

COMPETENCE & MENTAL STATUS

How the two are related...

Competency

- Competency is a **legal concept**; it refers to having the ‘mental capacity to decide in accordance with one’s goals, concerns and values’.
- **Decision-making capacity** is a synonymous term.
- Patients are considered competent *legally* unless a court has found otherwise.
- Competence is absolute but specific: Either a person is or is not competent to make a *particular decision*
- Competency, however, is fluid and can change over time.
- Incompetence may be *isolated* or global (from which follows the idea of ‘limited’ vs. general guardianship)

Decision-making Ability

- Related to the functional elements necessary for competent decision-making
- These elements are **dimensional** – that is, people will have varying degrees of these abilities (and these abilities may vary over time within an individual)
- The four most frequently discussed elements include the ability to:
 - Understand (*what is being discussed*)
 - Appreciate (*the significance of the information*)
 - Reason (*apply it to the current context*)
 - Express a choice (*indicate a preference*)

Informed Consent

(for medical treatment)

- The legal rationale for informed consent is based on a person's right to self-determination
- For informed consent to be achieved:
 - The person must be *clinically* competent to make decisions regarding personal health care (i.e. have decision-making capacity)
 - The person must receive the *appropriate information* (to allow a reasoned and rational choice to be made)
 - The decision must be *voluntary* (i.e. not coerced) and can be withdrawn at any time
- Informed consent applies to both 'yes' and 'no' decisions about care
- Remember that competent individuals are 'allowed' to make foolish choices

What are the elements of competence?

- There are 4 ‘accepted’ standard elements:
 - Communication of choice
 - Understanding of information
 - Appreciation of one’s situation & risks/benefits of choices made
 - Rational decision-making
- Courts prefer the first two, psychiatry the latter

How is competency determined?

- Competence is not a pure, scientifically determinable state because it is colored by personal value judgments and social policy
- Competency is *contextual*. Only a minimal competency is necessary (maximal capacity is irrelevant) for the task at hand; some things require a higher degree of competence than others
- Competency is ‘fluid’ and thus must be assessed ‘at the moment’

What conditions might impair competence?

- Medical/Neurological disorders that impair cognition (i.e. thinking abilities) such as dementia, delirium, and intoxications - usually by impairing memory, concentration and/or judgment.
- Psychiatric disorders that impair thinking and/or judgment. The difference here is the inclusion of mood/emotional disorders and psychosis that may profoundly affect judgment even with clear cognition.

What Is a Mental Status Exam?

- Assessment of cognitive, emotional & perceptual aspects of brain functioning
- It is **current** (i.e. 'Right now')
- It is **objective** (not judgmental)
- It is part of the neurological exam which is part of the physical exam
- It is mostly observational – though history can provide the context.

What Is the Purpose of a Mental Status Exam?

- To describe a person's current mental functioning
- To compare current functioning to past functioning (this is the historical context)
- To help make a diagnosis or suggest avenues for further exploration when changes in function are identified
- To help determine competence

How Is a Mental Status Exam Done?

- Ideally it is melded into a normal patient interview and includes elements of:
 - Observation
 - Listening
 - Active questioning

What Are the Components of a Mental Status Exam?

- **A** - Appearance and behavior
- **S** - Speech (rate, rhythm, etc.)
- **S** - Sensorium
 - Cognitive - memory, orientation, calculating, etc.
 - Perceptual - hallucinations, illusions
 - Intellectual - abstract thinking, judgment, insight, etc.
- **E** - Emotional state (mood, affect)
- **T** - Thought process and content

MSE in regards to competence

- Particular focus on cognitive function
 - Short-term memory, concentration, executive functioning -> a number of screening instruments and assessment tools can be used
- Also focus on insight and judgment
 - For example hallucinations and/or delusional thinking may greatly impair judgment
 - Mood changes can also influence this (grandiosity, hopelessness)

Ways In Which Competency Might Be Impaired

- *Cognitive disorders* (such as dementia, delirium)
- *Emotional disorders* (such as depression)
- *Thought impairment* (from psychotic disorders like schizophrenia)

