

FORMS AND DECISIONS! THE IMPLICATIONS OF MENTAL CAPACITY

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ABSTRACT

Much has been written about the deputyship regime in Singapore¹ and the operation of the Mental Capacity Act 2008 (MCA)² in relation to it. In addition, there are articles on the pertinent issue of capacity assessments and writing of medical reports for deputy applications.³ In reality, however, there remains a significant gap in the understanding on how theory and practice meet in the area of capacity assessment and a desire for a more grounded approach towards implementing the framework set out in the MCA for capacity assessment. In particular, there is difficulty in setting the threshold of understanding required in the functional component of the test. This article aims to provide some user-friendly guidance that can be adopted in capacity assessments and a practical explanation on how we can ensure that capacity assessments are as robust and accurate as they can be.

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INTRODUCTION

Individuals make decisions all the time, from the mundane, such as what to have for breakfast in the morning or how to get to school or work, to the profound, such as whom to marry or which religion to follow. The beauty of choice and its importance in our lives reflects how much society values autonomy. Despite its universal importance, the right to make decisions about one's life has only very recently been extended to individuals with mental impairments. With this shift comes the challenge of understanding what it means to exercise autonomy in the context of impairment and disability, within the framework of the Mental Capacity Act 2008 (MCA).

At its core, the legal concept of mental capacity captures the intuitive idea that we need to display a level of decision-making competence in order for our choices to be respected. Accordingly, when we make an assessment on mental capacity, we focus on assessing the person's cognitive abilities (to understand, retain, and use information relevant to the decision). For example:

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- Can the individuals understand and reason with the various available options?
- Can they understand the consequences of their decision?
- Are their reasons internally consistent?

However, in practice, the interpretation of capacity and our understanding of autonomy is fraught with difficulties. Sections 3 to 5 of the MCA provide a statutory definition of capacity and how-to guidelines for evaluation, yet we need to consider whether capacity is a strict cognitive test or whether it is, at least in part, determined by the individual and their relationships. Relationships can enable and disable – we need to appreciate that people are situated within complex relationships that can support or obstruct their ability to decide, to act, and to secure their own interests.

From my interactions with healthcare professionals and social workers involved in assessments of capacity on a daily basis, I find that there is often a lack of legal literacy on the MCA. While there exists some degree of working knowledge on the definition of “mental capacity”, “clinical capacity”, and “functional capacity”, most do not know how to implement the full suite of the MCA provisions in their area of practice and, more worryingly, are unaware of how the MCA impacts their professional practice on the whole.

For example, in a hospital setting, the MCA can be thought of as a means of providing legal justification for actions in connection with a person, which would normally require the consent of that person, when it is not possible to obtain consent on the grounds that the person lacks the decision-making capacity to give or withhold legally valid consent.

In other words, if a healthcare professional needs to do something that requires the patient's consent, but the patient is unable to give consent, then the MCA provides a framework.

MENTAL CAPACITY TEST

Whether a person has or lacks capacity to do something is a question that must be decided in reference to the MCA framework. Some common law tests of capacity may require additional or different considerations, for example, in relation to testamentary capacity.

One particular challenge that MCA practitioners (i.e., legal, medical practitioners) regularly face is in translating theory into practice across a number of different areas, particularly in the area of capacity assessments. Sometimes, but not always, this is due to poor training delivered by those who have little actual experience of implementing theory. The result is that practitioners feel disempowered, fearful, and lost in their attempts to conduct capacity assessments in

either a clinical or legal setting. Poor assessments will lead to poor or wrongful outcomes, the impact of which can be devastating for individuals, families, and practitioners alike.

