Assessing Capacity in the Medical Setting

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THANKS TO
LESLIE LOPATO AND EVELYN MICCIO

- Robert Olsen is 89 years old and lives alone. One day he calls 911 because he feels ill and has fallen on the floor. The emergency medical personnel transport him to the hospital, noting that he is confused, unbathed, and his home is dirty, with spoiled food, urine, and feces in the house. They also found medications in disarray and empty beer bottles. Mr. Olsen is hospitalized for treatment for acute renal failure with malnutrition and dehydration. With medical intervention, his cognition clears considerably. However, there are residual problems with memory and reasoning. A brain scan shows no acute problems but a mild degree of cerebrovascular disease. Mr. Olsen reports anxiety in the hospital. He asks to be discharged and assures the team he can manage his medications, personal care, and meals. He expresses discomfort with home care services. Mr. Olsen values his independence and wants to return to his home of 63 years. The medical team asks the psychologist "is he competent?"

What would you do?

- Patient shows up in the emergency room with crushing chest pain.
- After basic assessment and EKG, patient is informed that he needs a cardiac catheterization.
- Patient refuses – says he is leaving.

- **Does the Psych On Call staff let him leave?**

Definition of Terms

- Capacity is a non-legal, clinical determination assessed by a health care professional.
- It is a clinical term concerned with the integrity of functional abilities.
- Tangible evidence is key-this can be clinical observations, a mental status exam, and/or formal test results.
- Documentation of the reasoning behind the compromised capacity is critical.

Definition of Terms 2

- **Competency is determined by a judge, with capacity being only part of consideration.**
- **It is** a legal term.
- It is the ability to make decisions by yourself.
- The revocation of this ability can deprive an individual of rights and autonomy (self determination).
- Distinction no longer works, as most states have moved away from the terminology of "competency" in favor of function-specific "capacity" and "incapacity."
- Use "Capacity "as preferred term

Capacity ≠ Competency

- Clinical judgment
- Can be assessed by physician or psychologist
- Usually question-specific, time-specific, short-term
- Surrogate decision-makers, if necessary

- Legal concept
- Can only be adjudicated by a court
- Usually more global, long-term
- Designated decision-maker by judge

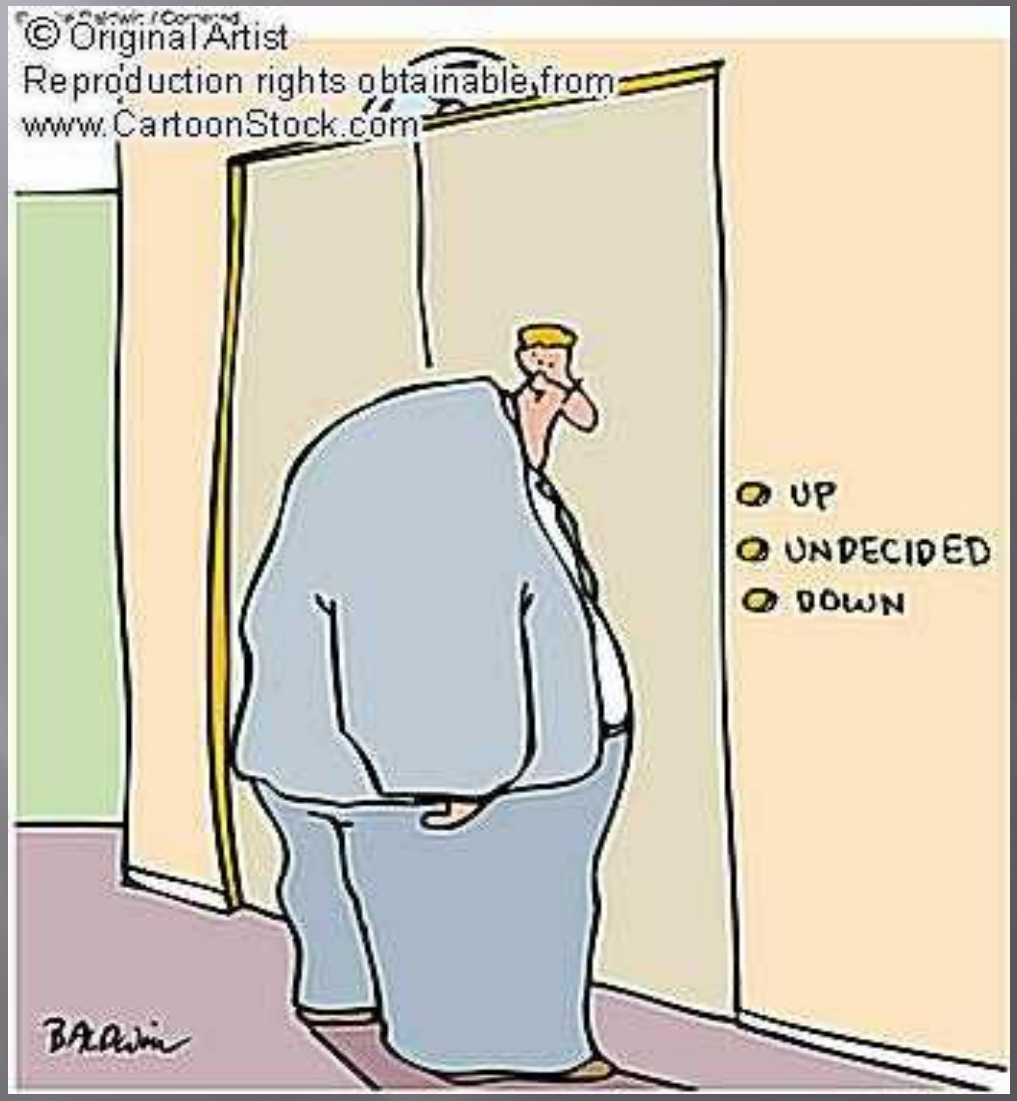
Patient Self-Determination Act of 1990

- The PSDA requires many Medicare and Medicaid providers--including hospitals, nursing homes, hospices, and HMOs--to give patients information about their rights, including their right to accept or refuse medical or surgical treatment.
- Informed consent in a medical context consists of 3 elements: disclosure of information, voluntary acceptance of treatment, and mental capacity.
- Patient's consent be given voluntarily. This implies that the patient's decision is free from coercion.

Informed Consent

- The third essential element in the informed consent process--the capacity to consent to treatment--is the most crucial aspect for the clinician to consider.
- To be considered capable of consenting or refusing treatment, the patient must be able to:
  - Communicate a clear choice without vacillating significantly.
  - Demonstrate a factual understanding of the medical issues at hand, including the risks and benefits of the treatment and any reasonable alternatives.
  - Show comprehension of the situation as it applies to him and the consequences of his decisions. This implies that the patient has psychological insight into his illness and need for treatment.
  - Display a rational manipulation of the information presented with a coherent and logical thought process in analyzing the various courses of action. This element examines the process and not the content of the person's thoughts.
  - People are allowed to make decisions that are contrary to their physician's best advice, as long as all 4 of these criteria are met.

Decision Making



Capacity

- Uniform Health Care Decisions Act:

"Capacity" means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.

