ASSESSING COMPETENCE

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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 mostly 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

- Depends on 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  - The decision must be voluntary (i.e. not coerced) and can be withdrawn at any time.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.

Ways In Which Competency Might Be Impaired

- **Cognitive impairment** – can’t think straight, understand or remember what is being discussed (causes include dementia, delirium, epilepsy (post-ictal states), brain injury, mental retardation)
- **Emotional disorders** – reasoning is influenced by pathological emotionality (examples: depression, mania, severe anxiety, PTSD)
- **Thought impairment** – idiosyncratic or delusional thinking (e.g. schizophrenia, paranoid disorders)
- **Dissociative disorders** – patient ‘not all there’ to make decisions (e.g. fugue states, MPD)

Assessing Competence

- Information gathering
- Defining past versus current functioning
- Identifying areas of concern (i.e. what level of competence is needed for specific tasks)
- Psychiatric assessment (including mental status examination)
- Consideration of further testing for clarification of deficits (such as neuropsychological testing)
Information Gathering

➢ Obtaining history is the most critical first step
  • Patient-provided history may not be reliable
  • Need info from relatives, friends and health-care providers
  • Most essential determination is ‘what is patient’s baseline and how does he/she differ from it now?’

Assessment Goals

➢ Establish current functioning
➢ Establish baseline functioning
➢ Determine cause of change
  • Especially interested in reversible causes
➢ Determine extent of impairment – is competence affected?
➢ Determine prognosis – will it likely get better, stay the same, or worsen

Establishing Current F’n

➢ History (as noted above)
➢ Functional assessments
  • IADLS (financial competence, keeping appts, following directions, etc.) – what is baseline??
  • ADLs (toileting, grooming, eating, safety) – every competent person, if not physically impaired, should be able to do these things
➢ Physical assessment – can person hear and see? Do they have an expressive aphasia?
➢ Cognitive, emotional and thinking assessment -> mental status exam
What Is a Mental Status Exam?

- Assessment of cognitive, emotional, thinking & 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
  - Specific instruments of assessment (esp. cognitive tools)
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)

Cognitive Assessment Tools

- Screening Tools (quick and easy to use, need to be sensitive enough)
  - MMSE (Folstein mini-mental status exam)
    - Easy to administer, takes about 10-15 minutes
    - Little formal training needed
    - Applicable to all but those with very limited education (see graph)
      - Sensitivity: 87%  Specificity: 82%
  - Clock-drawing test (very simple to do but interpretation of impairment difficult) – tests visuospatial and planning skills
Other Assessment Tools

- **List Generation** – number of category items in one minute – normative data available, tests parietal lobe f’n. Very impaired in Alzheimer’s.
- **Trails B** – most useful for determining frontal lobe (i.e. executive f’n) deficits
- Many other scales are available

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Neuropsychological Testing

*(When is it necessary?)*

- Cognitive testing and functional testing are at odds or there is suspicion of early dementia in a high IQ individual with normal MMSE
- Mild impairment in a person with: low IQ or limited education, trouble with English, impairments less than 6 months
- *Determining capacity for legal purposes when deficits are mild*

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Diagnostic Work-Up

- Physical and mental status exams may provide clues
- Laboratory work-up (chemistries, CBC, drug screens, etoh screen, urinalysis, thyroid, B12, RPR, etc)
- Other tests: CXR, EKG, Head imaging
- Specialized testing (when indicated): LP, genetic testing, functional imaging, neuropsych testing
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.

Executive Function

- This is the ‘highest’ level of cognitive function (and likely separates humans from other primates)
- Represents the ability to plan ahead, anticipate consequences, abstract meanings, and arrive at appropriate judgments about things
- Requires ‘intact’ memory systems
- Last to develop; first to go (frontal lobe systems)
- Not everyone develops the same level of competence in these areas

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 (the illness): 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.
  - Rule out normal grief (bereavement), unhappiness.

- MANIA: 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.).

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.

Thought Disorders

- Treatment can restore patients to competence but treatments are not as predictably effective as they are for mood disorders.
- Also the concept of ‘delusional thinking’ is a tough one and can overlap with the concept of ‘free will’ (at what point do people’s thoughts no longer represent free will??)

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 court system.
- To have a full guardian appointed is to lose all legal 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

- Competence (or decision-making capacity) is legally assumed until proven otherwise (people are allowed to be ‘stupid’). Only minimal level of competence to do task is necessary
- Incompetence can be global or isolated, permanent or temporary.
- Medical procedures require informed consent.
- Informed consent requires an adequate level of competence to understand procedure, risks and benefits.

Summary (cont)

- 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
- Involuntary commitment can sometimes prevent the need for guardianship (at least in the short run)