Revisiting Mental Capacity Assessments

for Primary Care Doctors

Text by Dr Chen Shiling and Dr Giles Tan

The SMA Centre for Medical Ethics and Professionalism (CMEP) in collaboration with the College of Psychiatrists, Academy of Medicine, Singapore (AMS) conducted a hybrid seminar on 1 October 2022, titled "Revisiting Mental Capacity Assessments for Primary Care Doctors". We had 91 medical practitioners join us online, while another 13 attended in person at Camden Medical Centre. Practitioners in the field of mental capacity spoke on various aspects of capacity assessments and shared their practical experience. The presentations were followed by a panel discussion.

LPA in family practice – a practical approach

Dr Wong Tien Hua, a family medicine practitioner and director of Mutual Healthcare, first recapped for the audience what a Lasting Power of Attorney (LPA) is, as well as its purpose. Using case studies, he stressed the importance of making LPAs while one still has decision-making capacity, rather than face the challenges of applying for deputyship orders if one loses capacity without an LPA in place.

He highlighted the importance of explaining the duties of a donee to patients and to ensure that the various parties understand their responsibilities. It is critical that the legal document is signed with full knowledge and consent by all parties involved, as this will also help protect against difficult situations if there are subsequently differing views or questions on the choice of donee. This is particularly important as the donee chosen need not be a related family member, and can be any trusted adult.

Dr Wong also stressed the importance of the best interest principle, if and when the donor loses capacity and the donee has to step in to manage his/her personal welfare and finances. To this end, Dr Wong advised doctors to encourage donors to share their wishes with their donees when the LPA is being done, so that these wishes can be adhered to.

Dr Wong then spoke about the practical aspects of filling an LPA form. He reminded all certificate issuers (CIs) of their duty of care to their patients. This translates in practical terms to spending an appropriate length of time with the donors and donees to explain what an LPA entails, assessing their capacity objectively, and observing carefully for any potential red flags such as undue influence in the choice of donee. The CI must not be a family member of the donor or donee, nor can he/she be named in the LPA or be related to the donor as a business partner or employer. There needs to be proper documentation and record keeping to safeguard the donor, donee and CI.

Dr Wong highlighted segments in the LPA form that may be confusing or overlooked by CIs. He assured all attendees that he personally became more accustomed to filling up the form after doing it several times, and reiterated that ultimately, doing an LPA is for the long-term benefit of the patients. If in doubt, doctors can refer the patient to psychiatrists, who can perform more complex capacity assessments.

Mental capacity assessments in dementia

Dr Barathi Balasundaram, clinical assistant professor and senior consultant (Old Age Psychiatry) of the Department of Psychological Medicine, Changi General Hospital, focused her presentation on sharing real-life case studies.

The first case was about a 95-year-old lady who lived alone with a domestic helper, and whose children were not quite involved in her care. Assessment revealed possible mild cognitive impairment (MCI) which, coupled with her psychosocial circumstances, was a red flag for decision-making ability. However, after a careful assessment, Dr Barathi certified that this lady had capacity and assisted her with her LPA. This case illustrates the delicate balance between a vulnerable but capacitated older person and the need to safeguard yet promote autonomy.

The second case involved a 68-year-old patient with chronic schizophrenia who needed to add another family member's name as a joint tenant in her HDB flat. Some factors to consider in this case included the stability of her mental health condition, her current functioning level as well as the family dynamics involved. On assessment, Dr Barathi diagnosed her with MCI due to suggestive cognitive features. However, despite the presence of both MCI and chronic schizophrenia, she was still deemed to have decision-making capacity. A key learning point here is that capacity should always be assumed unless proven otherwise, and that the presence of schizophrenia or MCI does not equate to a lack of capacity.

> *Furthermore, the lack of ability in making complex decisions does not indicate that the individual has no ability to make simple decisions.*

The third case was an elderly gentleman with early dementia, who seemed able to communicate his wishes clearly despite his cognitive impairments. However, the family provided additional information that there had been unusual withdrawals from his bank account, and he was not able to account for what happened to the funds. This behaviour demonstrated the presence of poor judgement and, with his difficulties in handling financial matters, he was deemed to lack mental capacity for making financial decisions. In this case, if he required someone to manage his finances, a court-appointed deputy would have to be obtained.

