MARCH 2009

Hong Kong Psychogeriatric Association Newsletter
香港老年精神科學會會訊

www.hkpga.org
email: info@hkpga.org

MESSAGE FROM THE NEWSLETTER COMMITTEE

Welcome to the March issue of the HKPGA Newsletter. In this issue, Dr. Victor Lui shares with us on how to assess mental competence in clinical practice. It is followed by the information on consent to medical and dental treatment provided by the Guardianship Board. A new section in this issue brief us the study by Ms. Ada Fung et al, the emotional reactions towards percieved loss of function in people with dementia. Last but not the least, one of our clinical psychologist members, Ms. Cindy Chan has kindly sent us a brief report on her expert experience in performing CBT with older people in Hong Kong.

The Committee would like to announce that from the year 2009 onwards, HKPGA Newsletter would have a regular section to introduce recent local research articles on elderly mental health and/or articles from overseas professional bodies. The Newsletter also accepts a limited number of promotional materials to cover the publication cost of the newsletters. Please do not hesitate to send your feedback to info@hkpga.org and share your experience with other members in the field through this newsletter.

RETHINKING ASSESSMENT OF MENTAL COMPETENCE IN CLINICAL PRACTICE

Dr. Victor Wing-cheong Lui, Department of Psychiatry, Tai Po Hospital

For consent to be valid, the patient must have the capacity to consent. In a classical case of *Re C* (Adult: refusal of treatment)[1], it was questioned whether a schizophrenic patient had capacity to refuse consent to amputation of his gangrenous foot. The patient was a sixty-eight years old man. He was reported to have a number of delusions, including the belief that he had had an international career in medicine. His consultant was of the view that, unless his leg was amputated, he had a very high chance of death. However, he chose to die with two feet rather than to live with one. The High Court held that an adult has capacity to consent to (or refuse) medical treatment if he or she can:

1. understand and retain the information relevant to the decision in question;
2. believe that information, and;
3. weigh that information in the balance to arrive at a choice.

The above *Re C* test has formed the standard of mental competence at common law and the basis of the statutory test of incapacity in the Mental Capacity Act 2005 of the United Kingdom For a psychiatrist, like me, this case has refreshed some of our understandings in mental capacity. In the above case, the patient was seriously mentally ill. Despite the presence of delusions, he could be judged to be mentally capable of making a decision about whether or not to have his leg amputated provided the above 3 stage test were passed. It illustrates the fact that the mental disorder and mental incapacity are not synonymous with each other. Moreover, mental patients,

like other patients, are presumed to be mentally capable to make treatment decision: their lack of mental capacity must be demonstrated. We may be required to prove their mental incapacity. This case highlights the importance of proper assessment and documentation of mental competence.

Assessment of mental competence is in fact relevant to all clinical practice. "A physician shall respect a competent patient's right to accept or refuse treatment." (International Code of Medical Ethics) Physicians are required to obtain informed consent before initiating treatment to the patients. It is not uncommon for a physician to face a patient planning to make a decision which is believed to be contrary to his or her own best interests. The principles of autonomy and beneficence will come into conflict. The decision that which of these principles will take priority depends on one's mental competence. If a patient is mentally competent, his or her choice must be respected even when the chosen treatment option or refusal is not a wise choice. If a patient is mentally incompetent, the clinician needs to consider protecting the patient and giving treatment in accordance with applicable legal principles.

It is well recognized that many psychiatric conditions, including dementia, depression, schizophrenia, learning disability and bipolar affective disorder, while even at early or mild stage, can impair mental capacity. Psychiatrists are often asked to perform formal competence evaluation and provide expert opinion. However, the potential assessors of mental capacity are not limited to psychiatrists. Impairment in decision-making capacity has been found in other patient groups and correlate with other factors such as old age and fewer years of education. Physical conditions like stroke and delirium of various causes can also impair mental capacity.

