dr Wai Ming Wong, Hong Kong	Hong Kong Mental Health Ordinance - a local geriatrician's perspectives
10.15 - 10.40	Poster snapshot session		Embedding the Mental Capacity Act 2005 in clinical practice: an audit review (Dunlop & Sorinmade); Guns, dementia and mental illness: What should a clinician do (Wand et al); Concurrent validity of a family caregivers self-reported potentially harmful behavior (PHB) towards their care recipients (Arai et al); A collaborative approach to supporting communication in the assessment of decision making capacity (Zuscak et al); Abuse of elders in India: an overview of the issues (Kardile); Sexual expression, consent and capacity in residential care: a person-centred, human rights approach (Peisah et al)
10.40 - 11.00	Morning tea	POSTER VIEWING	
11.00 - 11.30	Plenary	Ass/Prof. Jin Narumoto, & Ass/Professor Yuka Kato, Japan	J-DECS: Health care decision-making support for people with dementia in Japan
11.30 - 12.00	Plenary	Dr Yumiko Arai, Japan	When driving capacity is lost: a support manual for caregivers
12.00 - 12.30	Plenary	Dr Elsie Hui, Hong Kong	End of life decision-making in residential care homes
12.30 - 1.30	Open Papers Speakers underlined	**Theme:** Abuse and undue influence	**12.15 - 12.25** – A Collaborative approach to the "Grand Compromise" in the abuse of older people Speaker: Therese A Findlay & Kerry Marshall **12.25 - 12.45** - Enduring Powers of Attorney and Undue Influence Speaker: Dr Elizabeth A. Merson **12.45 - 1.05** - The road to hell is paved with good intentions Speaker: Andrew Verspaandonk
1.30 - 2.15	Lunch	POSTER	VIEWING

Afternoon	Session		
2.15 - 3.35	Open Papers Speakers underlined	**Theme**: Capacity assessments in health and law **Chair:** Sue Field	**2.15 - 2.35** Client capacity – do lawyers get it right? Speaker: Sue Field; Karen Williams, **2.35 - 2.55** An assessment protocol for determining decision making capacity Speaker: Mr Simon J. Zuscak and Prof. Ian Coyle. **2.55 - 3.15** From the Coalface – a Lawyer's perspective Speaker: Barbara Campbell **3.15 - 3.35** Capacity to give legal instructions: A human rights perspective Speaker: Dr Ilana Hepner
3.35 - 3.50	Afternoon tea	POSTER VIEWING	
3.50 - 4.30	Open Papers Speakers underlined	**Theme**: Miscellaneous mysteries	**3.50 - 4.10** The Mental Capacity Act (MCA) and Individual autonomy in England and Wales. Speaker: Dr Oluwatoyin A. Sorinmade **4.10 - 4.30** The policies and practices of financial institutions in respect of substitute decision making instruments Speaker: Ms Sue Field
4.30 - 5.30	End of life/end of session Speakers underlined	Open paper	**4.30 - 4.50** A Single-Centre Cross-Sectional Analysis of Advance Care Planning among Elderly Inpatients Speaker: Dr Flora Cheang **4.50 - 5.20** A panel discussion on decision making at the end of life: Speakers: Ass/Prof Carmelle Peisah; Dr Elsie Hui; Dr Wai-ming Wong
		Panel	
5.20 - 5.30	CLOSE/WRAP-UP		

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Reference: 1. Davis KL, et al.: JAMA. 281, 1401-1406(1999).

Our keynote speaker

Associate Professor Carmelle Peisah

Bio: Old Age Psychiatrist; President Capacity Australia; Conjoint Associate Professor, University NSW; Clinical Associate Professor Sydney University; Clinical Director Specialised Mental Health Services for Older People, Northern Sydney Local Health District, Australia;; Chair of the International Psychogeriatric Association (IPA) Taskforce/Shared Interest Group on Capacity; Co-author with Mr Nick O'Neill of the textbook "Capacity and the Law" http://www.austlii.edu.au/au/journals/SydUPLawBk/2011/1.html; multiple publications and presentations on Capacity; former Member of the Guardianship Tribunal NSW; acted as an expert both in Australia and internationally in >300 cases related to capacity; consultant to state and national groups on a range of capacity issues including end of life decision making, informed consent for psychotropics, and elder abuse; lead in a national research project with Australian Banking Industry looking at knowledge translation and awareness raising to prevent financial abuse.

Title: Supported decision making: putting our actions where our mouths are in human rights.

Abstract: The United Nations Convention on the Rights of Persons with Disabilities (CORPD) entered into force in May 2008, and has since been signed by 123 countries. Article 12 recommends signatory parties take appropriate measures to provide access by persons with disabilities to the support they require in exercising their legal capacity. This paper will discuss opportunities for health care professionals to meet these obligations by supporting the decision making of people with decision-making disability. Notwithstanding the right to presumption of capacity for all adults, when that presumption is rebutted and triggers exist for the assessment of capacity, the priority of such assessment should be to maximize opportunities for supported decision- making, using the ASK ME model.[1] This model recommends a step wise approach to assessment and support involving: (i) Assessing strengths and deficits; (ii) Simplifying the task; (iii) Knowing the person; (iv) Maximizing the ability to understand; and (v) Enabling participation in the discussion. Practical applications of this model in health, finance and legal settings will be provided.

[1] Peisah C., Sorinmadeayo D. Mitchell L., Hertogh C., (2013) Decisional capacity: towards an inclusionary approach The International Psychogeriatric Association Task Force on Capacity International Psychogeriatrics 25 (10): 1571-9.