Decisional capacity in health care is rooted in the concept of *informed consent.*

- It is up to clinicians to evaluate a patient's capacity for medical treatment

Required for Incapacity

- For incapacity finding, there must be evidence of a clinical condition that is causative (i.e. dementia, delirium, depression, psychosis, and drug intoxication, along with other psychiatric syndromes, schizophrenia, mania, TBI, etc.)

- Mere presence of a condition is insufficient.

- Question for clinician is whether patient is sufficiently impaired as result of condition to be considered to be lacking in capacity.

Capacity evaluations

- Capacity evaluations are legal evidence.
- In guardianship, judges use our capacity evaluations as one form of evidence in arriving at their determination of the need for guardianship or conservatorship.
- **The judge makes the final determination of legal capacity.**

Capacity is the Presumption

- A person is assumed competent unless proven otherwise. In all states, the law starts with the presumption of capacity.
- Generally, a **competent adult patient has** the right to **refuse treatment.**
- Even if it means that he/she may die.
- The burden of proof is on the party bringing the petition to establish sufficient diminished capacity to justify the appointment of a guardian or conservator.

Who makes decisions for incompetent patients?

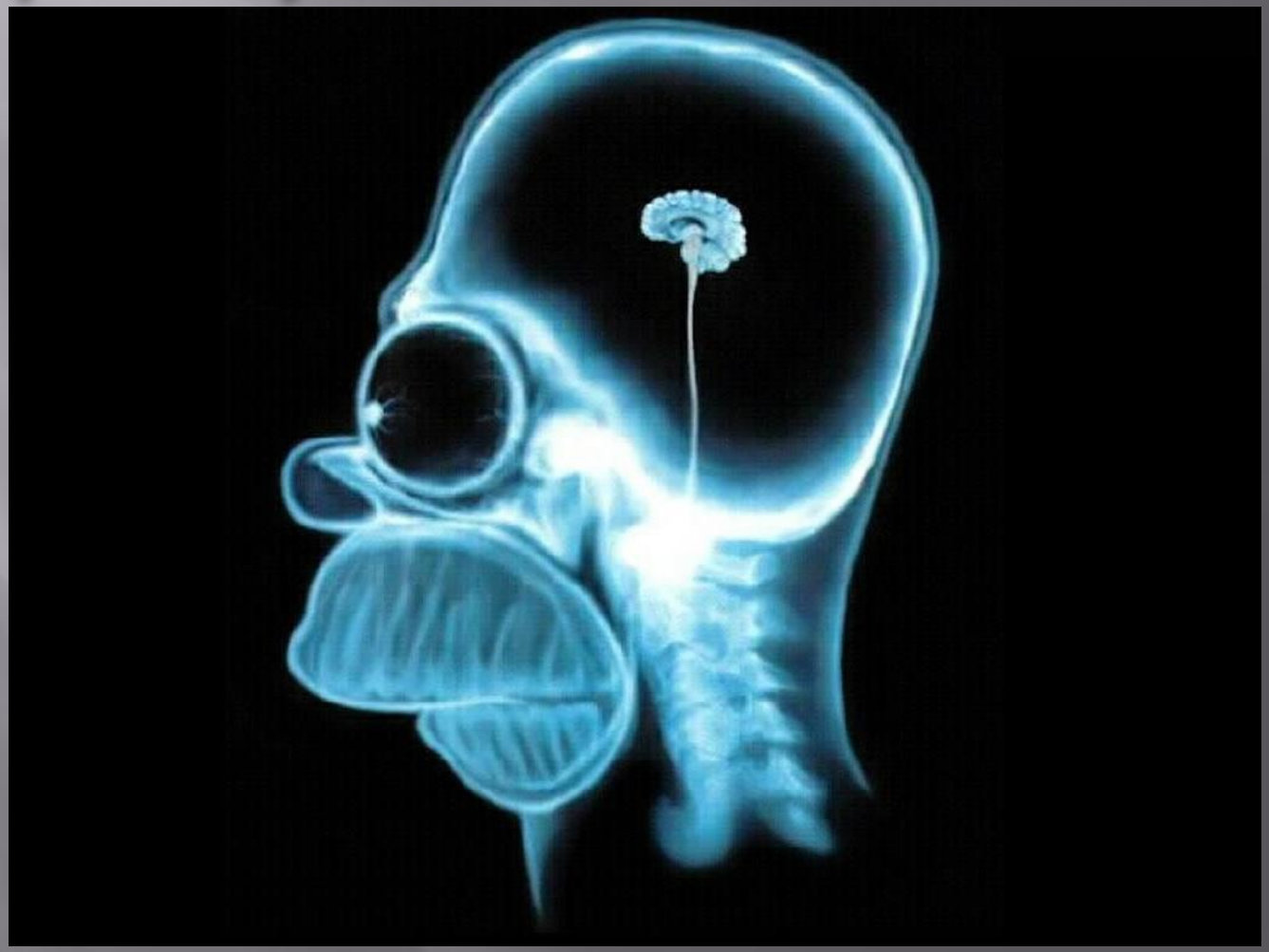
- Guardian (if one exists).
- Direction in an Advance Health Directive.
- Health care agent (an individual identified in a Health Care Power of Attorney).
- Health care representative (such as a close family member, as determined by the statute).
- Provider, if evidence of incapacity

Not all or nothing

- A patient may be legally "competent", i.e. not determined to be incompetent, but still have impaired decision making capacity due to illness or other acute event, i.e. being drunk

- Patients may be legally incompetent in some areas, e.g. finances, but still retain medical decision making capacity

Does the individual have the capacity to make decisions?



Got Capacity? Capacity for what?

Not a Yes or No Question!

Decision making capacity is specific to a specific task

- a patient may be able to make some decisions but not others (buy groceries, but not buy a house)

Diagnosis does not equal incapacity

- a patient may be demented or mentally ill, and retain some capacity

Capacity is not necessarily a stable, permanent state

- a patient's ability to make decisions may vary with acuity, and may be regained even when previously inadequate

When should you assess DMC?

- A) Always
- B) Never
- C) Whenever the patient disagrees with you

It's really "A"

We usually assess DMC spontaneously and automatically on every encounter; in most cases the result is clear

Certain circumstances should trigger a more deliberate and formal evaluation:

1) An abrupt change in mental status, which may be caused by an acute medical or psychiatric process.

When to assess DMC formally…

2) When patients refuse recommended treatment, especially if they are unable or unwilling to explain why, or if the reason seems irrational or due to misinformation or misunderstanding

3) When a patient gives overly hasty consent, and it seems apparent that he has not given thoughtful consideration to the risks and benefits

4) When his physician asks for a consult

Groups at high risk for decisional incapacity

- Patients with diagnoses or treatment that compromises cognition (delirium, sedation, etc.)
- High rate associated with mild-moderate Alzheimer's; universal with severe dementia.
- Schizophrenia > depression.
- Symptomatic bipolar disorder.
- Patients in ICU and Extended Care Facilities.
- Incapacity correlates with measures of neuropsychological impairment.
- Decision making impairment correlates with increasing age and fewer years of education
- Low IQ
- Hospice patients

(Walaszek, 2009).