Two-Step Test

In order to decide whether an individual has the capacity to make a time-specific and decision-specific choice, the starting point is to apply the two-stage test for mental capacity under **Sections 4 and 5 of the MCA**, which sets out two questions that need to be answered:

Step 1: Is the person unable to make a particular decision? (**Functional component**)

Step 2: Is the inability to make that same decision caused by an impairment of, or disturbance in the functioning of, the mind or brain? (**Clinical component**)

Section 5 of the MCA elaborates on what it means when an individual is unable to make a decision (functional test component). The person must be unable to do any one of the following:

- Understand information given to them;
- Retain that information long enough to be able to make the decision;
- Weigh up the information available to make the decision; or
- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

In the Singapore High Court case of *Re BKR*,⁴ the learned Justice Lai Siu Chiu stated that the distinction between the two components is critical because it affects the lens adopted to assess the evidence. Justice Lai illustrated the difference as follows:

“... if factual instances are raised to show that an individual is generally forgetful (alongside expert medical evidence), this may aid the court in finding that the person suffers from dementia, which may satisfy the clinical component of the test. However, there is an additional step to be taken to satisfy the functional component of the test – the court must be further satisfied that the individual is unable to make a decision. To do so, the court is then to be guided by the principles contained in the MCA. In considering the factual instances, for example, the court must consider whether all practicable help had been given. If no such help was given, the court must then be satisfied that even if all practicable help was given in that factual scenario, the individual would still have been unable to make a decision, before finding that he lacks capacity.” (emphasis mine)

Such a distinction has legal significance. A clinical finding is essentially a finding of fact, whereas the Court must be satisfied that the principles contained in the MCA have been applied within the context of the individual’s unique social circumstances, in order to rule that the functional component of the test is met. The UNHRC Committee on the Rights of Persons with Disabilities (CRPD)⁵ put in no uncertain terms:

“Mental capacity is not, as commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.”

The inference is that mental capacity is a subjective, contextualised assessment, and the corollary is that as capacity assessment is judgement-based, the focus is equally on, if not more, on the *assessor* than the person being assessed.

For the practitioner, the real challenge lies in determining to what degree we need to become acquainted with the person we are assessing (beyond clinical assessment), in order to assess if they have the capacity to make the specific decision in question.

Threshold of Understanding

For the functional component of the test, the law provides clarity on the threshold of understanding required for a specific act – for example, the capacity to deal with one’s financial affairs or to make a will.

In the latter, also known as the test for testamentary capacity, the common law position is found in the leading authority of *Banks v Goodfellow*,⁶ which our Singapore Court of Appeal has followed in the case of *Chee Mu Lin Muriel vs Chee Ka Lin Caroline* (*Chee Ping Chian Alexander and another, interveners*)⁷. The essential requisites are as follow:

- The testator understands the nature of the act and what its consequences are;
- He knows the extent of his property of which he is disposing;
- He knows who his beneficiaries are and can appreciate claims to his property; and
- He is free from an abnormal state of mind (e.g., delusions) that might distort feelings or judgements relevant to making the will.

In other words, the person being assessed need not understand every single aspect of the situation or decision at hand, just the salient parts. All the relevant information that an individual needs to understand in relation to a particular decision can be simplified using what I will term the **CPD Principle**.

CPD Principle

C = Concept
P = Procedure
D = Duration

For example, take a scenario where we are assessing if an individual can make their own decision with regards to their property and affairs. We can use the CPD principle to set the threshold for the knowledge that the individual should demonstrate in order to satisfy the functional component.

For **Concept**, we are interested in whether the individual has a notion of “money and finance” and its source and nature. For **Procedure**, we are interested whether the individual understands the mechanics of money and finance, such as how to earn/obtain money, how to invest, and how to manage money. For **Duration**, we are interested in the individual’s ability to consider issues within a timeframe that is either short-term or long-term. The individual will need to understand how spending money in the short-term impacts their disposable income in the long-term.

The gist of it is that practitioners should identify in advance the various elements that you would require the individual to understand, and then consider the extent to which the individual should understand them. The bar of expectation must be set at the level of the average man-in-the-street. In other words, we are not expecting the individual to demonstrate mastery at the level of an expert, but to be aware of the salient features.