Plenary speakers:

Dr Elsie Hui

Bio: Consultant and Chief of Service of the Department of Medicine and Geriatrics at Shatin Hospital, as well as the Leader for Clinical Services, Division of Geriatrics at the Chinese University of Hong Kong. Responsible for a convalescent medical unit which serves patients transferred from acute care and oversees community geriatric services which support residential care homes for the elderly and high risk elderly who live at home. Works with the Hong Kong Hospital Authority in planning new services for integrated and community care, geriatric day hospitals and end of life care. Published in over 50 peer-reviewed international journals; latest research interests include end of life care and applications of innovative technologies in the care of older persons with cognitive impairment.

Title: End of life decision-making in residential care homes

Abstract: The paper will describe the End Of Life care model in nursing homes in Hong Kong. The challenges of navigating services around issues such as the automatic rendering of cases as Coronial Case when deaths occur outside of hospital and the novelty of concepts such as advance care planning in Hong Kong society will be discussed. The experiences in engaging patients, family and carers in advance Care Planning and accepting End of life care will be shared.

Associate Professor Joshua Tsoh, Honorary Clinical Associate Professor Department of Psychiatry, Faculty of Medicine, The Chinese University of Hong Kong (CUHK), Hong Kong Special Administrative Region (HKSAR), China

Title: Guardianship laws and surrogate decision-making practices in Hong Kong and selected Asia-Pacific Rim Nations: A comparison and the ways forward

Abstract: Guardianship and surrogate decision-making processes rely on a complex interplay between judicial and health systems, culture and family traditions. In this presentation, the current guardianship laws are compared, and jurisdictional variations in proxy decision processes to support persons with decision-making disabilities (DMDs) and health and social needs in Hong Kong SAR, Mainland China, Japan, Thailand and Australia are explored, with the aim to enhance mutual understanding of diverse approaches to guardianship and administration law, and as a step towards the ultimate goals to promote autonomy, proper access to care and dignity of persons with DMDs across the nations, an important task for us multidisciplinary professionals especially as according to the WHO global population ageing is accelerating at an unprecedented pace and is most prominent in the Asia Pacific Region.

Dr Jin Narumoto, Associate Professor, Department of Psychiatry, Graduate School of Medical Science, Kyoto Prefectural University of Medicine, Kyoto, Japan; Japan Science and Technology Agency, Center of Innovation Program.

Ms Yuka Kato, Assistant Professor, Department of Psychiatry, Graduate School of Medical Science, Kyoto Prefectural University of Medicine

Title: J-DECS: Health care decision-making support for people with dementia in Japan

Abstract: Capacity assessment and support are especially important in highly aged societies to help older people with their decision making for healthcare, finance and other economic activities. In Japan, such systems have not been developed because hitherto, families have made decisions on behalf of older people. However, recent growing trends of aging and increasing nuclear family composition have increased the need for such a system. Here, we will present the concept and purpose of the project which aims to develop a new center to develop support systems for older adults in economic activities through collaboration of various professionals in law, technology and medicine with private companies. Also, we will present data from our research about consent capacity to treatment of anti-dementia drugs in Alzheimer's disease.

Dr Yumiko Arai, Departmental Head, Department of Gerontological Policy National Center for Gerontology and Geriatrics

Bio: Dr. Yumiko Arai is the head of Department of Gerontological Policy at the National Center for Geriatrics and Gerontology (NCGG). She developed her strong desire to work with family caregivers when she was young. As a medical student trainee in Neurology in Sendai city in Japan, she was assigned to see a patient suffering from ALS and his family members for 2 months. This experience made her aware of the fact that there was a lack of systems in Japan which support family caregivers of patients with a chronic and degenerative disease. Not only, a lack of system, but also there was a lack of awareness of the fact that family caregiving can be a burden partly due to the long standing Confucian beliefs. She subsequently developed her strong desire to contribute to family caregivers by providing scientific evidence which will guide long-term policies through research.

Having done a residency in psychiatry in Tokyo, she subsequently obtained training in public health in Edinburgh, Scotland. She received the outstanding researcher award conferred by the Japan Epidemiological Association in 2004 and the Japan Medical Association in 2005. She also received the Best Presentation Award conferred by International Psychogeriatric Association (IPA) in Oct., 2013. She published a manual for patients with dementia and their family caregivers where the patient must give up driving due to dementia.

Title: When driving capacity is lost: a support manual for caregivers

Abstract: Older people with dementia are eventually forced to give up driving as their symptoms progress. Making the decision to stop driving involves significant difficulties for the patients, and also their family caregivers. One reason for this is that an inability to drive can significantly hinder everyday life if driving is a crucial means of transportation both for the patient and for their family, and so there might be strong resistance to the decision. To ease such difficulties among caregivers and patients, we created a 35 page manual with the title ‘Supporting family caregivers of older drivers with dementia’ (hereafter referred to as ‘the manual’). In order for the manual to be used widely, we made it available as a PDF file, which can be downloaded at no cost from the homepage of our department website since February 2010. We also sent

details of the manual and its availability to professionals in charge of welfare for older people in all municipalities nationwide. Consequently, this manual has received nationwide coverage. Japan's NHK (equivalent to the BBC in the UK) ran a news item about this manual during a nationwide news program. Also, it has featured in various newspapers. Cumulatively, it has been accessed over 99,000 times over the last four years.

We subsequently conducted a postal survey of all municipalities (n=1,750), in order to investigate their utilization of the manual (number of responses=1,067). As a result, 88 % of the municipalities answered that they found information that they wanted or needed.