The concept of mental competence is broad and the assessment is not always straightforward. Studies have suggested that capacity assessment in patients with Alzheimer's disease by physicians may not be reliable. Different clinicians might focus on different cognitive tasks to assess mental capacity. For other disorders such as delirium or psychotic disorders, patients may present with fluctuating mental condition and make the assessment unreliable. In practice, evaluating uncooperative patients may pose an additional but important challenge to clinicians, especially in the context when an emergency exists. Collateral information and evidence may need to be sought.

Competence assessment may be assisted by measuring instruments. Mini-mental state examination (MMSE) is perhaps the most commonly used tool in old age psychiatry. Many health care professionals are familiar with this test. It assesses one's general cognitive function and has been used to support the results of mental competence determination. Generally speaking, the MMSE scores correlate with clinical judgement of mental incapacity. A very high or very low MMSE scores were associated with mental competence or incompetence respectively. However, the MMSE does not help to differentiate mental capacity for patients with mild degree of cognitive impairment. There are no single MMSE cutoff scores with high sensitivity and specificity for these patients. Moreover, conceptually, cognitive impairment, such as disorientation to time and place per se, is not regarded to be equivalent to mental incapacity. The MMSE is essentially an indirect measurement for mental competence only. More specific and direct assessment tools for mental capacity are required.

In recent years, specific tools for assessment of mental competence could be found in the literature. Dunn et al (2006) have conducted and published a comprehensive review for these tools.[2] The MacArthur Competence Assessment Tool for Treatment (MacCAT-T) and for Clinical

Research (MacCAT-CR) are recommended assessment tools for consent to treatment and research respectively. These tools have most empirical support, when compared with other instruments. The four decision-making abilities assessed by the MacCAT-T or MacCAT-CR, namely understanding, appreciation, reasoning, expressing a choice, are consistent with most western legal standards for mental competence. It is of interest to note that, based on the framework of the MacCAT-T and MacCAT-CR, a new instrument, known as Assessment of Capacity for Everyday Decision-Making (ACED), was recently published to measure everyday decision-making capacity such as financial decisions. The performance of MacCAT-T and ACED has been tested in Chinese psychiatric patients and the results were promising.[3,4] These instruments provide a useful structure for comprehensive competence assessment and documentation and illustrate the usefulness of direct and specific assessment tools for decision making capacity. While the use of assessment tools is increasingly popular, it is worthwhile to emphasize that they are primarily intended to assist, rather than to replace, clinical judgement. Clinical judgement remains to be the best method because the final determination of mental competence should involve incorporation and balance of different moral, clinical and legal standards and values, including the risks and benefits of the proposed intervention, autonomy, non-maleficence, and beneficence. However, use of specific assessment tools together with clinical judgement can probably enhance the reliability of the overall evaluation.

A clinical determination that a patient is probably mentally incompetent should not be the end of a competence assessment. Patients' decision-making rights and autonomy should not be deprived lightly. The physician should evaluate whether the mental incapacity is likely to be temporary and help patients to retain decision-making capacities as far as possible. The physician should look for the way to maximise a patient's mental capacity and ameliorate the causes of mental incapacity if possible. For example, causes of delirium should be suspected and ruled out. If the proposed treatment is not an emergency one, treatable psychiatric conditions such as depression, over-sedation, presence of untreated medical condition should be tackled before final competence determination. Other possible enhancement techniques such as reducing patients' anxiety, use of translators, where appropriate, should be considered. Studies have suggested that repeated presentation of materials and procedures to enhance disclosure of treatment information may improve the understanding of patients. Last but not the least, the value of reevaluation at a later time should not be ignored. For example, patient with delirium may be mentally not competent at some time and be mentally competent on another occasion.

Therefore, all physicians, not limited to psychiatrists, may be required to carry out a formal assessment of mental capacity. Specific and direct assessment tools can assist the clinical judgement, guarantee a thorough evaluation and enhance the reliability of the overall assessment. A comprehensive clinical assessment of mental capacity should include looking for the causes of mental incapacity, amelioration of the identified causes and helping the patients to maximise their decision-making abilities. The value of repeated evaluation at a later time must not be underestimated.