Cognitive Disorders

- Impairments might be seen in memory (esp. short-term memory), orientation, concentration, abstract reasoning, etc.
- Mini-mental state exam (MMSE) is an easy and useful screening tool (18/30 – 24/30 is a borderline score regarding competence).
- *Complex reasoning may be impaired before significant impairments are seen on MMSE.*

MMSE 'norms' by Age and Educational Level

MMSE SCORES

| AGE | 0-4y | 5-8y | 9-12y | >12y |
|-------|------|------|-------|------|
| 18-24 | 23 | 28 | 29 | 30 |
| 35-39 | 23 | 27 | 29 | 30 |
| 50-54 | 22 | 27 | 29 | 30 |
| 70-74 | 21 | 26 | 28 | 29 |
| 80-84 | 19 | 25 | 26 | 28 |

Types Of Cognitive Disorders

- DEMENTIA

- Primary impairment in is Short-Term Memory- ‘learning’. Can’t remember appointments, medication changes, new people and faces, instructions, etc.
- Social skills (including casual conversation) are often preserved early as is comprehension and long-term memory (i.e. memories of past events).
- Also see problems with apraxia (motor memory), aphasia (speech and language memory), agnosia (recognition) and/or abstract reasoning or executive function impairments
- Usually progressive and irreversible

Epidemiology: Prevalence of dementia increases with age

| Age | Prevalence* | Age | Incidence |
|-----|-------------|--|-----------|
| >65 | 5-10% | 65-74 | 0.5-1% |
| >75 | 10-20% | 75-84 | 2-4% |
| >85 | 25-50% | 85+ | 6-8% |
| >95 | 40-70% | May level off or decline after age 100 | |

*Lower numbers represent moderate to severe dementia

Associated Findings in Dementia

- Personality change with impaired social judgment and insight
- Psychosis (usually related to memory failure)
- Depression and apathy/withdrawal
- Agitation/Aggression
- Delirium (sudden worsening)

Some Causes of Dementia

- **Common causes:** Alzheimer's disease, vascular dementia (usually in people with heart disease, hypertension, and/or diabetes), alcohol-induced, Lewy Body disease
- **Less common causes:** Drugs, AIDS, Parkinson's Disease, other neurological disorders, metabolic, Pick's disease, MAD-COW disease, etc.
- Some causes are reversible – low thyroid, B12 deficiency, normal-pressure hydrocephalus
- Some are relentlessly progressive – Alzheimer's disease, Lewy Body dementia
- Some are less predictable but usually progressive – vascular and alcohol dementias for example.

Types of Cognitive Disorders

- DELIRIUM
 - Global physiological disturbance of brain function
 - *Impaired consciousness*, attention, orientation plus higher cognitive functions
 - Symptoms wax & wane
 - Often life-threatening
 - Very common in dementia and post-surgical patients, ICU patients, etc. DT's is a type of delirium.
 - **Usually reversible if recognized early and aggressively treated**

CASE EXAMPLE

- 84 y/o male with dementia brought by family to have new glasses made. Patient keeps misplacing his old glasses and they have been lost again. Patient is pleasant, but disoriented and can't remember what is said to him for long but is worried about "his money". He says he doesn't have any money and so does not want new glasses.

EMOTIONAL DISORDERS

- **DEPRESSION** - profound mood disturbance leading to dysfunctional behavior. Associated with sleep and appetite changes, suicidal ideation, & loss of pleasure (anhedonia). Cognitive impairment (pseudodementia) and delusions (psychotic depression) are common in severe cases.
- Subtypes: **Dysthymia** (less severe), **Major Depression**, **Bipolar disorder**, **Adjustment disorder**.
- Rule out: normal grief (bereavement), unhappiness.
- Demographics: age 65 and over: 1-2% prevalence of depression, 27% with depressive symptoms. Lifetime prevalence: 10%.
- **Insight is poor** – patient often feels hopeless about treatment and may misjudge circumstances. Judgment may be severely affected if delusional.