Dr Wai Ming Wong, Geriatrician, Tuen Mun Hospital, Hospital Authority of HK

Title: Hong Kong Mental Health Ordinance – a local Geriatrician's perspectives

Abstract: The laws providing the framework for acting and making decisions on behalf of adults who lack capacity in Hong Kong is mainly the Mental Health Ordinance (MHO). As a local geriatrician practising in a public hospital, we find that there are difficulties in applying the laws. With the development of Mental Capacity Act (MCA) in England and Wales in 2005, I found that it has its own merits for us to learn. In this presentation, I will compare and contrast the MHO and MCA; hoping to bring new messages for future reform to be made.

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References: 1. Seroquel XR Package Insert Version July 2011. 2. Kahn RS et al. J Clin Psychiatry 2007; 68: 832-842. 3. Peuskens J et al. Psychiatry 2007; 4 (11): 34-50. 4. Cutler A et al., Clin Ther 2011; 33: 1643-1658. 5. Suppes T et al. J Affect Disord 2010; 121: 106-115. 6. Cutler A J et al. J Clin Psychiatry 2009; 70(4): 526-539. 7. Bauer M et al. J Affect Disord 2010; 127: 19-30. 8. Bandelow B et al. Int J Neuropsychopharmacol 2010; 13: 305-320. 9. Liebowitz M et al. Depression and Anxiety 2010; 27: 964-976. 10. Katzman MA et al. Int Clin Psychopharmacol 2011; 26: 11-24.

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Presentation: Quetiapine fumarate extended-release tablet. **Indications: Bipolar Disorder:** Maintenance treatment of bipolar I disorder, as monotherapy or in combination with lithium or sodium valproate, for the prevention of relapse/recurrence of manic, depressive or mixed episodes. Treatment of depressive episodes associated with bipolar disorder; Treatment of acute mania associated with bipolar I disorder as monotherapy or in combination with lithium or sodium valproate **Schizophrenia:** Treatment of schizophrenia, prevention of relapse and maintenance of clinical improvement during continuation therapy. **Major Depressive Disorder:** Treatment of recurrent major depressive disorder (MDD) in patients who are intolerant of, or who have an inadequate response to alternative therapies. **Generalised Anxiety Disorder:** treatment of generalized anxiety disorder (GAD). **Dosage:** Once-daily **Schizophrenia:** Initial dose: 300 mg (Day 1), 600 mg (Day 2) and up to 800 mg after Day 2. Range 400-800 mg/day depending on clinical response & tolerability of patient. Same dosage is used for maintenance therapy. **Bipolar Disorder: Acute Mania:** Starting daily dose is: 300 mg (Day 1) & 600 mg (Day 2) & up to 800 mg (after Day 2), alone or in combination with a mood stabilizer. Range 400-800 mg/day. **Bipolar Depression:** Starting dose is 50mg (Day 1) & 100 mg (Day 2) & 200 mg (Day 3) & 300 mg (Day 4). Titration can be up to 400 mg on Day 5 and up to 600 mg by Day 8. **Maintenance treatment:** Use same dose as active treatment for prevention of manic, depressive or mixed episodes in bipolar disorder. Range: 300-800 mg/day. **Recurrent major depressive disorder:** Once-daily in the evening. Initial dose: 50 mg (Day 1 & 2), increased to 150 mg on Day 3 & 4. Usual effective dosage: 150 mg. Range of 50 – 300 mg/day. Same dosage is used for maintenance. **Generalised Anxiety Disorder:** Initial dose: 50 mg (Day 1 & 2), increased to 150 mg on Day 3 & 4. Range of 50 – 150 mg/day. **Switching from Seroquel IR:** Switch at equivalent total daily dose. Individual adjustments may be necessary. **Elderly:** Initial dose: 50 mg/day up to target dose depending on clinical response and tolerability of patient. Slower dose titration is recommended. **Elderly MDD:** Initial dose: 50 mg (Day 1-3), increased to 100 mg (Day 4), 150 mg (Day 8) and then up to 300 mg. **Elderly GAD:** Initial dose: 50 mg (Day 1-3), increased to 100 mg (Day 4), up to 150 mg on day 8. **Patients with hepatic impairment:** Initial dose: 50 mg/day up to target dose. **Patients with renal impairment:** No dosage adjustment needed. **Contraindications:** Hypersensitive to the active substance or excipients of this product. **Precautions:** Not recommended for below 18y old; Clinical worsening and suicide risk associated with psychiatric disorders; Somnolence; Severe neutropenia; Known cardiovascular & cerebrovascular disease; Conditions predisposing to hypotension; Orthostatic hypotension; Extrapyramidal symptoms; History of seizures; Tardive dyskinesia; Neuroleptic malignant syndrome; not approved in elderly patients with dementia-related psychosis; Established diabetes mellitus; Dysphagia; Jaundice development; Venous thromboembolism; Galactose intolerance; Pregnancy & lactation. **Interactions:** CYP3A4 inhibitors; centrally acting drugs; grapefruit juice thioridazine; lorazepam; levodopa and dopamine agonists; carbamazepine, phenytoin, ketoconazole; ADHD medications & cardiovascular medicines that cause electrolyte imbalance or to increase QTc interval. **Undesirable effects:** Tachycardia; vision blurred; mild asthenia; peripheral edema; irritability; increased appetite; dysarthria; elevations in serum transaminases (ALT, AST), syncope; rhinitis; abnormal dreams & nightmares and elevations in serum prolactin. **Full local prescribing information is available upon request. API.HK.SXR.0711**

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Oral Presentations

(In order of appearance)

Title: A Collaborative approach to the "Grand Compromise" in the abuse of older people

A planned approach developed by NSW Elder Abuse Helpline and Resource Unit (EAHRU)

Authors: Therese A Findlay & Kerry Marshall

The "Grand Compromise" is the position adopted by abused older people to live in situations of abuse in order to maintain in order to avoid residential care, or maintain a relationship with the abuser.

