

CAPACITY, DEMENTIA AND NEUROPSYCHOLOGY

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CASE STUDY FROM THE GUARDIANSHIP TRIBUNAL

Martin (not his real name) is a 58-year-old former solicitor who wanted to revoke the Enduring Power of Attorney (EPOA) in which he appointed his ex-wife his attorney. Martin had been diagnosed with a form of dementia known as primary progressive aphasia (progressive loss of language). Martin's ex-wife challenged the revocation, believing his dementia meant he lacked the capacity to revoke the appointment and relied on the opinion of a neurologist who had seen Martin as part of a brain study. The neurologist based his medical opinion on the diagnosis of dementia and the typical progression of the disease. Martin's lawyers sought the opinion of two independent neuropsychologists. Although Martin had lost his speech and could only communicate through gesture, the neuropsychologists were able to administer tests that could measure Martin's visual reasoning, abstract thinking, problem solving and decision-making ability. Both neuropsychologists found that Martin did not exhibit the "typical" progression of the disease. Although his language was selectively and severely affected, he maintained other decision-making skills that he could exhibit if he was tested visually, rather than verbally. The Guardianship Tribunal found in favour of Martin and he was able to revoke the EPOA.

Capacity to instruct

The Office of the Legal Services Commission (OLSC) is increasingly receiving complaints that lawyers have accepted instructions from elderly people who lack decision making capacity. Solicitors can only take instructions from a person who is competent to give them (Solicitors' Rule 8), and lawyers should be aware that a failure to properly assess the capacity of a client can lead to disciplinary action or the potential for an action in negligence (*Goddard Elliott v Fritsch* [2012] VSC 87). The "Capacity Toolkit", published by the NSW Attorney General's

Snapshot

- Dementia is the most common threat to loss of legal capacity among the elderly
- The Office of the Legal Services Commission is increasingly receiving complaints that lawyers have accepted instructions from elderly people who lack decision-making capacity
- There appears to be a lack of knowledge within the legal profession as to the differing skill mix of medical specialists who are typically involved in capacity assessments

Department, and the NSW Law Society's "Guide for Solicitors When a Client's Capacity is in Doubt" both provide helpful guidance for lawyers involved in this task, but the content of the complaints filed at the OLSC suggests some solicitors are not aware of the guidelines or are unsure about how to apply them. The Law Society guidelines include a table summarising the expertise of the health professionals who may be able to carry out a capacity assessment. However, solicitors unfamiliar with the professions may not be equipped to select the most appropriate specialist on an individual client needs basis.

The required standard of capacity was set out by the High Court in *Gibbons v Wright* [1954] HCA 17 at [7]: *The law does not prescribe any fixed standard of sanity as requisite for the validity of all transactions. It requires, in relation to each particular matter or piece of business transacted, that each party shall have such soundness of mind as to be capable of understanding the general nature of what he is doing by his participation.* This means that capacity is decision specific and cannot be inferred from one decision to another. Each decision requires a fresh assessment, based on the complexity of the decision and context in which it is being made.

Dementia as a cause of loss of legal capacity

Lawyers often provide services to an older person because a diagnosis of dementia has prompted them into putting their legal affairs in order, including writing a will and appointing a suitable Enduring Power of Attorney. A diagnosis of dementia is not evidence that a person lacks capacity. Dementia is most accurately conceptualised on a continuum. As dementia progresses it is associated with increasing levels and forms of cognitive difficulty. At its inception, however, cognitive deficits can be relatively mild and affect only one or two cognitive functions. Memory is not always the predominant difficulty for dementia sufferers. The type of cognitive difficulties that initially arise will depend on the site at which changes first occur within the brain.

Barriers to assessing an elderly client's capacity

Some conditions that give rise to loss of capacity are difficult to recognise. In the early stages of dementia, the preservation of social façade can make it difficult to establish the true extent of a client's cognitive impairment. It has been estimated that up to 91 per cent of mild dementia cases are missed by GPs (V Valcour et al, 'The Detection of Dementia in the Primary Care Setting' (2000) 160(19) *Archives of Internal Medicine* 2964). Solicitors should be aware that the absence of a dementia diagnosis in an elderly client does not equate to the absence of dementia per se, just as a diagnosis of dementia does not equate to a loss of legal capacity.

The same may be said for the absence of memory impairment. There are a number of forms of dementia wherein memory ability remains preserved well into the disease course. While memory impairment may become apparent in conversation, higher-level cognitive functions, such as reasoning ability, abstract thought and the ability to hold information in mind whilst manipulating it (known as working memory), which are arguably of greater import in the determination of legal

capacity, are more difficult to assess, even with the use of cognitive screening measures.

Medical opinion in the assessment of capacity

Disputes over whether an older person has capacity to make a legal decision most often arise where there is a background of family conflict. Solicitors should be alert to the potential for future challenges to the capacity of an older person in these situations, sometimes occurring years down the track. One way solicitors may seek to protect the decision-making rights of older clients is through obtaining an assessment from a medical professional.