Prevalence

- As many as 25% of psychiatric consultations in hospitals involve patients' capacity to make treatment-related decisions.

- 48% of patients in one study lacked capacity to consent to medical treatment although only 25% were identified as such.

Appelbaum, PS. Assessment of patients' competence to consent to treatment. N Engl J Med 2007,357:1834-40

Risk Assessment

- Capacity evaluations in the hospital are at heart a risk assessment.

- Similar to 5150 decision regarding grave disability.

How dangerous is the decisional consequence

- The most stringent standard of capacity is reserved for those decisions that are very dangerous and fly in the face of both professional and public rationality.
- When diagnostic uncertainty is minimal, the available treatment is effective and death is likely to result from treatment refusal (and treatment is refused) then competency in this context requires a capacity to *appreciate the nature and the consequences* of the decision being made.

Who can evaluate for capacity

What California law says:

…explicitly designates the physician with "primary responsibility for the patient's health care" as the person to determine capacity

What the research says:

Comparing the judgments of psychiatrists to other physicians shows "they are no better at assessing capacity in practice."

- Lack of interrater reliability

Types of Capacities

- **Ability to leave hospital AMA
- **Medical decision making/consent capacity
- **Capacity to live independently
- Consent to treatment (informed consent)
- Refusal of Medications
- Financial capacity
- Testamentary capacity (to make a will)
- Contractual Capacity: durable power of attorney or a health care directive
- Sexual consent capacity (MR; dementia)
- Capacity to drive

** = common referral ? at Kaiser

Capacity is not static

- Decision-making capacity must be evaluated for each medical decision, because it is neither static nor broad-based.
- A patient may lack the capacity at one time and later have that capacity restored.
- Some common factors that can temporarily and reversibly cause a person to lack medical decision-making capacity include delirium, depression, polypharmacy, nonadherence to medication, or an acute medical illness or infection.
- Many patients with mild to moderate dementia have fluctuations in their levels of capacity, depending on the familiarity of the setting, time of day, and medications taken."

Specific Decisions

- Each person must be evaluated to determine whether he has the capacity to consent to the specific treatment at a particular time in the course of his illness.
- Patients with severe and chronic dementia, those who have a Mini-Mental State Examination (MMSE)[9] score of less than 16, have a high likelihood of being unable to consent to treatment. One study of 98 patients with Alzheimer-type dementia found that only 11% of the patients with MMSE scores of less than 16 retained decision-making capacity.[10]
- Other studies have found that patients who have mild cognitive impairment (i.e., those with episodic memory impairment who do not meet criteria for dementia) are more likely than those without cognitive impairment to have impaired decision-making capacity. Mild cognitive impairment can erode the ability to remember, understand, and apply medical information that has been presented, thereby impairing decision-making capacity while leaving the person relatively intact during activities of daily living.[11]
- Other investigators have noted that patients with mild cognitive impairment frequently display deficits in executive functioning, specifically in areas of abstract thinking and cognitive flexibility. These deficits also degrade decision-making capacity, especially understanding the consequences of a treatment choice.[12,13]

Incapacity may not be permanent

- Capacity is task specific, not global.
- Capacity can fluctuate.
- Capacity is situational. (Is there support?)
- Capacity is contextual. (Undue influence?)

- Capacity status can fluctuate over time and in some instances a capacity that was initially lost (e.g., as a result of a head injury, transient acute psychosis, delirium, severe depression that later remits with treatment) will be recovered.
- If not permanent, need to reassess later.

- Many medical practitioners rely on a sliding scale approach to setting thresholds for accepting a patient's treatment decisions. In the case of a patient who wishes to consent to a low-risk, high-benefit intervention, a relatively lower standard of capacity is used. Requiring only minimal capacity protects the patient's autonomy as well as his physical well-being. Patients are generally allowed to consent to low-risk, high-benefit treatment, such as an antidepressant, as long they can communicate a choice

When patient refuses

- Feinberg and Whitlatch[15] found that patients with mild to moderate cognitive impairment were able to state consistent choices regarding decisions that affected everyday life. They also found that patients with dementia and their caregivers appreciated that the patient's choices and preferences were elicited and attended to.
- Capacity is typically only called into question when a patient refuses the proposed treatment. Patients who oppose treatment are routinely held to higher standards of capacity because they run the risk of physical harm, which goes against the right to treatment and the ethical principle of beneficence.[16]

Undue Influence

- Definition: the intentional abuse of social influence, deception, and manipulation to gain control of the decision making of another.
- In cases of undue influence, a person may have full capacity. Alternatively, there may be cognitive impairment that increases susceptibility and dependence.
- Most typically, financial exploitation is the driving force.
- While diminished capacity may make one more vulnerable to undue influence, it is not a necessary component of the dynamic. Therefore, undue influence can be present even when the victim clearly possesses mental capacity.

A medical treatment refusal is incompetent if patient is:

- Unable to understand information about the recommended treatment
- Unable to respond knowingly and intelligently to questions about treatment
- Unable to participate in treatment decisions using rational process

Decision Making Capacity: 4 criteria

- 1 Ability to understand information relevant to decision: nature of condition, treatment, risks, benefits

- 2 Ability to reason, to weigh information in a rationally defensible way.

Applebaum & Grosso, 1998

Decision Making Capacity 2

- 3 Appreciation: Ability to understand how information applies to their situation

- 4 Ability to communicate decision:

  expression of choice

Applebaum & Grosso, 1998

1. Understanding Relevant Information

"Understanding Life" by Javier Lopez Barbosa

- Patients must be fully informed of options before capacity can be determined
- The doctor should provide information that a "reasonable person" would want to know in order to decide whether to accept or refuse the proposed treatment.
- Pts must understand what they are being asked and that they are being asked