1. Background

The rate of abuse of older people in NSW is difficult to quantify. Current data collected from the EAHRU gives a snapshot of calls to the newly developed free anonymous and confidential helpline.

2. Aim

The release of ***Preventing and responding to abuse of older people NSW Interagency policy*** (2014) by the NSW State Government is driving the imperative to act from a local, district or regional level. The policy determines the main theme, that a multipronged (interagency) approach is required.

3. Method

In response EAHRU has established a collaborative model (interagency) to ensure that agencies across NSW are resourced to respond at a local level.

4. Results

The establishment of pilot interagency collaboratives in regions of NSW is enabling learning and evolutionary changes to meet the requirements of the policy and the expressed needs of the older person being abused.

5. Summary/Conclusion

This paper discusses best practice, the drivers and processes taken to address the abuse of older people from a top down bottom up approach.

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The presentation will focus on actual case studies 'from the coal face' with examples of real clients who have given permission for medical records and facts to be used. The presentation will illustrate the burgeoning problem of not only lack of capacity in clients, such as those with Downs Syndrome as well as the elderly, but the burgeoning problem of undue influence and duress.

Title: **Enduring Powers of Attorney and Undue Influence**

Author: Dr Elizabeth A Merson
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Background: Undue influence is a concept often understood as applying to will-making, yet the law acknowledges a concept called "equitable doctrines of undue influence……" [1] that relates to gifting outside testamentary gifts. Moreover, in most Australian jurisdictions, enduring powers of attorney may be rendered invalid if the maker was induced to make it by undue influence. Certainly, from a clinical point of view, the phenomenon of undue influence is seen across a broad range of capacity contexts, yet often missed by legal and health care professionals alike.

Aim: To elucidate the importance of undue influence in the setting of the making of powers of attorney.

Method: Case presentation and a selective review of the laws relating to undue influence and powers of attorney. A case of a divided family with shifting alliances with a mother with mild cognitive impairment, "secret business" and multiple changes in powers of attorney will be presented.
Results: This case will highlight the way family dynamics and conflict can be a prime driver for the exertion of undue influence enacted in the making of powers of attorney.

Summary/Conclusion: Health and legal professionals should be alert to the various causes and manifestations of undue influence which impact upon the execution of legal documents

References: **Andrew Sykes** (2006) 'Unfair' results and unfair doctrines: Structuring the application of the equitable doctrines of undue influence and unconscionable dealing. Available at: https://elaw.murdoch.edu.au; last accessed 11 July 2014.

Title: **The road to hell is paved with good intentions**

Author: Mr Andrew J Verspaandonk, TEP, Barrister

Affiliation: email: andrewv@vicbar.com.au

1. Background
Increasing longevity has a concomitant problem, an increase in the impact of cognitive decline on will making. The elderly are increasingly vulnerable to the coercive actions of those around them however well intentioned.

2. Aim
To draw attention to the additional risk factor for undue influence where others(including professionals) may erroneously perceive that the Willmaker is at risk of abuse and may by their misguided attempts at protection, end up preventing the Willmaker from implementing their real wishes. This can also compromise testamentary capacity. This "white line fever" occurs when an erroneous conclusion is quickly reached and governs all subsequent actions of those who ought to be protecting the Willmaker.

3. Method
Case Study- *Dickman-v-Holley* [2013] NSWSC 18

4. Results
The well meaning but misconceived actions of the various "protectors" of the Willmaker (including her legal advisor) resulted in the Willmaker being coerced into making a Will that she did not want. Moreover, the context of conflict into which the Willmaker was placed deprived her of the ability to weigh and judge the claims upon her bounty, an essential element of testamentary capacity.

5. Conclusion
It would be a grave mistake to assume that undue influence only occurs with malign motivations. Benign motivations can just as effectively result in coercion and the loss of testamentary freedom. This case demonstrates that the genuinely held protective instincts of the various actors were completely derailed by their misconceptions so that the "protectors" of the Willmaker became the problem. This emphasises the need for professionals to ensure they do not misconceive the situation of the Willmaker, particularly by uncritical acceptance of the assessments of well meaning actors who may themselves be in error.

Title: CLIENT CAPACITY – DO LAWYERS GET IT RIGHT?

Presented by Sue Field Adjunct Fellow in Elder Law, University of Western Sydney & Karen Williams, Social Worker and Barrister-at-Law

1) What Tools exist to help lawyers?
    a. Lawyers are to act carefully:
        i. As shown by recent cases
        ii. Be informed about indicators of capacity.
        iii. Told to gather collateral information, if they form suspicions
        iv. This should be done with client "assent" or agreement rather than consent.
            1. Problems with some statutory bodies do not recognize such assent.
            2. Can lead to confusion over "who is the client".
    b. Lawyers are to seek capacity assessment for client.
        i. Lawyers have no clinical background and do not understand clinical specialties.
    c. Difficulties can arise in lawyers managing the relationship if person lacks capacity ?
        i. Can refuse to take instructions.
        ii. Can encourage other family/friends to seek an appointment.
        iii. Applications may be undertaken, effectively working against their own client.
    d. Multi-disciplinary approach.
        i. Capacity is an issue that requires collaboration between lawyers and health professionals.
        ii. Few collaborative learning opportunities exist for students or professionals to learn from each other in a practical sense.
2) What is achieved?
    a. If this minefield is effectively negotiated, and, for example, someone with early dementia is able to execute a valid Enduring Power of Attorney, who will pay attention to it?
    b. What is the current state of research in this area?

Mr Simon J. Zuscak and Prof. Ian Coyle.

