The practical side of judging capacity

In the second of a two-part series on mental capacity, Karena Hanley looks at the practical approach to assessment.

**Assessment of Mental Capacity** is a grey area, but fortunately we have some guidance. The BMA has produced a book in conjunction with the UK Law Society entitled *Assessment of Mental Capacity*, and this is excellent. There are no hard and fast rules on which type of doctor should assess capacity. Where capacity is in question in a younger adult on the grounds of mental illness, it is probably more appropriate for the attending psychiatrist to make the assessment.

The psychogeriatrician may have more specialised knowledge in testing frontal lobe function in a patient who suffers more advanced dementia. The GP can often handle the assessment in less severe cases of dementia and has the advantage of knowing the patient well, and of understanding some of the family dynamics.

There is guidance on the time interval between a medical assessment and execution of an enduring power of attorney (EPA) or testamentary capacity: within 30 days (either way). Ideally, the certification and execution should be contemporaneous. The time of the day of the actual assessment should be planned to suit the patient – are they more alert in the mornings? It behoves the assessor to make the best environment to maximise a patient’s capacity, and more than one visit may be necessary.

**Beginning an assessment**

Begin the assessment by explaining to the patient you are not in the usual doctor-patient therapeutic relationship on this occasion, but that this is an examination for legal purposes. Capacity should be assessed on the individual; there is no list of medical conditions in which mental incapacity is automatically assumed. It is good to test and record the mini-mental test score but this is for your medical records and the score result does not need to appear on the opinion for the solicitor as it does not have legal meaning. It may be appropriate to conduct a mental state examination, with consideration of appearance and behaviour, speech, mood, thought content and form and insight.

GPs will get quite a lot of experience in forming an opinion on how the underlying thought processes affect a patient’s ability to make a decision as we will be called upon to certify, on form 4 of the Nursing Homes Support Act 2009, that the patient has the capacity to sign their contract. The opinions of two medical practitioners are required and as this is now law, we will be asked to get involved in this area. The legal test for testamentary capacity is that: the patient understands the general nature and effect of a will; the patient knows the extent of their assets; and the patient is able to bring to mind the people who should be considered beneficiaries.

People making a will should understand who the executor is and why they should be appointed executor. They should understand whether they have already made a will and if so, how and why the new will differs from the old. They do not need to know the value of their assets, just the general extent, and in this they can be prompted. The patient should be able to manage the third task unaided. They should be able to call to mind those who would expect to benefit from a will. The patient should be able to express reasons for preferring some beneficiaries and perhaps excluding others.

The legal test for EPA is that: the donor understands that the attorney will be able to assume authority over their affairs; and once the donor becomes mentally incapable and the EPA is registered, that power is irrevocable. The actual authority may be general or may be limited, for example authority to dispose of property may be withheld, so the examining doctor will need some prior knowledge of what is planned. Currently, Irish law does not allow a facility for an attorney to make medical or treatment decisions on behalf of the donor – the powers are limited to decisions on finances and personal care – the proposed Mental Capacity Act will address this deficiency. Central to all assessments of mental capacity is the ability of the patient to retain information and to be able to weigh that information in the decision to be made. If short-term retention of information is markedly impaired, seek another opinion.

**Records a GP should keep**

The record of the examination should include the start and finish time of the consultation, and record that consent has been given. Your notes may also include a mental state examination if this is deemed appropriate, the mini-mental state examination and its score, and the diagnosis which is pertinent to the question of capacity. It has been recommended this diagnosis should be recorded in ICD10 or DSM-IV format, but I think this is optional. Do record the questions and answers of the legal test verbatim.

**The form of the opinion returned to the solicitor**

It is one of the difficulties in this country that there is a dearth of standard forms, reports or certificates which are universally recognised as being an acceptable format for conveying the opinion of the doctor on mental capacity. Improvement in this area has begun with the Nursing Homes Act, where the reporting form is standard. Also, form D, which executes an EPA, is standard, but the certificate which must accompany the registration of the EPA has not been standardised. On completion of an assessment of...
mental capacity, does the GP return a certificate, a report or an affidavit?