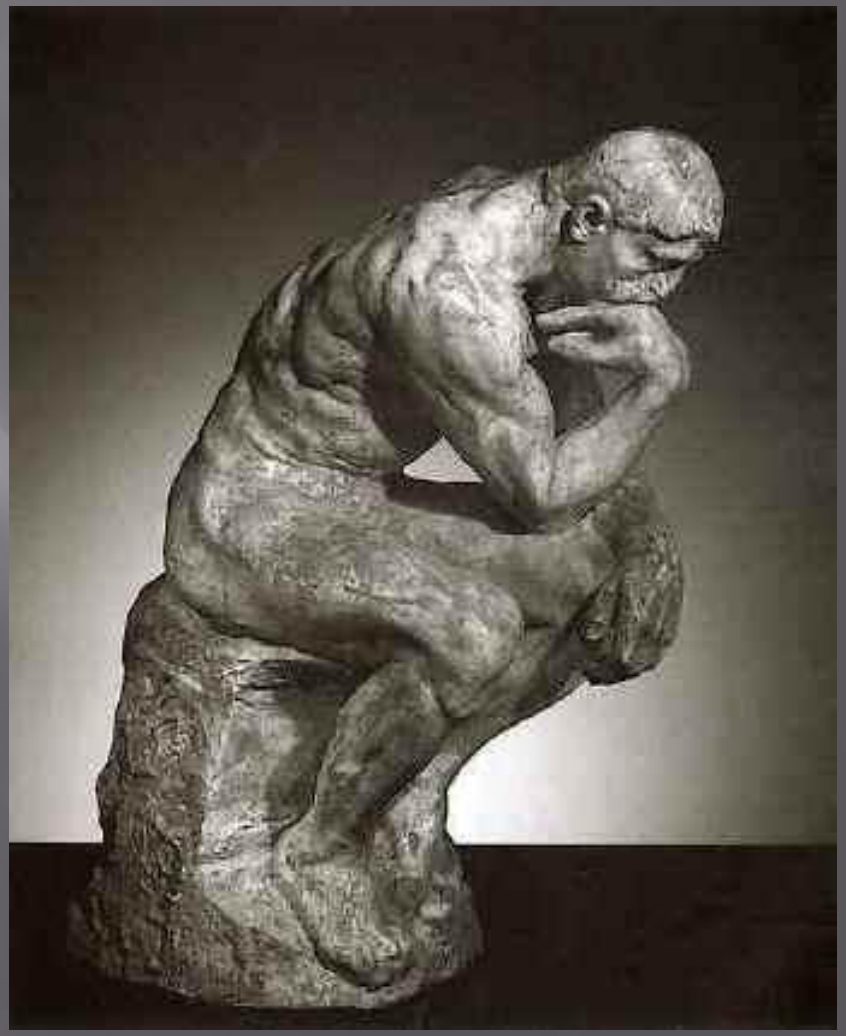
Understanding the relevant information

- Demonstrate a factual understanding of the medical issues at hand, including the risks and benefits of the treatment and any reasonable alternatives.
- "Tell me in your own words what your understanding is of
  - the nature of your condition,
  - the recommended treatments,
  - the benefits and risk of those treatments?
  - How likely are the benefits and risks to occur?"

- Limits: memory impairment, as well as impaired conceptualization, and comprehension, low intelligence, attentional problems
- It is acceptable for physicians to exercise therapeutic privilege and withhold certain information at their discretion if they deem that the information would pose a serious psychological threat by cognitively overwhelming the patient or causing panic.

2. Manipulating Information Rationally

- Display a rational manipulation of the information presented with a coherent and logical thought process in analyzing the various courses of action
- Their process of thinking (process by which the decision is reached), not decision itself, is important
- Decision based on "recognizable reasons"



Can the patient engage in a rational discussion about treatment options

- What makes one option better than another?
- How did you come to decide to accept/reject this treatment?
- How will this treatment affect the things or people who are important to you?

- Requires executive abilities, such as attention, mental flexibility, and the ability to recall information after a delay.

- Limits: psychotic thought disorder, dementia, delirium

3. Appreciating Situation & Consequences

- Show comprehension of the situation as it applies to them and the consequences of their decisions. This implies that the patient has psychological insight into his illness and need for treatment.
- Does patient understand what the information means for them?
- Limits:
  - Denial or lack of understanding on basis of cognitive/affective impairment
  - Delusion

Does the patient appreciate the situation and its consequences

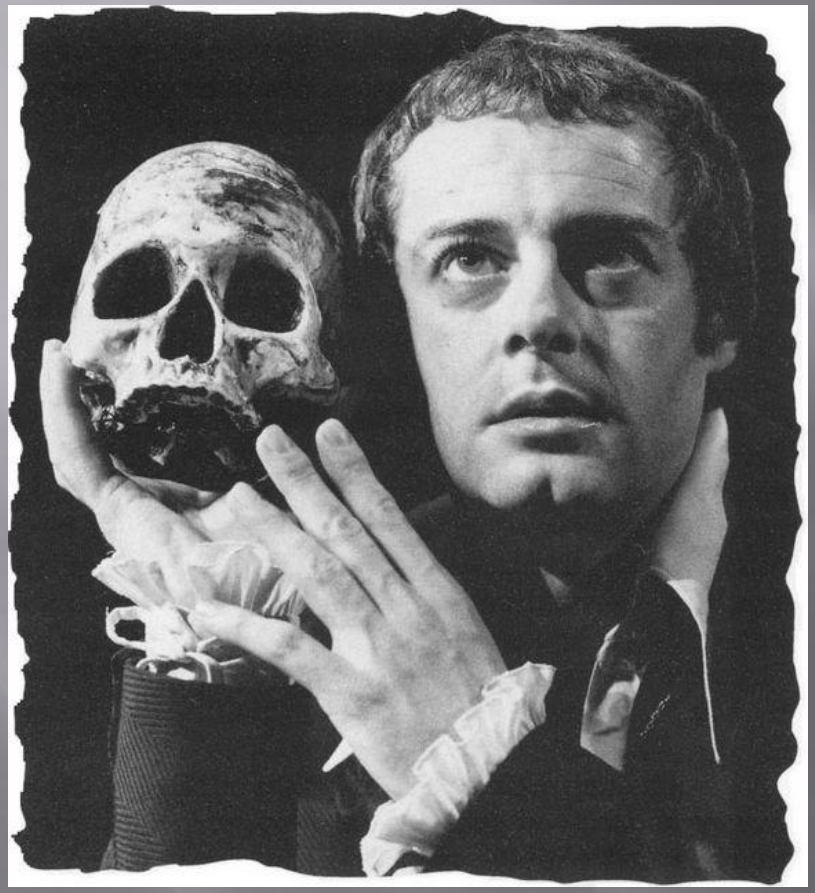
- What do you really believe is wrong with your health?
- Do you believe that you need some kind of treatment?
- What is the treatment likely to do for you?
- What do you believe will happen if you are not treated?
- Why do you think your doctor recommended this treatment?
- Do you believe the doctor is trying to harm you?

- Test: "Do the risks your doctor told you apply to you?"

- Note: If a patient fails to acknowledge his illness he cannot make a valid decision about treatment.

- i.e. Dr. Weber gets a free house; Depressive Psychosis patient

4. Communicating Choices



- Communicate a clear choice without vacillating significantly.
- Can they tell you their decision
- Maintain and communicate the choice long enough to be implemented

Can the patient communicate a choice

- “Have you decided whether to go along with your doctor’s suggestions for treatment?
- Can you tell me what you decided?

- Test: repeat question after several minutes
- Requires auditory comprehension and confrontation naming

- Potential limiting factors:
  - Language impairment (aphasia, monolingual)
  - Impaired consciousness
  - Thought disorder
  - Memory impairment
  - Severe ambivalence
- Stability of choice: Frequent flip-flopping may indicate lack of capacity due to memory deficit

Factors to remember

- Focus on decisional abilities, not cooperativeness or affability.
- Pay attention to changes over time; history is important.
- Beware of ageist stereotypes.
- Consider whether mitigating factors could explain the behavior (delirium, medications, etc.)

Factors to Remember 2

- Remember eccentric or risky choices in and of themselves are not grounds for incapacity.
- Sickness, eccentricity, and old age do not, of themselves, amount to incapacity.
- People have the right to make foolish or eccentric decisions and to govern their own affairs, unless they lack decision-making capacity and cannot understand the consequences of their decisions.