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Title: An assessment protocol for determining decision making capacity

Abstract

There is a bourgeoning elderly population, an increase in District Court estate disputes, and an identified need to refer at risk clients for formal assessment. However, there is limited research into effective and efficient assessment protocols vis-à-vis testamentary capacity and capacity to appoint an enduring power of attorney. Statistical limitations of neuropsychological tests are often overlooked. The current study reviews the interaction of legal principles and the scientic method in common law jurisdictions. Preliminary findings from expert opinions are presented. Participants are 13 general practitioners, seven lawyers and seven psychologists. Data was collected through a nominal group technique (focus group). Investigation of qualitative results indicated similarities and differences in approach adopted by the differing disciplines. The next phase of this research is to test-run an assessment protocol informed from the current findings.

"From the Coalface – a Lawyer's Perspective"

Presenter: Barbara Campbell

Principal of *Campbell & Co. Lawyers*

Director of *Legal Resolution Services Australia*

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From the perspective of a lawyer practising in Estate and Family Law, this presentation will examine the vexing issues of capacity, undue influence and the ethical requirements of both the legal and medical professionals in preventing the increasing problem being addressed in this conference.

The duty owed by lawyers is wider than in most other areas of law and the presentation will also elicit discussion about the requirements of the medical profession when asked to provide an opinion about the capacity of a patient/client. The associated paper will provide examples of the detail that should be included in correspondence between both professionals prior to advising and taking instructions from an elderly person where capacity is in any doubt.

Where undue influence and duress are present, actual case studies will illustrate how 'proving the obvious' is nigh impossible. Lawyers are usually on the scene *after* abuse has occurred. The illustrious audience may be invited to suggest how such abuse can be prevented – from learning from Succession Law in other countries to legal vigilance and medical awareness. Statutory Wills will also be explained as a viable, but little used option.

Capacity to give legal instructions: A human rights perspective

Dr Ilana Hepner
Sydney Adventist Hospital and Prince of Wales Hospital

1. **Background**
   A lawyer may be faced with doubts about a client's capacity to give legal instructions by virtue of the client's mental illness or disability.

2. **Aim**
   To highlight the human rights perspective for patients with mental illness who may seek to give legal instructions.

3. **Method**
   The author was asked to evaluate a patient with mental illness and provide an opinion as to whether they were a person under legal incapacity and whether they could manage their financial affairs. The tests for legal incapacity in Australia, the role of neuropsychological testing and ways in which to manage potential issues of undue influence will be discussed.

4. **Results**
   With reference to the legal tests as set out by the instructing solicitor, the author opined that the patient did not have the capacity to manage their financial affairs, but did have decision making capacity with respect to a specific set of legal instructions. Once available, judicial opinion will also be presented with respect to these issues.

5. **Summary/Conclusion**
   Capacity is decision specific and a lack of capacity with respect to one issue does not imply a lack of capacity for other types of decisions. A thorough examination of a person's understanding of the facts as well as their reasoning and appreciation of the potential consequences pertinent to each decision is of the utmost importance to uphold their rights and freedoms.

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Title: The Mental Capacity Act (MCA) and Individual autonomy in England and Wales.

Dr Oluwatoyin A. Sorinmade

English and Welsh Law have evolved a process of upholding the rights of individuals to self-determination. The MCA (2005) [1] in England and Wales enshrines in law the autonomy of *capacitous* individuals to make legally binding personal decisions for the current time and the future.

Under the MCA, an individual lacks decisional capacity on a *matter* if they have an impairment of, or a disturbance in the functioning of, the mind or brain that impairs their ability to either understand the information relevant to the *said matter*, or retain the same or use/weigh the said information in their decision making process or communicate their decision in whatever way possible.

Where non-capacitous, the MCA prescribes the process of determining the individuals 'best interests'.

Precedent autonomy is also promoted by the MCA through Advance Decisions to Refuse Treatment which, where valid/applicable to a specific treatment, has the same effects as if the individual had made it at the material time.

As with other mental health legislations the MCA has faced challenges in its uptake by professionals perhaps due to prevailing cultures of paternalism amongst health care professionals and risk-aversion amongst social care professionals. [2]

A possible solution is to introduce medical law module during undergraduate study to promote familiarity of health professionals with 'health care legislations'.

Reference:

1. Department for Constitutional Affairs. Mental Capacity Act 2005: Code of Practice. TSO, 2007.
2. http://www.parliament.uk/business/committees/committees-a-z/lords-select/mental-capacity-act-2005/news/committee-launches-its-inquiry/ (accessed March 2014).

e-mail address for correspondence:oluwatoyin.sorinmade@oxleas.nhs.uk

Title: The policies and practices of financial institutions in respect of substitute decision making instruments

Presented by Ms Sue Field- Director Australian Centre for Elder Law Pty Ltd

1. In Australia substitute decision making is state and territory based, with each jurisdiction having legislation governing powers of attorney (financial matters) and enduring guardianship (personal and health matters).

2. There is a growing body of evidence that there is little consistency within financial institutions as to the recognition of powers of attorney or financial management orders.

3. Our research is examining the policies and practices of financial institutions, in respect of these instruments, in the state of New South Wales and the consumer experience.

4. The research is both qualitative and quantitative and consists of depth interviews with senior staff in a number of financial institutions, questionnaires for front line staff in financial institutions, via survey monkey and focus groups for consumers who have been appointed as attorneys, within the last ten years (since the introduction of the *Powers of Attorney Act 2003* NSW) and who have acted, or attempted to act, upon the instrument which ostensibly gives them the power to act on behalf of the donor of the instrument.