REFERENCES

1. Re C (Adult: refusal of treatment) *1 Weekly Law Reports* 290, 1994.

2. Dunn LB, Mowrangi MA, Palmer BW, et al: Assessing decisional capacity for clinical research or treatment: a review of instruments. *American Journal of Psychiatry 2006*; 163: 1323-1334.

3. Lui VWC, Lam LCW, Luk DNY, et al: Capacity to make treatment decisions in Chinese older persons with very mild dementia and mild Alzheimer's disease. *American Journal of Geriatric Psychiatry*, in press.

4. Yu FOT, Lui VWC, Lam LCW, et al: Assessment of capacity to make financial decision in Chinese psychogeriatric patients – a pilot study. *Hong Kong Journal of Psychiatry*, in press.

CONSENT TO MEDICAL AND DENTAL TREATMENT: THE FACTS

Re-print approved by the Guardianship Board of Hong Kong

Mentally Incapacitated Person (MIP)

Anyone aged 18 or above is regarded by law as an adult who can make decisions on his/her personal, medical or financial affairs unless there is medical evidence that he/she lacks the ability to make these decisions. On the other hand, a "mentally incapacitated person" is an adult with a mental illness, dementia, mental handicap or a disability of mind (such as an acquired brain injury due to an accident or stroke) to the extent that he/she lacks the capacity to make such decisions.

Part IVC of the Mental Health Ordinance

Part IVC of the Mental Health Ordinance (Cap. 136) ("Part IVC") is a law that deals with medical and dental treatment of the mentally incapacitated persons. Part IVC empowers the medical practitioner or dentist to provide **urgent or non-urgent** medical or dental treatment to a mentally incapacitated person **without** his/her consent if the person concerned does not understand the nature and effect of the proposed treatment and provided that the treatment is necessary and in his/her best interests. This means that the treatment will save the life of the person concerned, prevent any damage or deterioration, or bring about an improvement, to his/her physical or mental health and well being.

Urgent and Non-urgent Treatment

A treatment is urgent if it is to save the life or prevent serious harm to the person concerned. Non-urgent treatment refers to all other treatments and it includes surgery for conditions like cancer. Before giving non-urgent medical treatment, the medical practitioner must have taken all reasonably practicable steps to ascertain whether a guardian has been appointed for the mentally incapacitated person. If there is, or appears to be no guardian appointed, or the guardian has not been given the power to consent to treatment, the medical practitioner can go ahead with the treatment without the consent of the person concerned. In fact, the vast majority of mentally incapacitated persons are not under guardianship. If a guardian has been appointed, then the guardian can consent if he/she has been given the power to consent to treatment. The appointed guardian can consent to all medical treatments, except special treatment and organ donation from the person concerned. A special treatment is a treatment of an irreversible or controversial nature, such as sterilization.

Guardianship Order

If the medical practitioner is acting on the best interests and is willing to give the treatment to the mentally incapacitated person concerned with/without a consent form signed by the family member, then there is no need to apply for a guardianship order. A guardianship application will be appropriate if the medical practitioner recommends treatment of the person concerned but is reluctant to go ahead without his/her consent, or with only the family member signing the consent form. A guardianship application may also be appropriate where a family member/carer or the person concerned objects to the proposed treatment recommended by the medical practitioner and the medical practitioner is reluctant to proceed because of the objection. Besides,

the family members may disagree with each other about the treatment. Alternatively, a social worker or medical practitioner may apply for a guardianship order if they think that the treatment is in the concerned person's best interests, despite objections from that person or the family.

For more information, please contact the Guardianship Board:
Address: Unit 807, 8/F., Hong Kong Pacific Centre,
28 Hankow Road, Tsimshatsui, Kowloon, Hong Kong
Tel: 2369 1999 Fax: 2739 7171 Email: gboffice@netvigator.com
Website: www.adultguardianship.org.hk

REFERENCE

Guardianship Board, Jan 2005, Consent to Medical and Dental Treatment [on-line], available at **www.adultguardianship.org.hk/index.aspx?cid=17&lang=e** (accessed 7 Feb 2009).