The Reality: Don't be afraid to decide capacity

- Capacity evaluations help physicians, nursing treatment, and placement decisions
- Except for dementia placements, most capacity cases never reach the courts
- If they do, the court's legal "determination of competency" usually agrees with the provider's overall "assessment of capacity."

How Do You Assess DMC?

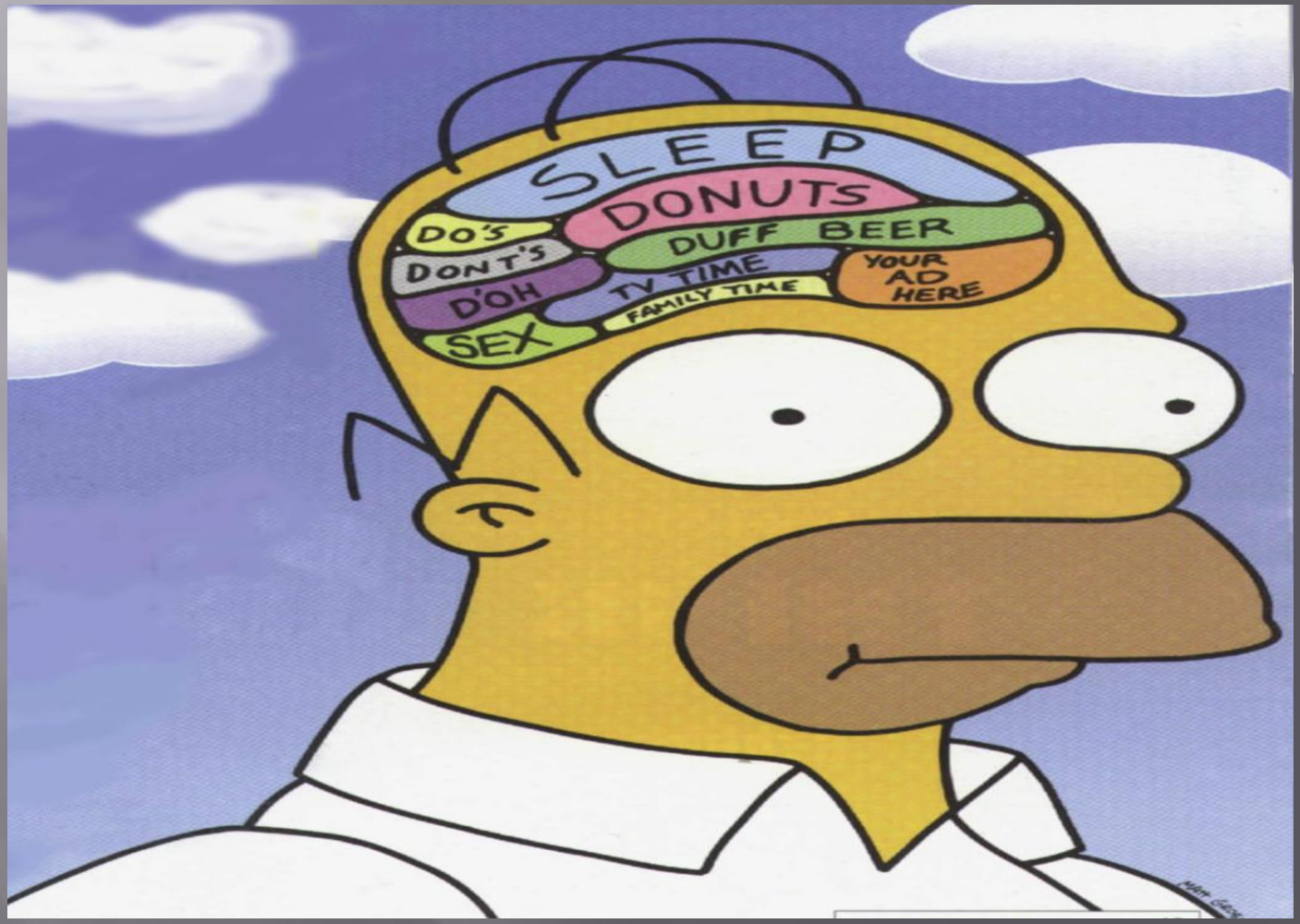
Several different approaches:

- Directed Clinical Interview
- Use of a formal assessment tool
- A combination of interview and formal assessment
- Use of legal or ethics consultation when necessary and appropriate

Before you start….

- Make sure someone else hasn't already made the decision for you (i.e. the courts)
- Make sure you have carefully given the patient all reasonable information needed to make a decision (remember pt. literacy studies)
- Make sure you address obstacles:
  - Language (use live, in-person translator if possible)
  - Hearing or visual impairment
  - Avoid technical jargon; use language appropriate to the patient's educational and intellectual level.
  - Limit sedative medication unless absolutely needed

The capacity evaluation is based upon history, presentation and formal test performance.



Consider the patient's abilities in the following areas:

- Self care
- Cognitive Abilities
- Treatment decisions
- Engagement in contracts/wills
- Management of financial affairs
- Live independently

Elements of a Capacity Assessment

- Who requested the evaluation?
- Why was the evaluation requested?
- What specific capacity has been called into question?
- What condition is the lack of capacity related to? (e.g.: delirious state, mental illness, cognitive decline).

Influencing factors to consider

- Medical conditions/history:
  * Clinical examples:
  Stroke victims-L CVA affects ability to communicate, while R CVA affects insight.

- Current Medications

- What is the prognosis of the medical condition?
  * Clinical example: TBI, stroke, dementia

Influencing factors to consider

- History of cooperation with treatment-if not cooperative, why not? (e.g.: inability, resistance, defiance?)
- Support network?
- Home evaluation? (e.g.: stairs, hand rails, trip hazards, cleanliness).

Causes of Delirium/Confusion

- **Drugs**
- **Electrolytes**
- **Lack of Drugs, Water, Food**
- **Infection or Intoxification**
- **Reduced Sensory Input**
- **Intracranial Causes**
- **Urinary Retention//Fecal Impaction**
- **Myocardial**
- Liver or kidney disease
- Vitamin deficiency
- Post surgical state

Qualitative Data

Mental Status : "JOIMMATT" effort/cooperation/task persistence/reliability of data

- **J**udgment
- **O**rientation
- **I**nsight
- **M**ood
- **M**ovement (gait, overall sensory functioning)
- **A**ttention/Affect/Appearance
- **T**hought Process
- Thought Content-idiosyncratic use of language is important, concrete thinking, comprehension, ESL, Non English Speaking

Global terms such as "wnl", are not as helpful as specific details and quotes

Neuropsych Issues in Assessing DMC

Use Mental Status Testing:

- Attention
  - Drifting (can't stay awake) vs Wandering (distractible)
- Language
  - Auditory and/or written comprehension
  - Spoken and/or written expression
- Memory
  - Immediate and recent memory
  - Recent past and remote memory (verifiable!)
- Frontal lobe (executive) function
  - Awareness
  - Judgment

Frontal Lobe Functions

- Awareness and insight
  - Has awareness of her own condition, e.g. grooming
  - Knows she has medical condition, seeks information and produces appropriate information about it
  - Knows the existence of treatments, the general value of treatment and the lower likelihood of getting better without treatment
  - Knows the specific treatments proposed, and the goal of each, e.g. diagnosis, decreased symptoms, cure