However, medical practitioners may be no better placed than solicitors in performing capacity assessments. General practitioners may not only lack knowledge of the relevant legal and cognitive tests, but may have little if any experience in inferring the likely functional implications of their findings to the legal test in question. There appears to be a lack of knowledge among the legal profession as to the differing skill mix of medical specialists who are typically involved in capacity assessments. This lack of knowledge (whilst understandable given the overlapping nature of the professions of geriatric neuropsychology, geriatric medicine and old age psychiatry) can result in the suboptimal use of specialist opinion and the at times inadequate and cursory assessment of a client's capacity (Victorian Law Reform Commission, 'Guardianship Final Report 24' (Victorian Law Reform Commission, 2012) 116).

The legal basis of any capacity assessment is dictated by the relevant legal test. The clinical conceptual framework for assessing capacity is widely held to encompass: 1) functional, cognitive and emotional evaluation; 2) diagnosis; 3) consideration of a client's values and risks; and 4) consideration of steps to enhance capacity. Despite consistency in the legal and clinical conceptual approaches to assessing capacity, the varied forms in which capacity issues emerge require differing clinical skill sets. The relevant medical specialist for any given client should have experience in assessing capacity within the context of the medical condition with which the client presents and also possess the training and skills necessary to conduct each of the components comprising an assessment of capacity.

Objective tests of capacity: the role of neuropsychologists

It may surprise lawyers to learn that some specialist medical practitioners, such as geriatricians, neurologists and old age psychiatrists, who are frequently called upon to provide opinion pertaining to legal capacity in the elderly, are not trained in cognitive (neuropsychological) assessment beyond administration of brief, low-level cognitive screening measures (comprising general questions relating to the date, current prime minister, and later recall of three objects). Nor have they had clinical training in the use of techniques to enhance cognitive performance (ie cognitive rehabilitation).

Without the use of objective formal assessment measures (which allow for detailed examination and precise quantification of a client's cognitive abilities and disabilities in relation to their age peers), clinicians are wholly reliant on information of a qualitative or observational nature in arriving at what is then ultimately a subjective opinion as to a client's cognitive capacity. The *objective* assessment of a client's cognitive ability is especially important where the question of capacity arises within a context of wider family conflict. In these situations, information provided by family members may be incongruent or incomplete, making it impossible to rely on subjective accounts of a client's capabilities.

As a discipline, geriatric neuropsychology is uniquely placed to assess capacity in the elderly, combining a knowledge base of neurodegenerative disease with extensive training in the administration and interpretation of standardised/objective cognitive and functional tests and the application of rehabilitative strategies to maximise cognitive function and client involvement in decision making.

What is your client capable of doing?

With a detailed understanding of the characteristic effects of different medical and neurodegenerative conditions on cognition and behaviour, the neuropsychologist has in-depth prior knowledge of which aspects of cognition and, by extrapolation, which aspects of legal criteria are likely to require more careful probing. Conversely, with knowledge of the underlying condition giving rise to cognitive impairment, the neuropsychologist is equally aware of the aspects of a client's cognition that are likely to remain intact.

For example, with knowledge of the distinct manners in which the different

disease processes of Alzheimer's disease, Dementia with Lewy Bodies and the Primary Progressive Aphasia's impact on cognition, we can predict that:

- a) Failure to remember and retain information will likely be a limiting factor in the early stages of the former condition but not the latter two
- b) Failure to comprehend complex instruction and express oneself in an organised, coherent manner may be a limiting factor in the latter two conditions but not in the early stages of the former
- c) Scope for delusional thinking or misidentification exerting influence on decision-making capacity may be a potential issue in the case of Dementia with Lewy Bodies but not early or middle stage Alzheimer's disease or Primary Progressive Aphasia
- d) Fluctuations in cognitive function, even within the course of a single day, may influence the decision-making capacity in Dementia with Lewy Bodies, whereas marked variability in cognitive performance would not typically feature in the early stages of Alzheimer's disease or Primary Progressive Aphasia.

Beyond capacity assessments

Enlisting the appropriate specialist will become increasingly important if law reforms expand the remit of capacity assessment beyond that of capacity determination alone to encompass the facilitation of maximum client participation and autonomy in decision making.

Overseas, initiatives such as the *Mental Capacity Act UK* (2005) and the more recent *Irish Assisted Decision-Making (Capacity) Bill* (2013) have replaced bright line capacity tests and substitute decision-making models with more nuanced consideration of the supports required by people with a cognitive impairment in order to honour their will and preferences in the decision-making process. Similar recommendations made in Australia, such as those of the Victorian Law Reform Commission, would see the introduction of several additional tiers of decision-making capacity with options for supported decision making. Determining the appropriate level and type of decision-making support for a cognitively impaired client will, by its very nature, necessitate a much finer grained analysis of cognitive abilities and disabilities than is required to simply assess for capacity in relation to a specified legal test. Knowledge of the relevant cognitive rehabilitative strategies and supports will equally prove crucial in ensuring the effectiveness of the support that is provided to the client. **LSJ**