EMOTIONAL REACTIONS TOWARDS PERCIEIVED LOSS OF FUNCTION IN OLDER CHINESE PEOPLE WITH DEMENTIA

AWT Fung, DNY Luk, VWC Lui, PWC Tam, RCM Chau, VWK Poon, CHL So, HWT Lo, FSL Ko, LCW Lam

Abstract *(reprint with the kind permission from the Hong Kong Journal of Psychiatry)*

Objective: To evaluate emotional response towards perceived loss of activities of daily living in Chinese elders with dementia.

Patients and Methods: Eighty one elderly people with a clinical diagnosis of dementia were recruited from residential homes and social centre for the elderly in Hong Kong. A purpose-designed questionnaire on subjective evaluation of ability, and emotional reactions, towards functional deterioration was derived. The association between the subjective evaluation of ability, emotional reactions, and actual activities of daily living performance measured by the Chinese version of Disability Assessment for Dementia was evaluated.

Results: There were no significant correlations between subjective evaluation of ability and the emotional reactions towards functional impairment. Subjects reported greater emotional distress over possible loss of basic activities of daily living than instrumental activities of daily living (t=3.04, p=0.003). Subjects with better basic activities of daily living abilities were likely to report greater distress if their instrumental activities of daily living were impaired (Spearman* rho=0.30, p=0.01).

Conclusion: Although elderly people with dementia may have compromised cognitive abilities, attention to functional training is an important means of improving their emotional well-beings.

Full text is available at www.hkjpsych.com/past0701.htm

THE ADAPTABILITY OF COGNITIVE BEHAVIORAL THERAPY FOR LATE-LIFE DEPRESSION IN HONG KONG

Ms. Cindy Chan, Clinical Psychologist (www.ccps.com.hk)

The adaptability of Cognitive Behavioral Therapy (CBT) for treating late-life depression of the Chinese older adults in Hong Kong has been questioned. In the West, CBT on its own was found to be an effective treatment for the older adults who cannot or are not willing to undergo physical treatment for mild to moderate late-life depression. (Laidlaw, Davidson, Toner, Jackson, Clark, Law, Howley, Bowie, Connery and Cross, 2008) In this randomized controlled study comparing CBT alone and treatment-as-usual (TAU) alone, older adults with late-life depression could benefit from either CBT alone or TAU alone with outcomes measured at the end of treatment and six months after the end of treatment. Furthermore, the number of older adults in the CBT condition who met Research Diagnostic Categorization (RDC) status for depression at the end of treatment and three months after the end of treatment was significantly lower than those who received TAU alone. In fact, older adults who had undergone CBT had significantly lower scores on measure of hopelessness compared with those in the TAU condition. This suggested that CBT enhanced the coping skills of older adults and increased their optimism in dealing with future problems.

There is no similar study on local application of CBT for Chinese older adults with late-life depression. In 2004, a number of CBT treatment groups were conducted for late-life depression for older adults in the New Territories West by the author. In this preliminary trial, significant difference between pre- and post-treatment scores of depression rating were found in one of the groups. In view of the uniqueness of the local elderly population, several modifications were made in conducting these CBT groups. First, these older adults have cognitive changes associated with aging, such as sensory and perceptual impairment, slower processing speed, and impaired ability to shift from abstract concepts. Logistic and hardware accommodation including the use of larger fonts for printed materials, slower presentation and more frequent summaries, as well as multiple modes of presentation can be done to cater for these cognitive deteriorations.

Second, older adults' indigenous beliefs about psychotherapy, such as authoritarian dependence and traditional Chinese medicine point of view may contribute to their misconception on CBT. They may expect CBT to be more directive and authoritative and have stronger preference for practical and immediate solutions to problems. They may also expect to receive drug treatment rather than "talk therapy". The strategies for cultural adjustment can be the emphasis on psycho-education and development of specific and well-defined treatment goals in the initial phase of treatment.