5. It is hoped that the results of the research will highlight the inadequacies of the current system and lead to harmonisation of the instruments (between jurisdictions) and a national registration scheme for substitute decision making instruments.

TITLE: A Single-Centre Cross-Sectional Analysis of Advance Care Planning among Elderly Inpatients

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ABSTRACT:

Background: Advance Care Planning(ACP) has been shown to provide beneficial outcomes for elderly patients, however it may not be commonly implemented.

Aims: To assess prevalence of Advance Care Directives(ACDs) and medical orders about end-of-life care for elderly inpatients; to explore the feasibility of an ACP Screening Interview.

Methods: A single-centre cross-sectional analysis of 100 patients aged ≥80 admitted for ≥48 hours to a tertiary hospital, conducted 16th-18th January 2013. Medical-records were reviewed for presence of 1) an ACD, 2) Resuscitation/End-of-Life Care Intervention Orders(REOLs), and 3) documented substitute decision maker(SDM). If able, patients completed an ACP Screening Interview exploring: 1) their views on ACP, and 2) if an ACD was previously documented.

Results: In 100 medical-records there were: zero ACDs, 17 REOLs, 8 with clear documentation of patients' preferred SDM. 33/100 patients completed the interview: 32(97%) could identify their preferred SDM, in 9(27%) the nominated SDM was different from their 'next of kin'. 7/33(21%) reported having an Enduring Guardian, 4/33(12%) an ACD. 23/29(79%) interviewees without an ACD were interested in discussing ACP further. 8/30(27%) interviewees without REOLs, said they would not wish to have aggressive life-prolonging measures. No patients reported discomfort with the interview.

Conclusions: ACDs and correct documentation of SDM were uncommon in the medical-records in this elderly sample. The ACP Screening Interview appears feasible, and may be a useful tool for identifying patients' preferred SDM and willingness to further discuss ACP.

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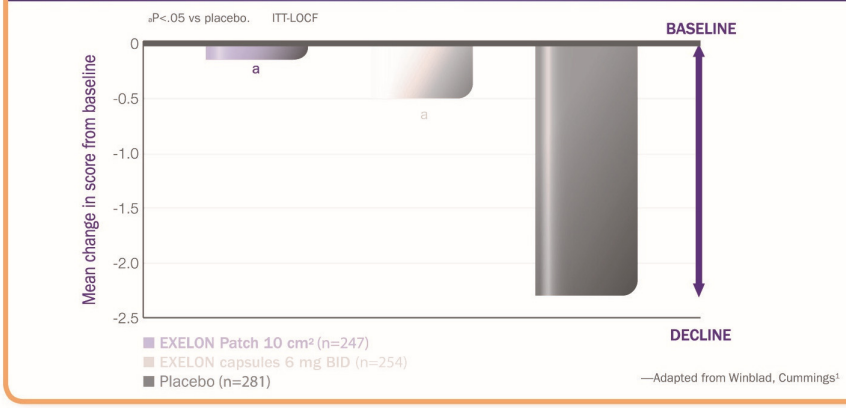

—Adapted from Winblad, Cummings[1]

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Presentation: Exelon Patch 5 contains 9 mg rivastigmine. The release rate is 4.6 mg/24 h. Exelon Patch 10 contains 18 mg rivastigmine. The release rate is 9.5 mg/24 h. Exelon Patch 15 contains 27 mg rivastigmine. The release rate is 13.3 mg/24 h.
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Dosage: In patients with mild to moderately severe dementia associated with Alzheimer's disease,: Initiation and re-initiation of therapy should start with one Exelon Patch 5 each day. If well tolerated, it may be increased after a minimum of 4 weeks of treatment to one Exelon Patch 10 each day which is the recommended effective dose. Patients treated by Exelon capsules or oral suspension with a maintenance dose of 6 to 12 mg may be switched to Exelon Patch 10. Some patients may benefit from higher dose; in this case the dose can be titrated up to Exelon Patch 15. A minimum of 4 weeks of treatment and good tolerability with the previous dose should be observed before titrating up to higher doses.
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Contraindications: Known hypersensitivity to rivastigmine, other carbamate derivatives, or other ingredients of the formulation. Previous history of application site reactions suggestive of allergic contact dermatitis with rivastigmine transdermal patch.
Precautions/Warnings: Medication misuse and dosing errors with Exelon transdermal patch (e.g. not removing the old patch when putting on a new one and the use of multiple patches at one time) have resulted in serious adverse reactions; some cases have required hospitalization, and rarely led to death. Patients and their caregivers must be instructed on important administration instructions for Exelon transdermal patch. ♦ If treatment is interrupted for longer than three days, treatment should be re-initiated with Exelon Patch 5. Gastrointestinal adverse effects have been observed at initiation of therapy and shortly after dose increase. ♦ Caution in case of prolonged vomiting or diarrhoea (risk of dehydration). ♦ Extrapyramidal symptoms may be exarcerbated by cholinomimetics and worsening of parkinsonian symptoms (particularly tremor) has been observed in patients with Parkinson's disease treated with oral rivastigmine. Adverse effects may respond to removing the patch. If they persist, the daily dose should be temporarily reduced to the previous well-tolerated dose. ♦ Patient's weight should be monitored during therapy with Exelon Patch. ♦ As with other cholinomimetics, caution is recommended in patients with sick sinus syndrome, conduction defects (sino-atrial block, atrio-ventricular block), gastroduodenal ulcerative conditions, history of or current respiratory disease, urinary obstruction, and seizures in predisposed patients. ♦ In case of disseminated skin hypersensitivity reactions with the use of rivastigmine, treatment should be discontinued. Use of rivastigmine patch may lead to allergic contact dermatitis, in this case treatment should be discontinued and patients should be switched to oral rivastigmine only after negative allergy testing and under close medical supervision. Some patients sensitized by exposure to rivastigmine patch may not be able to take rivastigmine in any form. ♦ Caution in patients with clinically significant hepatic impairment ♦ Caution in patients with body weight below 50 kg: carefully titrate and monitor these patients for adverse reactions (e.g. excessive nausea or vomiting) and consider reducing the dose if such adverse reactions develop. ♦ The safety of Exelon Patch is not established in pregnant and breast-feeding women. ♦ Not recommended in children.
Interactions: Caution in case of concomitant use with cholinomimetic drugs, anticholinergic medications, succinylcholine-type muscle relaxants during anaesthesia.
Adverse reactions: Very common: nausea.
Common: vomiting, anorexia, decreased appetite, anxiety, depression, insomnia, dizziness, headache, diarrhoea, dyspepsia, abdominal pain, urinary incontinence, application site reactions (erythema, pruritus, oedema), fatigue, asthenia, weight decrease, urinary tract infection.
Uncommon: dehydration, agitation, delirium, hallucinations, aggression, cerebrovascular accident, syncope, somnolence, psychomotor hyperactivity, cardiac arrhythmia (e.g. bradycardia, supraventricular extrasystole), gastric ulcers, gastrointestinal haemorrhage, hyperhidrosis, contact dermatitis, malaise.
Rare: hypertension, application site hypersensitivity, pruritus, rash, erythema, urticaria, blister, dermatitis allergic, fall.
Very rare: tachycardia, atrioventricular block, atrial fibrillation, pancreatitis, seizure, worsening of Parkinson's disease.
Not known: restlessness, sick sinus syndrome, hepatitis, abnormal liver function tests, disseminated cutaneous hypersensitivity reactions.
Additional adverse reactions observed with Exelon capsules/oral solution: severe vomiting associated with oesophageal rupture (very rare); angina pectoris, myocardial infarction, duodenal ulcers (rare); tremor, confusion (common).
Packs and prices: Country specific.
Legal classification: Country specific.
Ref : EMA June 2013