The cases shared by Dr Barathi illustrate some of the challenges faced in doing capacity assessments, but also reminds doctors to be mindful of stereotypes.

Mental capacity assessment in persons with intellectual disability

Dr Bhavani Sririam, head of the MINDS Developmental Disability Medical Clinic, focused her presentation on persons with intellectual disability (PWID).

Dr Bhavani defined intellectual disability (ID) as having an IQ of 70 or below, accompanied by limitations in adaptive functioning in at least two skill areas such as self-care and conceptual skills, and that these impairments originated during the developmental period. There are varying degrees of ID, ranging from mild to profound, but the presence of ID does not equate to lacking mental capacity. Particularly because PWID tend to have communication difficulties, it is easy to assume that they are not able to comprehend information and are therefore unable to make decisions for themselves. This is a pitfall that doctors have to avoid. Furthermore, many PWID are underdeveloped in their decision-making abilities due to psychosocial circumstances and lack of exposure to a broad spectrum of experiences.

In the process of capacity assessment for PWID, Dr Bhavani shared a few key pointers. First, assessors should find out what the best way to communicate with the PWID is and ensure that the interview is conducted in a conducive environment. Next, the domains that need to be assessed should include:

(a) Basic activities of daily living

(b) Instrumental activities of daily living

(c) Food management

(d) Transportation

(e) Personal safety

(f) Health matters

(g) Money matters

In each of these domains, the assessor should take time to speak with the PWID to answer both factual questions and questions that relate to their reasoning ability. For example, in addition to asking whether or not the individual can bathe daily, the assessor should go a step further and ask the individual why he/she needs to bathe every day and the consequences of not bathing regularly.

In the mental capacity assessment, PWID who are milder in disability may be able to fulfil the requirements for comprehension and expression, but may have significant challenges with reasoning and judgement. They may therefore not be able to foresee potential pitfalls and the consequences of their decisions and actions.

The clinician has to balance the need to safeguard versus promoting choice. Making unwise decisions does not equate to no mental capacity. Furthermore, the lack of ability in making complex decisions does not indicate that the individual has no ability to make simple decisions.

Deputyship – when is it necessary?

Ms Ruby Lee, lawyer and deputy director of Singapore Medical University Pro Bono Centre, discussed what happens when an individual no longer has the mental capacity to set up an LPA.

The law seeks to protect people without mental capacity by preventing them from being bound to the decisions they make while they are incapacitated. For example, a will or contract that is made without mental capacity is void, and consent to a medical procedure made while incapacitated is void. However, this can be a problem when there is a need to make decisions relating to the care of a person without mental capacity. This is where the Mental Care Act (MCA) provides a mechanism for decisions to be made for the individual without capacity (referred to as P) through a "proxy decision maker".[1]

These "proxy decision makers" include the Courts, the donees under the LPA, deputies, and caregivers and medical treatment providers under Section 7 of the MCA. Among the four proxies, there is a hierarchy of powers granted to each of them.

The MCA confers upon the Court the broadest powers to make decisions on behalf of P. These powers include the powers to make a will and make nominations for insurance. However, there are decisions which even the Court cannot make for P, which include changing P's religion and consenting to sterilisation.

As donees are chosen by the individual while he/she has capacity, the law assumes that since you have chosen whom you want to take care of you, this category of proxy decision makers' powers can be empowered with as much powers as you would want to give. However, the powers that can be given to the donee are not as broad as the Court's powers. For example, the donee cannot execute a will for the donor.

If P does not have an LPA, a deputy can be appointed by the Court to make decisions for P. As the deputy is not chosen by P, the Court will be cautious as to who can be appointed as a deputy and will also be reluctant to give broad powers to a deputy. The deputy would be limited by the specific powers listed in the court order.