Third, older adults' indigenous social/psychological characteristics, such as family orientation, relationship orientation and humility norm (Yang, 2003), may crash with the individualism of the younger generation and contribute to their difficulty in expressing their private thoughts and intense emotions. Modification of CBT in treating this local population may focus on the cognitive work for these indigenous beliefs and model emotional expression through video or case examples. Emphasis can also be made on the inter-relatedness of physiology, emotions, cognitions, and behaviors. The utilization of culturally sanctioned coping, such as zhong-yong (in a middle way) may also be useful. The emphasis can be placed more on the behavioral components including

activity scheduling, survey method, and behavioral experiment for enhancement of mood and modification of cognitive distortions. Practical techniques, such as relaxation exercises and sleep hygiene, can cater for their needs of more practical and immediate solution for problems.

Despite the lack of empirical evidence on the effectiveness of CBT for Chinese older adults in treating late-life depression, it seems that some of the CBT components are effective for local adaptation because of the significant results obtained in the preliminary trial. With modification, preliminary results are positive in the effectiveness of CBT for this population. Of course, more empirical evidence is definitely needed for the demonstration of potential utility of CBT for local older adults.

REFERENCE

Laidlaw K, Davidson K, Toner H, Jackson G, Clark S, Law J, Howley M, Bowie G, Connery H, Cross S. (2008) A randomised controlled trial of cognitive behavior therapy vs treatment as usual in the treatment of mild to moderate late life depression. *International Journal of Geriatric Psychiatry*, 23: 843-850.

Yang K. S. (2003). 中國人的心理與行為：本土化研究，中國人民大學出版社：中國

COUNCIL NEWS

The HKPGA 10th Annual General Meeting and Annual Scientific Symposium was successfully held at Centenary Room, G/F, Marco Polo (Hongkong) Hotel, Harbour City, Kowloon on November 8, 2008 (Saturday) from 9:15 am to 1 pm.

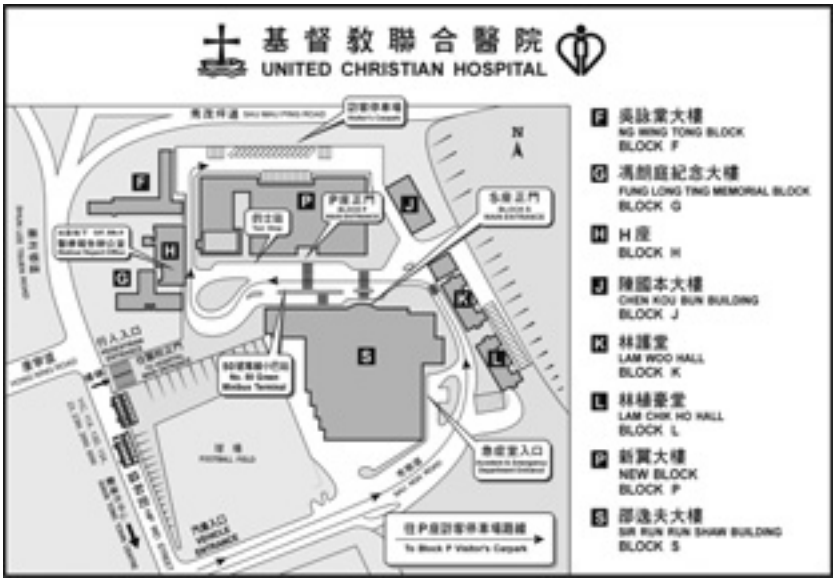


More than 150 participants attended the 10th anniversary ceremony and the meeting chaired by our current and two past Presidents: Dr. S.W. Li, Prof. Helen Chiu and Dr. W.F. Chan . We were honoured to have renowned local and overseas speakers (Dr. C.H. Leong, Dr. Vivian Leung, Prof. Helen Chiu and from the University of Nottingham, Prof. Tom Arie) to share with us their expert views on key issues in mental health for the elderly.