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Poster Presentations

Title: Embedding the Mental Capacity Act 2005 in clinical practice: an audit review [1]

Dr Claudia Dunlop, Dr Oluwatoyin A.Sorinmade

Background: The Mental Capacity Act (MCA)[1] 2005 came into force in England and Wales in 2007 and legalises the autonomy of capacitous individuals to make binding personal decisions including decisions to refuse specified treatments in future. It also outlines how to strike a balance between respect for fundamental rights to liberty and autonomy with the need to protect people when they lack capacity to make certain decisions.

Aims and Methods: Audit cycle assessed compliance of healthcare professionals in a Mental Health Trust in England with statutory requirements of the MCA in patient care. Each stage reviewed relevant patient electronic records retrospectively.

Results: Audit cycle demonstrated some improvement in clinical practice as well as need for further efforts at raising the understanding/compliance of clinicians and the public with provisions of the MCA. Recommendations made on ways of improving compliance with the requirement of the MCA by healthcare professionals and ways of improving public understanding of its provisions.

Conclusions: Healthcare professionals need further understanding of their responsibilities under the MCA. The public also requires an increased awareness of the provisions of the MCA in relation to their decision making autonomy. Stakeholders need to put strategies in place for these to be achieved.

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1. Psychiatric Bulletin *http://pb.rcpsych.org/content/early/2014/04/24/pb.bp.114.046870#BIBL*
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Guns, dementia and mental illness: What should a clinician do?

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Background: There are no formal guidelines outlining the role of health professionals in screening and assessing firearm use and ownership.

Aim: The aims are to provide an overview of the ethical, clinical and legal factors to be considered by clinicians when assessing suitability for a firearm licence and to recommend an approach which combines risk assessment with the determination of capacity.

Method: A literature review was conducted to examine rates of firearm ownership, the relationship between dementia and mental illness and firearm violence, and firearm licencing legislation in Australia.

Results: Newly diagnosed older adults with dementia are at greatest risk of suicide by firearms. Patients and their families may not comprehend the potential risks and have difficulty addressing them. Safe firearm use requires intact cognition, mental and physical health. In Australia, the person applying for a firearm licence must declare any relevant health concerns, not the clinician. However, health professionals must report risk concerns to authorities. Clinicians should combine their knowledge of an individual's medical status with assessment of capacity to use/own firearms and corroborative history.

Conclusion: Clinicians should screen for firearm access. The combination of individualised risk and capacity assessments may assist in evaluating suitability to have a firearm licence, with regular review. Clinicians should support patients and families in identifying and managing risks from firearm access.

Concurrent validity of a family caregivers self-reported potentially harmful behavior (PHB) towards their care recipients

Dr. Yumiko Arai, Dr. Chisato Noguchi, Ms. Teruko Ueda

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Abstract

Objective 1) To investigate the prevalence of potentially harmful behavior (PHB) among family caregivers of disabled older people. 2) To examine concurrent validity of one of the most frequently-used family caregivers self-reported checklist in Japan.

Method Four thousand one hundred and twenty eight (4,128) family caregivers of care recipients, who used the domiciliary services under the LTCI in the city of Toyama, and their care managers in charge, participated in this study. Family caregivers completed a questionnaire including a caregivers self-reported PHB checklist; this PHB check list was developed by Ueda (2003) and been most frequently used in Japan. The family caregivers mistreatment was assessed by the following three items threatened by their family caregivers, physical restraints by their family caregivers, and the confinement to care recipients bedroom by their family caregivers (Arai, 2005). Chi square tests compared caregivers self-reported PHB with family caregivers mistreatment observed by their care managers in charge.

