# More than memory loss

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Dementia is not a specific disease; it is a condition. There are over a hundred different diseases that can cause dementia. There are no real ante-mortem tests that definitively diagnose dementia. After all, the skull does a great job of protecting the brain from probing researchers. In fact, most tests are ordered to *rule out* other diseases and conditions. For the most part, dementia is a terminal condition. The gradual degeneration and atrophy of the whole of the brain leads to impaired cognitive function and, eventually, impaired physical function. Yet, with our ageing population, the chances of a client having dementia are very real. One in 10 people over 65 and one in three people over 85 have a level of dementia.[1]

Think of the brain like a network of connectors. Messages from the brain run along these connectors to particular parts of the body to promote *function and living*. In their unique destructive way, diseases can compromise those connectors so that the messages cannot get through, which can result in the presentation of any number of symptoms. As there is no real test for diagnosis nor are these symptoms confined to dementia, it is better to think of symptoms as flags for further investigation.

The four most common diseases causing dementia are Alzheimer's disease, vascular dementia, Lewy body dementia and frontotemporal dementia, although a client could have more than one disease. Understanding that these diseases are more than memory loss involves the recognition that each disease may occur with different symptoms, some of those symptoms may be more prevalent at different stages of decline. Equally, those symptoms may affect executive function differently.

Alzheimer's disease generally leads to atrophy of the connectors of the brain. As certain parts of the brain are more susceptible than others, generally in the earlier stages of the disease, the connectors related to forming memories and retaining short term memories are attacked first. Clients may recall long term memories, repeat conversations or be unable to recall recent events.

Vascular dementia is caused by strokes or mini-strokes, which compromise the blood supply to capillaries in the brain. As a stroke can be significant, so too, can the symptoms — impacted speech and mobility are the most obvious. However, mini-strokes can often go undetected but still affect different parts of the brain. Interestingly, a client can sometimes recover from a stroke but there is no guarantee. The brain is also capable of being retrained to find different pathways to communicate messages.

Lewy body dementia is very similar to Parkinson's disease. Abnormal proteins develop in the brain and can exhibit as dramatic changes in mood that range from apathy to hallucinations. Facial expressions can be stolid, despite the client speaking with animation. Movement can also be very palsy-like.

Lastly, frontotemporal dementia is an umbrella term for a number of diseases that affect the frontal and/or temporal lobes of the brain. These parts of the brain generally regulate behaviour, personality and language. A client may show a complete lack of self-control or inhibition, may call things by the wrong name or substitute words with something abstract. Whilst maintaining speech and pronunciation, a client may be unaware that the communication of their thoughts has broken down and resulted in abstract or incoherent speech. This type of dementia tends to affect people in their 40s and 50s more. It is aggressive and for that reason, the changes in behaviour may be more abrupt and more noticeable.

Above all else, it is important to remember that dementia is a condition of *change*. It is marked by changes in character and behaviour. Clients with stage 1 dementia may exhibit changes in their cognitive function around memory and executive function. They may also exhibit changes in their ability to perform instrumental functions like operating the TV remote or getting their driver's licence out of their wallet. Things that were once familiar and easy become exponentially more difficult. In stage 2, the more subtle symptoms that could once have been explained away become more profound. In stage 3, physical decline begins to manifest and clients may lose the ability to do activities related to daily living. This may lead to loss of continence, loss of the ability to swallow, loss of the ability to communicate, increased risk of other medical problems and eventually, to death. All the while, the cognitive function

will also continue to decline. Generally, out-of-character behaviour like wandering, calling out, biting and so forth can drop off as the condition takes a physical toll in this third stage.

Throughout, the condition affects the psychological health of a client. Clients may show out-of-character moodiness, irritability, social withdrawal, anxiety, aggression and symptoms similar to depression. Hallucinations and delusions can be associated with the condition but it is important to remember that these can also be caused by different, *treatable* things, such as delirium and depression, and may not necessarily be subsisting.

The legal industry has a duty to follow legal and competent instructions. Indeed, legal practitioners have a duty to act in the best interests of a client, whilst recognising that their duty to the court and to the administration of justice is paramount and prevails to the extent of any inconsistency with any other duty. Demarcating the line between a competent and incompetent client can be difficult. Perhaps the line of demarcation is complemented by questioning when is a client's particular vulnerability so compromised as to warrant the law's intervention.

In "'He was wearing street clothes, not pyjamas': common mistakes in lawyers assessment of legal capacity for vulnerable older clients",[2] Lise Barry suggests that vulnerability can be inherent, situational and pathogenic. Inherent vulnerability may be the product of a client's nature or lifestyle. For example, a client is more resilient because they have lived on an isolated property or less resilient because their husband of 40 years has always taken care of everything. Situational vulnerability may be the product of a client's "social, political, economic and environment context".[3] An example is a client caught between children feuding over the division of their estate. Lastly, pathogenic vulnerability relates to the actual structures in place around vulnerability and whether they are effective.

Identifying vulnerability and its extent could be crucial in identifying the point in which the law's intervention is justified. Clearly, there cannot be a blanket approach where competency is as much related to pathological impairment as vulnerability. The Law Society has published *When a client's mental capacity is in doubt: A practical guide for solicitors*,[4] which draws upon the test for testamentary capacity in *Banks v Goodfellow*[5] and should be strictly followed.