Lowest on the hierarchy of powers would be caregivers and medical treatment providers acting under Section 7 of the MCA. This is the most limited form of proxy decision makers. It allows caregivers and medical treatment providers to undertake various actions in conducting the day-to-day care of P. Such actions include feeding, changing of clothes and necessary medical treatment.

Ms Lee then shared some practical pointers with regard to applying for deputyship. There are two possible pathways to apply for deputyship: first is the traditional route in which documents need to be filed with the court and which usually requires a lawyer. Second is the simplified route in which documents only need to be uploaded to an online portal via the Family Justice Court website. However, the simplified route is restricted to deputies who are related to P, and for assets up to $80,000.

The role of the medical practitioner in deputyship applications is to assess the individual's mental capacity and fill up a medical affidavit which can be used to justify the application for a deputy. The Court will weigh the expert opinions and make the order accordingly.

Similar to an LPA, the intention of a deputyship is to make decisions in the best interest of a person without capacity. It is important that the appropriate deputy is chosen for a person without capacity. In the event that a suitable family member or friend cannot be found, an option to consider will be professional deputies. These deputies must be registered with the Office of the Public Guardian (OPG) and will be remunerated for their services.

Ms Lee emphasised that deputies bear a set of responsibilities, but these are ultimately for the best interests of the individuals they are deputising. She encouraged doctors to consider performing MCA assessments and assisting with the medical reports so as to benefit patients without capacity.

Office of the Public Guardian Online (OPGO) system

Ms Regina Chang, the Public Guardian, highlighted that the MCA was amended on 6 July 2021 to enable making and registering LPAs online, with the changes becoming operational at the end of 2022. The online system, OPGO, allows for Singpass and Corppass login, digital signing without the requirement for physical red seals, and for the CI to submit the LPA on behalf of the donor. The aim is for a seamless, guided and error-free LPA application process for donors and donees so that the CI can focus on the certification process.

The OPGO also aims to be a simple, secure and convenient online platform to transact with the OPG on deputyship matters. Some functions include automated processing, a quick online overview of the tasks required from the deputy based on the court order, guided filing of personal welfare and asset matters, and a financial tracker tool for income and expenses utilised.

To support members of the public and practitioners in using the platform, there will be resources available on the OPGO and OPG website via videos, FAQs and a quick reference guide, as well as telephone guidance, webinars and workshops.[2] For those who need more intensive support, one-to-one guidance and help can also be provided.

Panel discussion

The panel discussion featured the four speakers and was moderated by Dr Giles Tan (Senior Consultant, Department of Developmental Psychiatry, IMH) and Dr Chen Shiling (Founder and Executive Director, Happee Hearts Movement). Questions posed by the audience were addressed and there were discussions on the issues raised in the earlier presentations.

Conclusion

This hybrid seminar covered aspects of mental capacity assessments ranging from LPA certification to mental capacity assessments in persons with dementia and ID. The legal and practical aspects of performing medical assessments and applying for deputyships were also outlined. These important topics related to the issues faced by practitioners on the ground and, hopefully, encouraged more practitioners to undertake these assessments with confidence.

SMA CMEP continues to run free online training modules on mental capacity. In collaboration with the College of Psychiatry (AMS), there will be further training webinars planned so do look out for them! ◆

References

1. Mental Capacity Act (Cap 177A, 2010 Rev. Ed.) Available at: https://bit.ly/3rYAfSf.

2. Ministry of Social and Family Development. Office of the Public Guardian . Available at: https://bit.ly/32p34ji.

Further reading

a. Balasundaram B, Lim E, Frazer J, Tan LL, Lim YC. A Practical Approach to Testamentary Capacity and Undue Influence Assessment in Persons with Dementia. SAL Prac 2021; 10.

Dr Chen is a physician with special interests in dementia and intellectual disability. She is the founder of Happee Hearts Movement and practises in IDHealth and Khoo Teck Puat Hospital.

Dr Tan is a neurodevelopmental psychiatrist at the Institute of Mental Health, Associate Director of SMA CMEP, Honorary Secretary of the College of Psychiatrists at the Academy of Medicine, Singapore and Vice-President of the Singapore Psychiatric Association.