Executive Functioning

- Executive functioning examples:
  - Self monitoring behavior
  - Anticipate consequence of action
  - Ability to give reason for an action
  - Disregard erroneous strategies
  - Inhibit automatic but inappropriate response
  - Modify behavior in response to contextual changes
  - Finish what is started
  - Comply with treatment
  - Do something when needed (not just know how to do it)

Executive Dysfunction in Dementia

- Associated with impairment of prefrontal and frontal-subcortical circuits
- Most dementing disorders involve some degree of executive dysfunction
- Executive ↓ can be independent of Memory ↓
- New changes in behavior:

  dysinhibition, hypomania, apathy

Executive Dysfunction in Dementia 2

- Neurogenic denial of deficit, lack of appreciation
- Executive dysfunction associated with:
  - Functional decline
  - Need for care
  - Development of neuropsychiatric sxs
- Executive ↓ correlates with IADLS↓ (phone, letter, finances, meal prep)

- Most MS tests do not measure ECF, i.e. MMSE

Executive Deficits Predict:

- Functional autonomy ↓
- Impulsivity & apathy ↑
- ADLs and IADLs ↓
- Money management ↓
- Medication management ↓
- Poor geriatric orthopedic & stroke rehabilitation outcome

Qualitative Data

- **Cognitive and functional abilities**
- **Social Skills**
- **Developmental, educational, professional assessment-**this helps with determining a baseline.
- **Substance Use History**
- **Psychiatric History**

Sources of Incapacity

- Comatose
- Intoxication
- Agitation
- Delirium
- Dementia
- Medications
- Hallucinations, Delusions
- Absence of Hearing aides, Glasses
- **Stress, grief, severe depression, recent events**
- **Reversible medical factors**
- **Normal fluctuations in mental ability and fatigue**
- **Education**
- **Socio-economic background**
- **Cultural and ethnic traditions**

Consent & HIPAA

- An effort should be made to obtain informed consent or assent to the evaluation.
- A warning **of** the potential risks of participating in the evaluation should be provided, namely, that information will not remain confidential.
- But if evaluation is for crucial medical decision, do not need consent to evaluate if you believe they lack capacity.

What can they do at home: ADLS & IADLS

ADLS	IADLS
Dressing	Grocery shopping & meal preparation
Bathing	Driving
Toileting	Housework
Eating	Managing money
Walking	Managing medication
Transferring between bed/chair	Using telephone & mail

Do to command vs. do by themselves when needed

Hospital Consult Clues with Elderly

- APS involved
- Failure to thrive
- Inability to name medical conditions & Meds
- Medication non-compliant; what's their medication reminder method
- House: smell, garbage, feces
- Denial of deficit
- Impaired MS Testing

Don't get rejected by the Court

- The more serious the consequences of clinically deciding someone has lack of capacity, the more you need to use quantitative measures to backup your clinical decision.

Clinical Judgment

- A clinical judgment about capacity of an older adult is exactly that—a professional clinical decision.
- There is no equation, cookbook, or test battery for the assessment of capacity.

Quantitative Data

- Assessment Tools are used as **adjuncts** to clinical assessment.

  A few are the MOCA, MMSE, the MacCAT (specifically designed to assess capacity) and they offer some objective data to support your clinical findings. But important to remember- is this test designed to address what I am being asked to assess?

Am I administering it correctly, so that the data I collect is valid?

- The neuropsychological correlates with impaired capacity include:
  - Reasoning
  - Short term verbal memory
  - Executive Dysfunction
  - Slowed processing speed
  - *Insight is positively correlated with capacity

Directed Clinical Interview

TABLE 1

Patient Abilities to be Assessed in the Evaluation of Medical Decision-Making Capacity

1. Questions to determine the ability of the patient to understand about treatment and the proposed options for care:
   - What is your understanding of your condition?
   - What are the options for your situation?
   - What is your understanding of the benefits of treatment and what are the odds that the treatment will work for you?
   - What are the risks of treatment and what are the odds that you may have a side effect or bad outcome?
   - What is your understanding of what will happen if nothing is done?
2. Questions to determine the ability of the patient to appreciate how that information applies to their own situation:
   - Tell me what you really believe about your medical condition.
   - Why do you think your doctor has recommended (name of specific treatment or test) for you?
   - Do you think it (specific treatment/test) is the best treatment/test for you? Why or why not?
   - What do you think will actually happen to you if you accept this treatment? If you don't accept it?
3. Questions to determine the ability of the patient to reason with that information in a manner that is supported by the facts and the patient's own values:
   - What factors/issues are most important to you in deciding about your treatment? What are you thinking about as you consider your decision?
   - How are you balancing the pluses and minuses of the treatments?
   - Do you trust your doctor? Why or why not?
   - What do you think will happen to you now?
4. Questions to determine the ability of the patient to communicate and express a choice clearly:
   - You have been given a lot of information about your condition. Have you decided what medical option is best for you right now?
   - We have discussed several choices; what do you want to do?

