



Capacity and dementia

Mini-legal kit Series 1.10

A guide for Health Care Professionals in the Hong Kong Special Administrative Region (HKSAR)



Under the common law, and consistent with Article 12 of the UN Convention on the Rights of Persons with Disabilities (which entered into force for China, including the HKSAR, in 2008) ¹ a person is always presumed to have capacity to make decisions. Where a person has dementia this may be a trigger for a capacity assessment if a decision needs to be made.

In the HKSAR, while Presumption of Capacity exists, in the Mental Health Ordinance, Cap. 136 (MHO), "mentally incapacitated person"

(精神上無行為能力的人) means-

- (a) for the purposes of Part II, a person who is incapable, by reason of mental incapacity, of managing and administering his property and affairs; or
- (b) for all other purposes, a patient or a mentally handicapped person, as the case may be;

In the MHO, "mental incapacity" (精神上無行為能力) means-

- (a) mental disorder;
- (b) mental handicap,

and "mentally incapacitated" (精神上無行為能力) shall be construed accordingly;

In the MHO, "mental disorder" (精神紊亂) means-

- (a) mental illness;
- (b) a state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;
- (c) psychopathic disorder; or
- (d) any other disorder or disability of mind which does not amount to mental handicap,

In the MHO, "mental handicap" (弱智) means sub-average general intellectual functioning with deficiencies in adaptive behaviour.

Capacity is:

- ability to make & communicate a decision;
- not a unitary or global concept;
- domain specific: particular to the type of decision being made (e.g. personal, health, financial); and
- decision or task specific: different for every decision made, even within one domain.

Broadly, there are three areas or domains of decision-making: personal, financial and health. Within these domains there are numerous types of capacity decisions or capacity tasks.

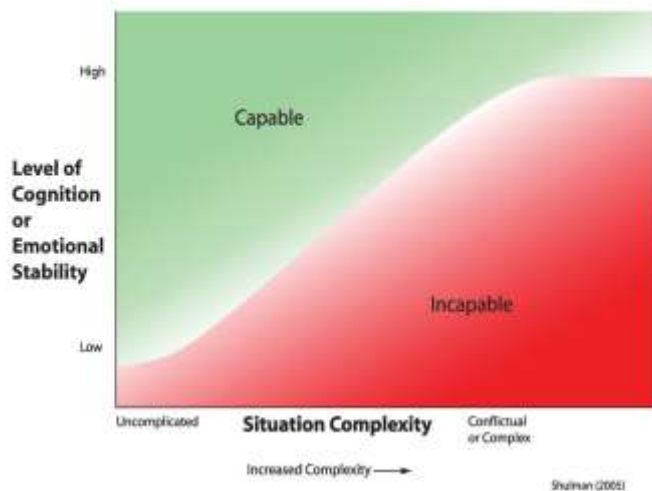
Capacity cannot be extrapolated from one decision to another. For example, a person's capacity to consent to medical treatment cannot be inferred from their capacity to make a decision to: execute a power of attorney; write a will; enter a contract or make a deed; or make an advance directive.

Capacity is decision-specific. Global capacity, where a person is either capable or incapable of making all decisions, has been rejected in law. It is inappropriate to state that a person "lacks capacity" without further reference to the type of capacity task. A person's capacity can vary in different circumstances, at different times, and even within domains for different types of decisions.

Within each domain there is a spectrum or hierarchy of decisions. People may be capable of making simple decisions (e.g. having a blood test) but not more complex ones (e.g. amputation).

Capacity is situation-specific. The greater the complexity and/or conflict within the decision-maker's environment, the higher the level of cognitive function or emotional stability/mental health necessary in order to be considered capable. For example, the weighing up of multiple potential appointees as attorneys by a person with severe dementia in the face of family conflict may be difficult; while the appointment of one's spouse in an uncomplicated relationship may be possible for someone with mild to moderate dementia. See Figure³ Reproduced with permission from the American Journal of Psychiatry (Copyright © 2000) American Psychiatric Association

Cognition, Emotions and Situation-Specific Capacity



Dementia is a degenerative condition associated with an inevitable decline in decision-making ability over time. Each decision or capacity task is different in complexity; consequently it will be lost at different points of the trajectory of the illness.

People should be encouraged to make the decisions they are capable of making as soon as possible. Early planning with regards to appointments of substitute decision makers will maximise personal control over decisions, as will promoting supported decision making for those needing assistance to make decisions. ASKME⁴ is a practical model of supported decision making, vis:

1. **Assess** strengths and deficits;
2. **Simplify** the task;
3. **Know** the person;
4. **Maximise** the ability to understand;
5. **Enable** participation.