In part, an assessment of testamentary capacity will assess a client's executive function, and dementia may affect executive function differently. Alzheimer's disease may lead to a client being unable to recall instructions, important people in their life and the nature of their current estate. Lewy body dementia may lead to a client having difficulty with abstract thought; being unable to plan, problem solve or address ideas that are not physically present. Frontotemporal dementia may lead to a discombobulation between thought and communication. A client may instruct you to gift money to their sister when they think they said brother. The lack of inhibition may also lead a client to being incapable of weighing up what is in their best interests.

Whilst *Banks v Goodfellow* famously accounts for the impact of hallucinations and delusions on testamentary capacity, it is worthy to reiterate that the hallucinations and delusions must relate to the limbs of the test set out in this case. It does not matter if the client thinks the sky is red per se.

If an assessment of capacity leads to doubt, then it is prudent, indeed recommended, to seek the assistance of a medical professional. General practitioners, psychiatrists, geriatricians and psychologists are valuable but neuropsychologists are the primary medical professionals who can test capacity.

Broaching the topic of a medical assessment may be difficult with any client, not least because it may also result in them having to pay for such an assessment. Tacts may range from "for your own benefit", "to prove them wrong", "it is an increasingly common angle to contest a Will" or "we cannot act for you where we are not satisfied as to your capacity". There are dementia specialists, such as Tim England (co-author), who can also assist clients who are facing an assessment. It is important to recognise that a client may be genuinely fearful of an assessment, may have brushed off symptoms as "going senile" or may have hidden a prior assessment. Whilst spouses and family members are the most obvious persons to recognise "change", they may be equally fearful of a diagnosis or dismissive of the symptoms.

When asking a medical professional to test capacity, it is important to provide a framework for the report and obtain an understanding of the tests administered and questions that may be asked. The framework may involve setting out the purpose of the assessment and testing whether a client can understand decisions to be made, can recognise the choices that could be made, can weigh up the outcomes of those choices and convey their decision.[6] The framework could also centre on executive function and the ability to think abstractly in relation to choices which could be brought back to the test set out in *Banks v Goodfellow*. Understanding the client's medical history and current social and living circumstances may also be invaluable. It may also be appropriate, depending on the situation, to advise the medical practitioner that their report may be used in evidence in court proceedings.

Whilst the report is no substitution for a legal practitioner's assessment of capacity, it should be a

factor in forming that assessment. In making that assessment, here is some further food for thought. Medically, stage 2 *generally* marks the exponential decrease of a client's autonomy and exponential increase of their dependency. Perhaps this may manifest as using a spouse or family member as a "crutch" in meetings to evade decision-making or communicating instructions. Identifying and removing any "crutch" is important in performing an assessment. It is vital that legal practitioners obtain instructions and make the assessment of capacity without the presence of other family members or friends.

However, if a legal practitioner does see a client with family or friends in the room, then it may be prudent to take additional precautions. File notes are vital and should particularly set out who said what. For example, did the client give the instructions, or was it their adult child doing all the talking? It may also be appropriate to have a colleague sit in as an additional file note taker or to ask the client whether the meeting can be video recorded. This could assist where a practitioner is subject to cross-examination. However, it remains vital that the legal practitioner meets with a client again, without family or friends present.

During meetings, it is important for the legal practitioner to ask the client open-ended questions to assess capacity and the client's understanding. Can the client follow a train of thought, or are they easily distracted, or unable to articulate or understand the components required to meet the *Banks v Goodfellow* test? Open-ended questions may include asking the client for the rationale for their instructions, what they presently have in place (and requesting a copy of), if they have been diagnosed with any medical conditions, or are taking medication.

It may also be necessary to use an independent translator, should language be a barrier.

If a legal practitioner has been forewarned of diagnosis and the client does not convey this, then it is cause for investigation into whether the client has forgotten the diagnosis, is concerned to bring it up, is deliberately not wanting to disclose, or has no awareness of the impact of the diagnosis on their decision-making ability.

Also, it is not uncommon for particularly intelligent clients to attempt to evade detection. The "reservoir" of connectors may be greater in intelligent clients, which means that their brain has more pathways to communicate messages, which can sometimes give the appearance of capacity. It is also not uncommon for intelligent clients to recognise a capacity assessment and respond with somewhat "pre-fabricated" answers, deflections or "fence-sit" to travel the path of least resistance. Clients with a deep reservoir can often give the appearance of a slow and steady decline but something like a procedure can trigger a severe plunge in the condition.

In summary, dementia is more than memory loss and understanding the nuances of the condition can only aid a legal practitioner in making an assessment of capacity and ultimately, assist a potentially vulnerable or soon-to-be vulnerable client. If a client has capacity, that assistance may take the form of the preparation of an Enduring Power of Attorney and Enduring Guardian. If a client does not have capacity, that assistance may take the form of a delegated decision-maker (under an Enduring Power of Attorney, Enduring Guardian or court appointment). It may also assist a vulnerable client against abuse by a family member, carer, friend or other interested person and potentially safeguard their former competent legal decisions.

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## Footnotes

1. Dementia Australia, Dementia Statistics, September 2018, www.dementia.org.au/statistics.
2. L Barry "'He was wearing street clothes, not pyjamas': common mistakes in lawyers' assessment of legal capacity for vulnerable older clients" (2018)21 *Legal Ethics* 3.
3. Above n 2.
4. Law Society of New South Wales *When a client's mental capacity is in doubt: A practical guide for solicitors* (2016) www.lawsociety.com.au/sites/default/files/2018-03/Clients%20mental%20capacity.pdf.
5. *Banks v Goodfellow* (1870) LR 5 QB 549.
6. Above n 2.