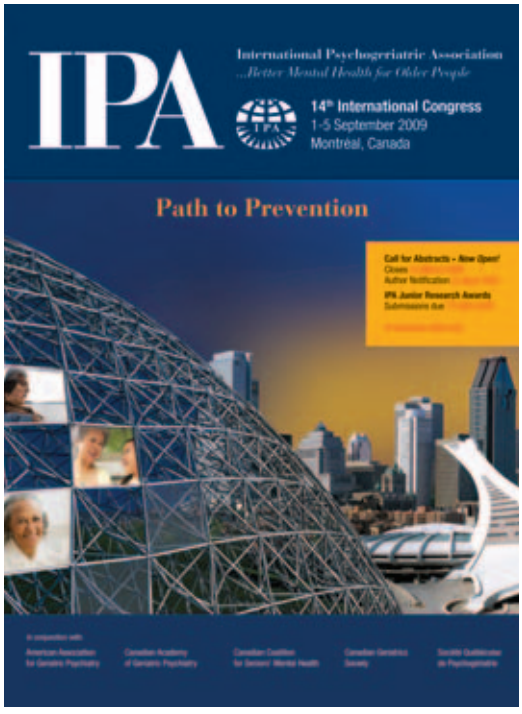


Fifty paid-up members attended the AGM and elected Ms. Violet Ng as the Council representative (social work/service). The anniversary slide show and the opening speech delivered by Dr. CH Leong are available at the HKPGA website *www.hkpga.org*.

HKPGA MID-YEAR SCIENTIFIC MEETING 2009



The HKPGA mid-year scientific meeting will be held at the Main Lecture Theatre, G/F, Block P, United Christian Hospital, 130 Hip Woo Street, Kwun Tong on June 12, 2009 (Friday, 2 pm-6 pm). Dr. Victor W.C. Lui from the Department of Psychiatry of Tai Po Hospital, Dr. T.C. Sim from the Department of Medicine of United Christian Hospital, Ms. Teresa Tsien from the HKADA and Mr. George Cheung of the Hong Kong Polytechnic University will share with the participants their expertise on "Caring for older persons with dementia in the community". Registration on first-come-first-served basis (200 seats); interested members please apply via email by sending their name, profession, organisation to wongmk63@gmail.com.



14th IPA INTERNATIONAL CONGRESS

The HKPGA Council is arranging a study tour to join the 14th IPA International Congress at the Montreal Convention Centre in Canada. The focus of the Congress is "Path to Prevention". The tour will include the residential care forum, ECT workshops and technical visits during the Congress period. There are two types of sponsorships to cover the expenses for registration, travel and accomodation for the tour. Full sponsorship will be provided by drug companies and partial sponsorship will be provided by HKPGA. Applications will be vetted by the Sponsorship Committee.

IPA is calling for submission to the Junior Research Awards in Psychogeriatrics and the award winners will be granted USD 1500 and complimentary Congress registration and an one-year IPA membership. The winners will present their submissions for the Congress. Please check the IPA website *www.ipa-online.org* for updated information.

EVENTS CALENDAR

Date	*Activity*	*Venue and contact*
May 4-7, 2009	IPA International Meeting	Windsor Barra Hotel Rio de Janeiro (Brazil) ipa2009@interevent.com.br
Jun 12, 2009	HKPGA Mid-year Scientific Meeting	Lecture Hall, Block P, UCH wongmk63@gmail.com
Sep 1-5, 2009	IPA 14th International Congress	Montreal Convention Centre (Canada) ipa2009@medplan.ca
Nov 7, 2009	HKPGA Annual General Meeting and Annual Scientific Symposium	pending

HKPGA membership application form is available for download at *www.hkpga.org* under the membership section.

Newsletter Committee :

Dr. CL Lam (North District Hospital)

Dr. Joshua Tsoh (Shatin Hospital)

Ms. Ernie Ma (Haven of Hope Hospital)