The publication on probate, mentioned in the previous article, has a suggested wording of three types of affidavit on mental capacity which would be very admissible to the Irish Probate Office. However, an affidavit needs to be sworn and signed in front of a solicitor or a commissioner for oaths, the organisation of which might be time consuming. I suggest we do not become involved with affidavits unless absolutely necessary, but instead prepare certificates which contain all the correct components, such that they will be deemed satisfactory. The essential components of a certificate of mental capacity include identification of self and identification of the subject, the date, time and duration of the examination, the diagnosis, the opinion, and the grounds for the opinion.

What if capacity is absent?

What if it is too late in the advancement of dementia for a person to be able to appoint an attorney? That person can be made a ward of court. Legislation on this is the Lunacy Regulation (Ireland) Act 1871. This is an expensive, antiquated, cumbersome and time-consuming process. It tends to be used only where the person involved has substantial financial assets. It is because the ward of court system is so difficult, and may be in breach of the Human Rights Convention, that there is such pressure to bring in a Mental Capacity Act.

Certificates of mental incapacity are required from two medical practitioners in the application for wardship. Application is made to the High Court, which then takes on a parental role. Any subsequent financial transaction must be approved by the High Court and there is no review of the status of wardship. A problem with the current structure of EPA is that there is currently no facility under Irish law to appoint an attorney who has the power to make decisions on medical matters. Powers of attorney are limited to financial and personal care decisions. It is planned that the new act will address this deficiency.

Where capacity to make a will is felt lacking, this may lead to reversion to an earlier will, or that the client/patient will die intestate. Where a will has been made and is later challenged on the grounds of capacity, the will is often upheld. These decisions are legal decisions, not medical ones. It remains to be seen what will happen with the Nursing Homes Act where two medical opinions are sought on capacity to sign the contract and those medical opinions differ. Again it is likely to be a legal decision in the end. All legal decisions on mental capacity will be made on the balance of probability. It is not necessary to prove that mental capacity is present beyond legal doubt.

It is noteworthy that Wardship of Court is the only vehicle in Ireland at present for decisions to be legally made on behalf of a person with specific learning needs extending from childhood. They do not have a period of capacity in which they can appoint an attorney.

The Mental Capacity Act

The Mental Capacity Act will replace wardship with guardianship, and also revises certain aspects of the current legislation on EPA. The most interesting aspect of this legislation will be the new office of a public guardian. This will most likely be a former judge whose office will oversee the entire structure of guardianship in the country. An early task of the public guardian will be to prepare codes of practice for all practitioners including a code for guidance on the assessment of mental capacity for medical practitioners. Also, there will be a code of practice on decisions with regard to care or treatment by healthcare professionals, including in emergency situations.

Instead of wardship, it will be possible to make an application to the court to appoint a personal guardian. It is likely that it will be considered that such a role will be better shared among more than one person. The presence or absence of capacity and the role and duties of the personal guardian(s) will be overseen by the public guardian and there will be an official review of the status at a minimum every 36 months. The public guardian may appoint, as necessary, a special visitor or a general visitor to help in his/her assessment of the appropriateness of a personal guardian and their duties.

The special visitor will be a registered medical practitioner with knowledge and experience in dealing with capacity issues. The general visitor will assess and advise on social, occupational or financial aspects of the case in question. A welcome aspect of the current scheme is the emphasis on support and encouragement. Throughout the proposed legislation, all persons dealing with assessment of capacity are urged to consider their language, the context of the assessment and the subject’s previously expressed wishes in assessing capacity. The emphasis is on a functional assessment, not on any documented status.

In the same vein, the new act strengthens the supportive role of the doctor in assessing mental capacity when the task is to execute EPA. The Act also allows the attorney to make decisions on healthcare of the donor but explicitly “does not authorise the refusing of consent to the carrying out of life-sustaining treatment”. The exact wording of this could cause problems and is not entirely consistent with the most recent publication of the Medical Council ethical guidelines 2009 which state: “There is no obligation on you to start or continue a treatment, or artificial nutrition and hydration, that is futile or disproportionately burdensome, even if such treatment may prolong life. You should carefully consider when to start and when to stop attempts to prolong life, while ensuring that patients receive appropriate pain management and relief from distress”.5

According to the proposed Mental Capacity Act, the solution where such a conflict might occur is for the decision on giving/withholding treatment to be delivered in the High Court. As can be seen from this account, there remain areas which are not clear-cut in the assessment of mental capacity. It is in the interests of the medical profession to cast an eye over the proposed new legislation, and to advise on areas with which our practice interact. On the whole, the new legislation is likely to improve current practice.

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References on request