How and when to assess capacity

Health care professionals may be asked to assess capacity in response to certain triggers:

1. To facilitate **future planning** – a person may be encouraged to appoint:
 - enduring power of attorney; or
 - document their wishes with regards to future treatment (advance care planning)
2. As part of a **routine clinical care assessment** - it may be necessary to ensure that a person has the capacity to consent to medical treatment or to drive
3. **Concerns from others** regarding a person's decision-making ability – these may have been raised by a lawyer, family member, carer or service provider, and an assessment may be requested.

Assess the person's ability to make a decision, not whether the decision is reasonable. A person has a fundamental human right to self-determination, and where they have capacity, to 'dignity of risk' - the right to take risks.

Any assessment of capacity must include a:

1. global assessment of the person's mental state and cognitive function (ideally with an estimate of severity and an assessment of the specific executive functions of judgment, reasoning and planning which are relevant to decision making; and
2. a functional assessment of decision making i.e. whether the person can show, using their own words, an understanding of the decision (as defined by the relevant legal test) in the domain in which they are making a decision (not just "yes, I understand").

The legal structure in HKSAR

Common Law is law developed by judges through decisions of courts and tribunals, while Statutory Law is law adopted through legislation. The HKSAR legal system is based on Common law and supplemented by local legislation.

Relevant legal tests

1. Assessment to aid future planning

Advance Directive (AD) – Health decisions only

An Advance Directive is a person's advance decision regarding their own future healthcare or medical treatment, when the person becomes unable to make those decisions.

In the HKSAR, there is no specific legislation pertaining to AD, although ADs are recognised by the Common Law.²

In August 2006 the local Law Reform Commission (LRC) published a report containing a “model form” of ADs for three scenarios (terminal illness, irreversible coma and a persistent vegetative state (PVS)). The Food and Health Bureau published a Consultation Paper in response in December 2009, in which the LRC model form was modified to allow a patient to request to continue artificial nutrition and hydration if clinically indicated. In 2014, the Hospital Authority published guidelines on ADs for their clinicians, in which an additional category of “other end-stage irreversible life-limiting condition” was added to the LRC model form. An additional shorter version of the model form was also designed.

In assessing capacity to make an AD consider:

1. The “what” of the AD:
 - Can the person understand the nature and effect of the instructions given about their health care preferences, any treatment options they are requesting or prohibiting, and the consequences of doing so? Do they have enough information about treatment options and alternatives (including no treatment) available? Do they suffer from conditions that might affect capacity to make such a decision such as delirium or depression?
2. The “freedom” of the AD:
 - Has all the relevant information been given to the person in a way they can understand?
 - Are they making the appointment freely and voluntarily and not being unduly influenced or “schooled”?

If a person does not wish to make an AD, it is good practice to encourage a process of advance care planning by supporting patients and their substitute decision-makers to think ahead and formulate goals of care as they confront the challenge of a progressive illness trajectory.

Such a practice should start early, be reassessed regularly with changes in health, and be sensitive to the patient’s idea about their autonomy – do they want to know about and be involved in decision-making or would they rather trust others to make treatment decisions on their behalf? ⁴

Enduring Powers of Attorney – Financial decisions

An enduring power of attorney (EPOA) allows the maker to appoint an attorney to make financial decisions for them when they lose capacity for financial matters (the capacity to manage their financial affairs).

In the HKSAR, in order to make a valid enduring power of attorney under the Enduring Powers of Attorney Ordinance, Cap. 501 (EPAO), the donor must have the mental capacity to make the enduring power and must sign it before a doctor and a solicitor. However the donor may sign before a solicitor up to 28 days after signing before a doctor.^{2,5}

General principles for assessing capacity to make a power of attorney include:

1. The “what” of the appointment. Does the person understand when it is explained to them:
 - that they are authorising someone to look after and assume complete authority of their financial affairs?
 - the nature and extent of what they are authorising the attorney to do (the more extensive and complex a maker’s affairs are, the greater their understanding needs to be)
 - the sort of things the attorney can do without further reference to them. Do the makers understand that the attorney can do anything with their property which they themselves can do?
 - that the authority will begin, or continue, when they are incapable of managing their financial affairs
2. The “who” of the appointment:
 - Why has the person been selected for appointment as an attorney? Has the person executed any Powers of Attorney previously? If so, how frequently have there been changes (i.e. revocations and new appointments)? Have they considered the trustworthiness and wisdom of the person they are appointing? Is this appointment in keeping with previous appointments (e.g. has someone else been consistently appointed as attorney in the past)? What is the history of the relationship between the person and the attorney and has there been any radical



change in that relationship coinciding with the onset or course of dementia?