EMOTIONAL DISORDERS (cont.)

- MANIA:
 - Usually part of **Bipolar Disorder** (aka manic-depressive illness) but can be caused by other organic factors (steroids, stimulant drug use, hyperthyroidism, etc.).
 - Elevated mood, decreased sleep, rapid pressured speech, flight-of-ideas, and grandiosity are common. Psychotic symptoms (impaired reality testing) are often present.
 - *Judgment and insight are often severely impaired.* Patients engage in regrettable and/or unsafe behaviors (promiscuous sex, spending money, threatening bosses, etc.).
 - Responds nicely to treatment *if patient will comply.*

CASE EXAMPLE

- A *depressed* elderly female has a few badly rotting teeth that are probably abscessed. Her doctors are concerned about systemic infection without treatment. The patient does not appear demented. (MMSE 29/30). She seems to understand her predicament but is convinced she will die soon anyway and welcomes it “because life isn’t worth living anymore”. She sees no point in any dental procedure. The daughter thinks mom should “make her own decisions”.

THOUGHT IMPAIRMENT

- This refers to non-cognitive disturbances in thought.
- **SCHIZOPHRENIA** is the classic thought disorder with impaired thought production, loosening of associations, distorted reasoning (paranoia for example), perceptual disturbances (such as hallucinations), poor motivation, poor social skills, and impaired reality testing (i.e. delusions).
- Related disorders include **DELUSIONAL DISORDER, SCHIZOAFFECTIVE DISORDER & PSYCHOTIC DISORDER NOS**. Organic disorders such as hallucinogen abuse, hyperthyroidism and some medicines can cause similar symptoms.

THOUGHT IMPAIRMENT

- While psychotic symptoms are common in dementia and delirium these are primarily cognitive disorders.
- INSIGHT is often severely lacking in these disorders. Delusions about physical symptoms and command hallucinations are not uncommon.
- People with *delusional disorder* are often quite intact in terms of their thought process and cognitive function but judgment can be very poor.

CASE EXAMPLE

- An attractive 39 year old woman comes to her new dentist's office requesting corrective dental surgery. She says that her last dentist horribly disfigured her mouth and distorted her smile. She is very distressed and frequently tearful and seems desperate to get help. Upon examination her teeth and smile seem well within the normal range of people with her level of attractiveness. What should be done?

HEALTH CARE POWER of ATTORNEY

- Competent adults can assign a HCPOA to act as their agent should they become incapacitated to make health decisions. (This is not quite the same as a POA)
- Patient technically can't do this when already impaired
- If patient 'not competent' then decision falls to the HCPOA
- *Doctor can usually make the determination about competence and thus avoid the guardianship process*

GUARDIANSHIP

- This is always decided by the courts.
- To have a full guardian appointed is to lose all decision-making capacity.
- Selection of appropriate guardian is important.
- Temporary guardianship (guardian ad litem) is used in emergencies to expedite process. This is used particularly to address isolated issues and when patient is expected to regain competence.
- Guardianship should be considered in almost all cases of dementia sooner rather than later.

Involuntary Commitment

- If a person is an ‘imminent’ danger to self or others AND this is due to a mental illness (such as dementia) then commitment is an option.
- Goals are *safety* and *treatment* – this can be used in lieu of guardianship in emergencies
- Guardianship can be considered after safety is assured – but remember: treatment may in fact restore a person to competence.

SUMMARY

- Medical procedures require informed consent.
- Informed consent requires an adequate level of competence.
- Competence is legally assumed until proven otherwise (and people are allowed to be ‘stupid’).
- Many things can impair competence and a basic understanding of mental functioning and the types of disorders that can impair competence are necessary tools for all mental health and geriatric clinicians.
- When competence is impaired guardianship may be needed to protect the individual (either temporary or permanent)
- Pre-existing POA or HCPOA can sometimes prevent the need for guardianship