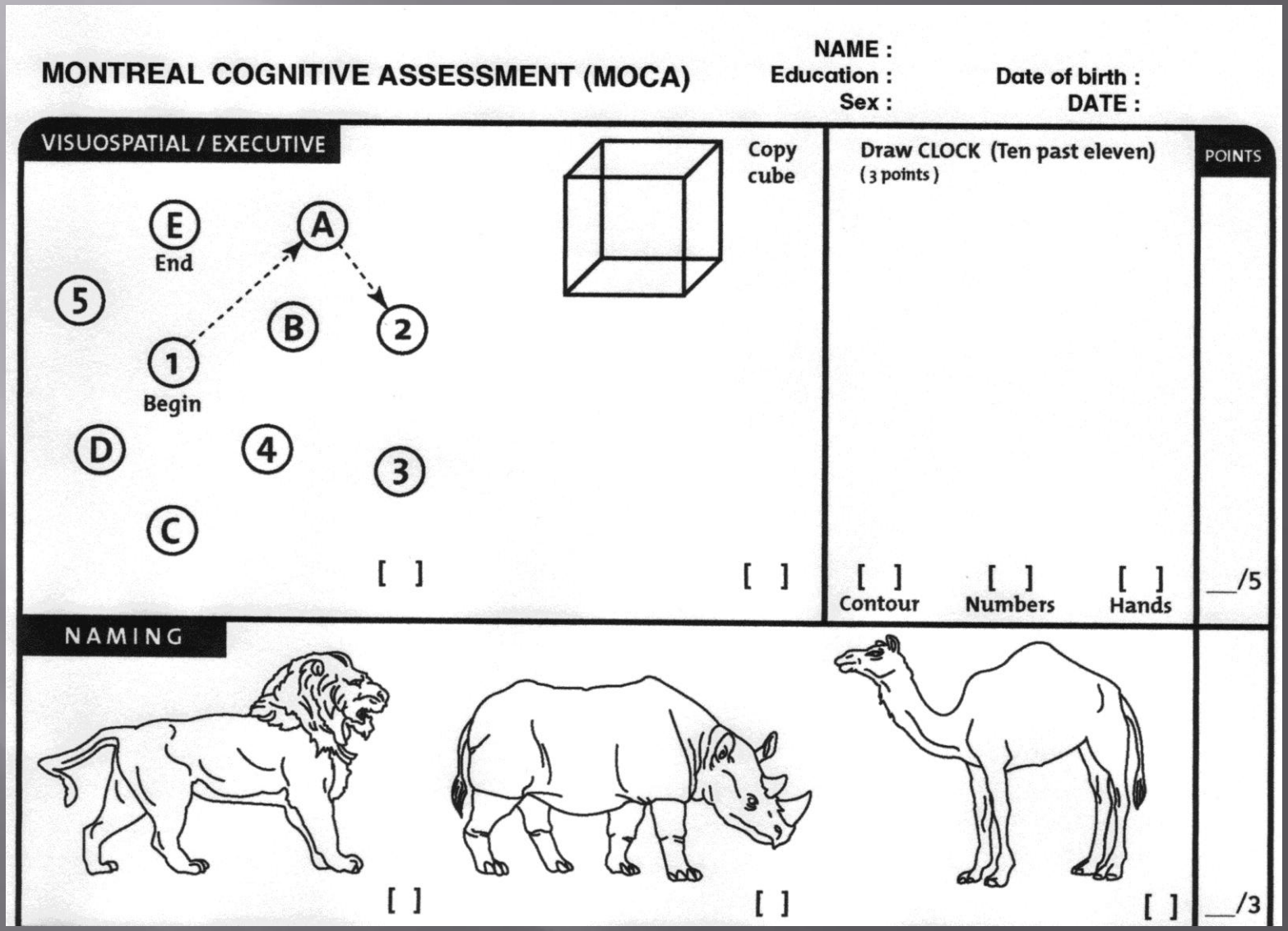
Formal Assessment Tools

Comparison of Methods of Assessing Capacities for Each Instrument

Capacity	Method
Understanding	
MacCAT-T	Paraphrasing, "in your own words," diagnostic and treatment information
HCAI	Series of questions about information described in the condition and treatment
CCTI	Series of questions about the details of information described in two vignettes
Appreciation	
MacCAT-T	Asks (1) if there is "any reason to doubt" information about the condition; (2) whether treatment "might be of benefit"
HCAI	Asks why the doctor wants the person to take the treatment (in the first vignette)
CCTI	Asks (1) preparation: what would need to be done to prepare for the chosen treatment; (2) projection: what life will be like 1 year after the treatment.
Reasoning	
MacCAT-T	Asks for (1) comparison of treatments; (2) consequences of treatments; (3) everyday impact of treatment alternatives; (4) logical consistency of reasoning.
HCAI	Asks why a choice was made, with query and credit for the risks and benefits considered
CCTI	Asks to give all the reasons why choice was made with credit given for the total number and accuracy of reasons provided.
Expressing Choice	
MacCAT-T	Rates if there is a clear choice
HCAI	Rates whether a choice is made
CCTI	Rates whether a choice is made for each vignette

CCTI = Capacity to Consent to Treatment Instrument
HCAI = Hopemont Capacity Assessment Interview
MacCAT-T = MacArthur Competence Assessment Tool for Treatment

Basic MSE - MOCA
Montreal Cognitive Assessment



MOCA (http://www.mocatest.org, with instructions)

MEMORY	Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.		FACE	VELVET	CHURCH	DAISY	RED	No points
		1st trial						
		2nd trial						
ATTENTION	Read list of digits (1 digit/ sec.).	Subject has to repeat them in the forward order [ ] 2 1 8 5 4						
		Subject has to repeat them in the backward order [ ] 7 4 2						/2
Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors [ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B								/1
Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65 4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**								/3
LANGUAGE	Repeat : I only know that John is the one to help today. [ ] The cat always hid under the couch when dogs were in the room. [ ]							/2
Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)								/1
ABSTRACTION	Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler							/2
DELAYED RECALL	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only	/5
Optional	Category cue							
	Multiple choice cue							
ORIENTATION	[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City							/6

 Version 7.0 www.mocatest.org Normal ≥ 26 / 30

TOTAL /30

Add 1 point if ≤ 12 yr edu

Administered by: _____

Executive Function Measures

Action Fluency Test: "Name what people do", as many verbs in 1 minute

Trail Making Test

Spontaneous Clock

IFS: INECO Frontal Screening

NAB Judgment

Problem Solving Questions (Cognistat):

- You are stranded in the Denver Airport with $1 in your pocket. How do you get home?
- You are walking along a lake. You see a 2 year old child at the end of the pier. No one else in sight. What do you do?.

- If Jane has an ulcer, and 85% of people are helped with this medicine, 10% stay the same, and 5% get worse, is this medicine likely to help Jane?

NAB Judgment

2. Judgment

Recording	Scoring	Discontinuation
Record responses verbatim. If examinee is queried to say more, place a Q in brackets [Q] at that point in examinee's response.	See criteria on page 7.	Administer entire task.

Administration Instructions

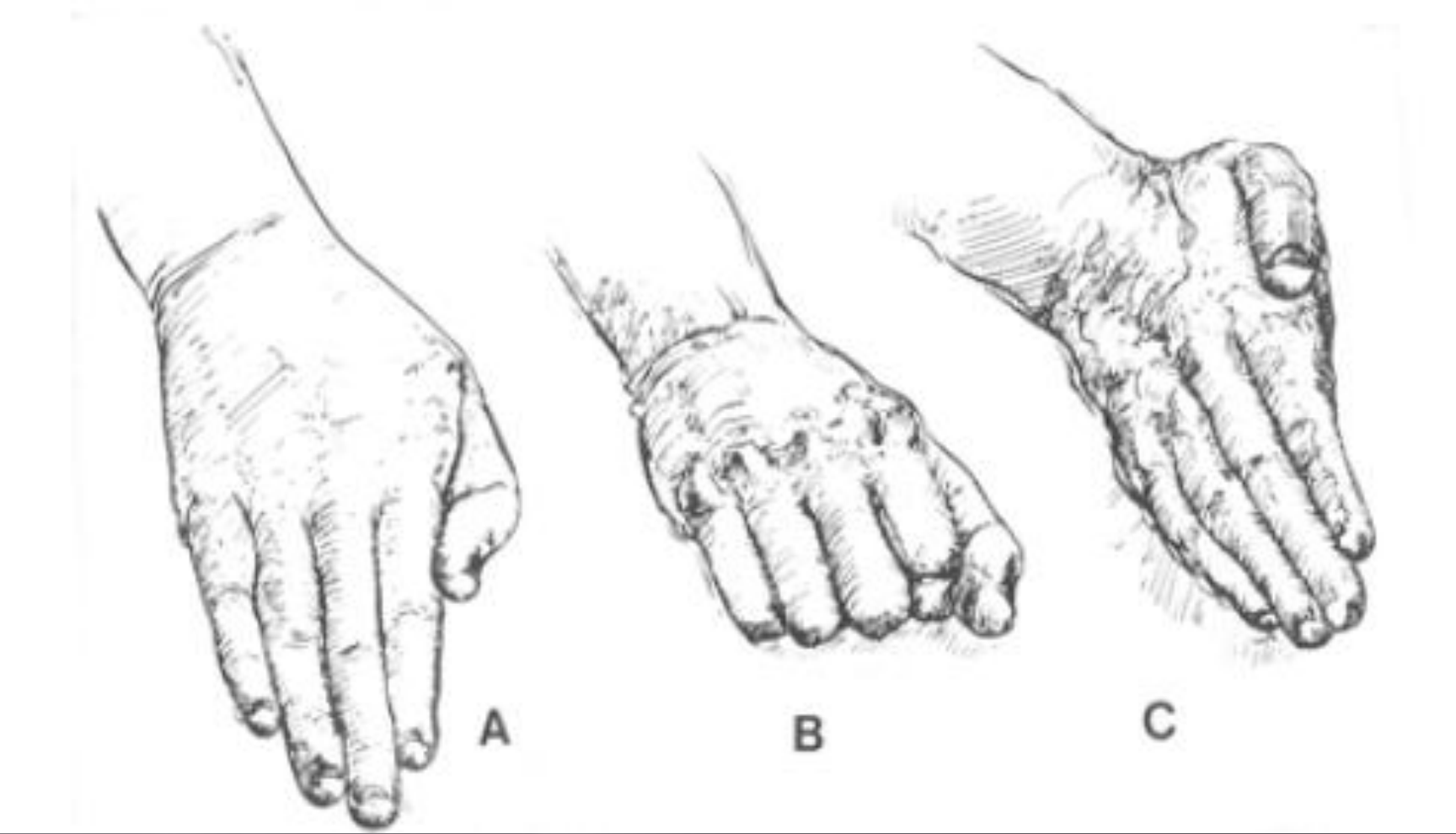
Say, **I am going to ask you a few questions. I want you to answer each question as fully as possible.** Questions may be repeated up to three times at examinee's request. If response is very brief or includes only a general concept (e.g., "For safety," "For health," or "It's dangerous") with no specific reference to the question, query by saying, **Tell me more.**