3. The “freedom” of the appointment:
 - Has all the relevant information been given to the person in a way they can understand?
 - Is the person making the appointment freely and voluntarily, not being unduly influenced or “schooled” to make the appointment?

The principles for assessment of capacity to appoint an attorney under an enduring power of attorney apply equally to the assessment of capacity to revoke. The “who” of assessment applies particularly in regards to revocation. It is important to enquire why the maker now feels that the attorney is inappropriate, as unfounded paranoid ideation and suspiciousness may underlie such changes in the case of dementia.

2. Assessment as Part of Routine Care – Health and Personal decisions

The capacity to drive

A diagnosis of dementia should be viewed as a warning sign that an individual may not be competent to drive, or will lose that competency at some stage in the future. However, a diagnosis does not determine individual ability to drive. There should be a routine review regarding the person’s ability to drive safely.⁷

Medical treatment consent

In broad terms, an adult may give consent to their own medical and dental treatment if they are able to:

- (i) understand the nature and effect of decisions about the matter ;
- (ii) can freely and voluntarily make decisions about the matter; or
- (iii) can communicate their decisions in some way.

General principles for assessing for capacity to give consent for treatment:

1. The “what” of the consent:
 - Does the person understand the general nature and effect of the proposed treatment:
 - what it is and what it involves;
 - risks and benefits of the treatment; and
 - alternatives to, or consequences of not having, the treatment; and
 - Has the person indicated consent?
2. The ‘freedom’ of the consent:
 - Has all the relevant information been given to the person in a way they can understand?
 - Are they making the decision freely and voluntarily and not being unduly influenced?
 - A person has a right to refuse treatment.



In the HKSAR, while it is considered good practice for a treating physician to consult the opinions of a patient’s relatives, a relative can *only* give proxy consent if he/she is a legal guardian. The treating physician may ask a patient’s relative or social worker to apply for guardianship before seeking legal proxy consent from that individual.

For more information regarding medical consent, see the summary guide to medical and dental consent for adults who cannot consent to their own treatment in Appendix 1.

In the moderate to advanced stages of dementia if there is no AD (advance directive), it is strongly recommended that the person’s General Practitioner or specialist develop (with family members and the person), a **Plan of Care**.

A Plan of Care⁸ is a consensus-based discussion involving the adult (who, regardless of not having capacity, may want to have some input into this discussion), carer and medical staff around best interests, as the person is no longer able to provide informed consent about their future treatment. This will help medical, nursing and other health professionals to know what type of care the person would want if their condition worsens. It also helps all parties to work together with a common understanding.

A Plan of Care is not a substitute form of consent. It is a guide to what, to the best of the carer/family’s knowledge, the patient would have wanted, had they been able to speak for themselves.

3. Assessment prompted by concerns from others

Capacity to Manage Financial Affairs – Financial decisions

Other people’s concerns about a person’s financial capacity may trigger a capacity assessment. This assessment guides others’ decisions about whether they: need to begin using an EPoA; or (where there is no EPOA) apply to either the Guardianship Board or Court of First Instance.

In the HKSAR, prior to the establishment of the Guardianship Board in 1999, any financial matter pertaining to MIPs was handled by the Court of First

Instance under Part II of the MHO. Guardians appointed by the Guardianship Board now have limited powers to deal with financial affairs, namely: to hold, receive or pay a specified monthly sum for the maintenance or other benefit of the person concerned (currently maximum at HK\$14000 per month).

For MIPs with substantial assets, an application to the Court of First Instance remains necessary if the need arises to make decisions regarding those assets.^{2,9}

General principles for assessing capacity to manage financial affairs include:

- Does the adult know their assets? Can they read a bank statement? Can they use a chequebook or ATM card? Can they identify currency and its relative value? Do they understand what bills they have and any debts they have? Have they planned for the future?
- The adult does not have to manage financial tasks in the best possible way, but they must be able to manage them.
- Are they vulnerable to financial abuse? Will they be disadvantaged in the conduct of their financial affairs if they do not have someone? Is there a risk their assets will be dissipated due to their lack of capacity?
- Can they afford food? Do they pay crucial bills such as rent, electricity, water, rates or a crucial accommodation bond?
- If they are unfamiliar with their financial affairs or have never managed their own affairs, have they made appropriate alternative arrangements for the management of their estate?
- Is there a working alternative or informal arrangement already in place (e.g. a family member looking after their affairs, an attorney under a power of attorney or an accountant)?

If you assess that the adult cannot manage all of their affairs consider whether there are parts of their finances that they can manage.

Guardianship – Personal decisions

The Guardianship Board is a legal quasi-judicial tribunal of Hong Kong (<http://www.adultguardianship.org.hk>).