NOT A FORM-FILLING EXERCISE

Buying bread and milk is more straightforward than deciding between two competing investment opportunities with different degrees of risk attached. The reductivist nature of the standardised forms issued by the Family Justice Courts as well as the Ministry of Social and Family Development (MSF) on capacity assessment may inadvertently lull the practitioner into a false sense of security and confidence.

We need to steer away from considering capacity matters in binary terms but rather to see decision-making ability as a spectrum, ranging in complexity depending on the nature of the decisions at hand. For example, instead of broadly writing-off decision-making capacity for finances and property, the practitioner might consider if the individual is able to receive small deposits each week to manage their own grocery shopping, or other modest regular expenses.

Any assessment of capacity involves making a decision that the practitioner might be asked to defend in court. It is important for the practitioner to demonstrate how they have arrived at the conclusion, preferably directly quoting the patient in the assessment.

THE IMPORTANCE OF CAPACITY ASSESSMENTS TO LAWYERS

The determination of capacity is important to lawyers. The key legal principle of the Mental Capacity Act is enshrined under Section 3(1)(2) of the Act, that a person must be assumed to have capacity unless it is established that he lacks capacity.

Many allegations of financial abuses involving vulnerable persons often begin with a legal transaction like conveyancing, facilitated by anticipatory decision-making legal instruments such as a lasting power of attorney (LPA), deeds of gifts, powers of attorney (POA), and testamentary instruments like wills and codicils. Capacity-related issues with duly executed legal instruments tend to surface after clients have lost mental capacity or have died. Suffice to say, in such an event, it is difficult to do discovery or conduct any remedial actions. In addition, the quality of life of clients without capacity during the period of a lawsuit tends to decrease.

With regards to the suggested framework, of particular relevance is the interplay between the concept of “relational autonomy” and the role of relationships in mental capacity. We need to recognise that people are capable of being situated in complex relationships that can support and enable, as well as obstruct and disable their ability to decide, to act and to secure their own interests. As our skillsets in evaluating mental capacity evolve, practitioners must resist the temptation to come up with simple, binary answers to complicated problems surrounding capacity assessments.

CONCLUSION

Capacity assessment is rarely straightforward, and should be taken seriously, given the important implications on a patient’s decision-making autonomy. Implementing the CPD Principle may provide practitioners with a tool to assess what information to gather and how to gather from the individual who is being assessed.

Practitioners assessing capacity at the request of a lawyer should also bear in mind the need to request for information on the purpose of the assessment (e.g., is it for the purpose of deputyship or will-making or to make a lifetime gift, etc), and what impact the assessment may have on the individual. They should also request for details on any common law tests of capacity that are required (to be explained in layman’s terms), in addition to the MCA framework. Information on the individual’s family background and affairs should be requested, to assist in the capacity assessment whenever relevant. A proper instructing note or letter containing the above should accompany the request for information.

Practitioners will need to acquire skills in the *interactions of assessment* – how the assessment itself is carried out, and the manner in which the assessor communicates with the person with impairment. The interaction needs to be carried out using skills of hermeneutic competence, to ensure that

a participatory and enabling ethos prevails. We need to encourage the development of a group of capacity assessors who can meet the demands and increased sophistication of how we preserve and enable autonomy, and to assist professionals, in particular doctors and lawyers, to cooperate with each other when a cross-disciplinary approach is required.

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LEARNING POINTS

- **Capacity assessments are not mere form-filling exercises using prescribed forms by the Family Justice Courts and the Ministry of Social and Family Development.**
 - **Understand that the capacity assessment is a two-stage test consisting of the functional component and the clinical component.**
 - **Start with the functional component first, and only if the individual is unable to make the decision, then proceed with the clinical component.**
 - **Practice using the CPD tool to establish the threshold of knowledge that you expect from the individual being assessed.**
 - **Consider the role of relationships in and “relational autonomy” in mental capacity assessments.**
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