Results One thousand five hundred and ninety nine (1,599; 38.7%) family caregivers reported that they had engaged in at least one PHB. The most frequently reported types of PHB were ignoring (21.5%) and verbal aggression (20.0%). The care managers observed the following types of mistreatment: care recipients seemingly feeling threatened by their family caregivers (5.0%), physical restraints by their family caregivers (0.3%), and the confinement to care recipients bedroom by their family caregivers (0.9%). The care recipients, whose caregivers had engaged in at least one PHB, were more likely to appear to feel threatened by their family caregivers ($p<0.01$), and were more likely to be confined to their bedroom by their family caregivers ($p<0.05$).

Conclusion This study revealed that the family caregivers self-reported PHB was significantly associated with family caregivers mistreatment observed by their care managers in charge.

Title: A collaborative approach to supporting communication in the assessment of decision making capacity

Simon J. Zuscak, Alison Ferguson, Carmelle Peisah

Abstract

Legislation is beginning to reflect the need to formally assess people whom are suspected of reduced mental capacity. However, these legislative changes have preceded research into effective and efficient assessment protocols. In order to demonstrate decision making capacity, an individual needs to communicate their understanding and wishes. However, decision making capacity can be masked when communication is impaired, for example, through impaired receptive and expressive language or unintelligible speech. For this reason, people with aphasia and related neurogenic communication disorders can be significantly compromised in their ability to participate in decision making, yet have a human right to the support required to facilitate such decision-making and to exercise their legal capacity (United Nations, 2006). Speech-language pathologists are integral to maximising a person's communication ability; however, commonly used speech pathology strategies are not well known by other disciplines (Ferguson et al, 2010). We present up-to-date guidelines and practical strategies to facilitate communication in people with aphasias and other language deficits. A collaborative, multi-disciplinary approach is achievable and consistent with an inclusive human rights approach to decision making.

Title: Sexual expression, consent and capacity in residential care: a person-centred, human rights approach

Carmelle Peisah; Rumandeep Tiwana; Susan Mary Benbow

Abstract

Doctors or other health care professionals are sometimes asked to intervene when two people - either one or both of whom have cognitive impairment – enter into a sexual relationship. Referrals are usually prompted by concerns from family members, residential care or service providers regarding issues related to capacity, consent, physical and emotional injury, and sexual assault. Sometimes referrals are simply prompted by ignorance, insensitivity to the sexual needs of cognitively impaired individuals and ageist perceptions that such needs are funny or disgusting. Sexual expression in dementia is influenced by a range of neurodegenerative changes in the frontal, temporal and parietal lobes causing disinhibition, memory impairment and misidentification and misinterpretation of social cues; as well as mood disturbance, psychosis, drug effects and libidinal changes. Despite these myriad causes and manifestations, sexual behaviour in dementia is most often classified by its social context and its “appropriateness” or perceived “improper” nature, mainly because the context of referral is usually a public setting - the residential care setting. The discourse on the subject is often treatment, rather than needs and risk-management focused, with a goal of extinguishing the behaviour, and there is a tendency to polarise participants into victims and perpetrators. We advocate an individualised, human rights approach to sexual behaviour in dementia geared to promote autonomy, dignity and protection from abuse. This would encompass a stepped approach involving the determination of systemic and family factors contributing to the referral, and the needs, capacity, and potential exploitation/abuse of each partner in the relationship.

Title: Abuse of elders in India: an overview of the issues

Mangal Kardile, India

Abstract

Objectives
The current population of India is rapidly ageing and will exceed 300 million people over 60 by the year 2050. While National and International legal and human rights frameworks such as the NPHCE 2011, SCAct 2007 and the UN conventions are in place, there is lack of implementation. Many elders are vulnerable to abuse, particularly those with cognitive impairment. We aim to review the laws and promote awareness raising regarding elder abuse in an Indian context.

Method
A small case series will illustrate the manifestations of abuse of ageing, vulnerable, cognitively impaired elders by family members in India.

Results
Abuse can be financial, emotional, psychological or neglect, or combinations thereof. Lack of mandated intervention frequently leads to deprivation of justice often perpetuated by a lack of awareness regarding mental health laws, human rights, and elder laws, and little discourse about this problem.

Conclusion.
Health care professionals have a role to encourage discourse and awareness raising regarding human rights and abuse of vulnerable elderly in India.

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References:
1) H. Lundbeck A/S, Data on file, Ebixa EPAR.
2) Winblad et al. Dement Geriatr Cogn Disord. 2007; 24: 20-27.
3) Jones. Int J Geriatr Psychiatry 2009 online.
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1. IMS Health December 2011
2. HKAPI data Full Year 2013
3. Data on file

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Notes

Our Vision

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Our Mission (What we do)

Capacity Australia's mission is to increase awareness and understanding of decision-making in disability, and to help facilitate the full participation by persons with disabilities in all aspects of life, in line with the objects of the United Nations Convention on the Rights of Persons with Disabilities. To this end, Capacity Australia:

- assists persons with disabilities, carers, health professionals, providers of legal and financial services and others to have a greater understanding of the legal and practical requirements for decision-making in disability, and to provide training in assessing decision making capacity in different types of cognitive impairment,
- promotes awareness about planning ahead so that individuals can make advance directives about care and choose who will make decisions for them if it becomes necessary in the future, and
- contributes to education and research into supporting the capacity of all persons to fully engage personal decision-making to the greatest extent possible.

Capacity Australia also supports initiatives to protect the safety and wellbeing of persons with decision-making disabilities and to prevent their abuse and exploitation

Our values

Autonomy, Choice, Respect, Dignity of risk, Support, Freedom from exploitation, Authenticity