It has the legal power to make guardianship orders to appoint a private guardian (family member or friend) or a public guardian (the Director of Social Welfare). The Guardianship Board may grant a guardian the following powers regarding personal decisions:

- to require the person concerned to reside at a specific place;
- to bring the person concerned to a specific place and to use reasonable force (if necessary);
- to require the person concerned to attend at a place and time for medical or dental treatment, special treatment, occupation, education or training;
- to consent to medical or dental treatment if the person concerned is incapable of understanding the general nature and effect of the treatment
- to require access to the person concerned to be given to any doctor, approved social worker or other person specified in the guardianship order.

When making its guardianship orders, the Board must respect the views and wishes of the person the subject of the hearing, in so far as they may be ascertained. However the Board must promote the interests of that person the subject of the proceedings, and this may include overriding the views and wishes of the person where the Board considers such action is in the interests of that person.

Before making a guardianship order, the Board must be satisfied that the person the subject of the application is a mentally incapacitated person (see above). The Board may make an order after conducting a hearing into a guardianship application for the purpose of determining whether or not a mentally incapacitated person should be received into guardianship, if it is satisfied that the person is a person **in need** of a guardian.

In considering the merits of a guardianship application to determine whether or not to make a guardianship order, the Guardianship Board must be satisfied:-
(a)

(i) that a mentally incapacitated person who is mentally disordered, is suffering from mental disorder of a nature or degree which warrants his reception into guardianship; or

(ii) that a mentally incapacitated person who is mentally handicapped, has a mental handicap of a nature or degree which warrants his reception into guardianship;

(b) that the mental disorder or mental handicap, as the case may be, limits the mentally incapacitated person in making reasonable decisions in respect of

all or a substantial proportion of the matters which relate to his personal circumstances;

(c) that the particular needs of the mentally incapacitated person may only be met or attended to by his being received into guardianship under this Part and that no other less restrictive or intrusive means are available in the circumstances; and

(d) that in the interests of the welfare of the mentally incapacitated person or for the protection of other persons that the mentally incapacitated person should be received into guardianship

General principles for health practitioners assessing whether a person warrants reception into guardianship include:

1. Is the person a **mentally incapacitated person**? If so, what nature and degree of mental incapacity?
2. Does this mental incapacity limit the person's ability to make reasonable decisions (**i.e their capacity**) in respect of all or a substantial proportion of the matters which relate to his personal circumstances?
3. Is there **a need** for an order? What is the current situation regarding practicability of services, assistance and care being provided without the need for an order? Is there any risk? Why might an order be needed or what are the consequences of making or not making an order?
4. Any other comments **in the interests of the welfare** of the mentally incapacitated person or for the protection of other persons

Testamentary Capacity

A will is only legal if the person made it with "testamentary capacity". The assessment of testamentary capacity is complex and highly specialised area of expertise. If there is doubt about a person's will-making capacity when they are making or remaking their will, it is recommended that they are examined by a health professional with expertise in assessing will-making capacity.

For additional information on capacity, go to Capacity and the Law by N O'Neill & C Peisah at: <http://www.austlii.edu.au/au/journals/SydUPLawBk/2011/1.html>

and NSW Capacity Toolkit at:

<http://www.lawlink.nsw.gov.au/lawlink/diversityservices>

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Appendix One

Summary Guide to Consent to Health Care for adults 18 years and over who cannot consent

Medical treatment includes; “any medical or surgical procedure, operation or examination carried out by, or under the supervision of, a registered medical practitioner (doctor) and any care associated therewith”.

Dental treatment includes; “any dental procedure, operation or examination carried out by, or under the supervision of, a registered dentist and any care associated therewith”.

Category	Treatment	Who can consent
Urgent medical or dental treatment		No consent required
Non-urgent Medical or dental treatment		<p>Guardian – if empowered by the guardianship order appointing them to consent to medical treatment for the person under their guardianship.</p> <p>If no Guardian: No consent required. The doctrine of necessity is extended to non-urgent cases, providing it is performed in the patient’s best interests based on the opinion of the treating physician to improve or prevent damage to or the deterioration of the patient’s physical or mental health (Common law; Part IV C of the MHO – s 59ZF in particular).</p>
Special treatment	<p>Any medical or dental treatment or both of an irreversible or controversial nature specified by the Secretary for Food and Health.</p> <p>The Secretary has specified: Sterilization operations (except for operations that are intended primarily to treat other diseases of the reproductive system but having the effect of sterilization).</p>	<p>The Court of First Instance. However the Court must not consent under this Part to the carrying out of special treatment in respect of a mentally incapacitated person to whom the Ordinance applies unless the Court is satisfied that the special treatment is the only or most appropriate method of treating that person or that the special treatment is in the best interests of that person.</p>