Question	Response
1. **Why should you blow out candles before going to bed?**	
2. **Why should you not leave a young child alone at home?**	
3. **Why should you replace the batteries in a smoke detector regularly?**	
4. **What should you do if you take too much of a prescription medication?**	
5. **Why should you not unplug electrical appliances while your hands are wet?**	
6. **Why are certain foods marked with an expiration date?**	
7. **Why is it important for people to brush their teeth?**	
8. **Why is it important to tell your doctor all the medications that you are taking?**	
9. **Why should you wash your hands before eating?**	
10. **What does it mean when your doctor says that there is a 25% chance of having serious side effects from a treatment?**	

Go to page 8 →

Neuropsychological Assessment Battery® (NAB®), Executive Module, PAR

Serial Hand Sequences



Hayling Test

- *Initiation:* **"Listen carefully to these sentences and as soon as I am done reading them, you must tell me, as quickly as possible, what word completes the sentence."**
  - I put my shoes on, and I tie my ... (laces)
  - It was raining cats and ... (dogs).
- *Inhibition*: **"This time, I want you to tell me a word that makes no sense whatsoever in the context of the sentence, and it must not be related to the word that actually completes the sentence."**

  "For example: Daniel hit the nail with a ... rain."
  - 1. John bought candy at the .....
  - 2. An eye for an eye, a tooth for a .....
  - 3 . I washed my clothes with water and .....

Aid to Capacity Evaluation (ACE)

- Developed by U. of Toronto Joint Centre for Bioethics
- Takes ~ 10-15 minutes to administer (maybe…)
- Is in the public domain and on the web:
  - http://www.utoronto.ca/jcb
- Has a form for administering, and instructions for scoring
- Uses increasingly specific, then leading questions to establish patient's level of knowledge and understanding

Measure Functional Ability

- If possible, use measure of ADLs or IADLs
- Use all sources of data regarding functioning:
  - Functional observations,
  - Collateral interviews,
  - Multidisciplinary team input

Incapacity and Guardianship Need

- Four incapacity requirements under state guardianship law:
- Presence of disabling condition.
- Functional behavior: inability to meet essential needs.
- Cognitive dysfunction.
- Finding that guardianship is necessary and is "least restrictive alternative."

Self Neglect: Incapacity to live independently

- Is an individual a significant danger to her or himself due to
  - limited functional abilities, or
  - cognitive or psychiatric disturbances
  - And cannot accept or appropriately use assistance that would allow him or her to live independently.

Living Independently

- Understand the day-to-day requirements of taking care of self and home?
- Is the individual able to either perform the tasks required for managing home and health or direct another person to assist them?
- Does the presence of a cognitive disorder, emotional disorder, or thought disorder affect the person's judgment as it relates to care of self or the home?
- The disorder likely to affect the capacity to live independently is dementia.

Capacity Declarations

- CAP DEC's (aka Capacity Declaration Forms) are legal documents that are completed once an individual has been determined to lack capacity and a conservatorship process is in process.
- The CAP DEC's are to be completed by a licensed physician or licensed psychologist with at least 2 years of experience diagnosing dementia.

GC-335

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):

TELEPHONE NO.: FAX NO. (Optional):
E-MAIL ADDRESS (Optional):
ATTORNEY FOR (Name):

To keep other people from seeing what you entered on your form, please press the Clear This Form button at the end of the form when finished.

SUPERIOR COURT OF CALIFORNIA, COUNTY OF
STREET ADDRESS:
MAILING ADDRESS:
CITY AND ZIP CODE:
BRANCH NAME:

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (Name):
☐ CONSERVATEE ☐ PROPOSED CONSERVATEE

CAPACITY DECLARATION—CONSERVATORSHIP

CASE NUMBER:

TO PHYSICIAN, PSYCHOLOGIST, OR RELIGIOUS HEALING PRACTITIONER

The purpose of this form is to enable the court to determine whether the (proposed) conservatee *(check all that apply)*:

A. ☐ is able to attend a court hearing to determine whether a conservator should be appointed to care for him or her. The court hearing is set for *(date)*: _____. *(Complete item 5, sign, and file page 1 of this form.)*

B. ☐ has the capacity to give informed consent to medical treatment. *(Complete items 6 through 8, sign page 3, and file pages 1 through 3 of this form.)*

C. ☐ has dementia and, if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she needs or would benefit from dementia medications. *(Complete items 6 and 8 of this form and form GC-336A; sign and attach form GC-336A. File pages 1 through 3 of this form and form GC-336A.)*

(If more than one item is checked above, sign the last applicable page of this form or form GC-336A if item C is checked. File page 1 through the last applicable page of this form; also file form GC-336A if item C is checked.)

COMPLETE ITEMS 1–4 OF THIS FORM IN ALL CASES.

GENERAL INFORMATION

1. *(Name)*:
2. *(Office address and telephone number)*:
3. I am
   a. ☐ a California licensed ☐ physician ☐ psychologist acting within the scope of my licensure ☐ with at least two years' experience in diagnosing dementia.
   b. ☐ an accredited practitioner of a religion whose tenets and practices call for reliance on prayer alone for healing, which religion is adhered to by the (proposed) conservatee. The (proposed) conservatee is under my treatment. *(Religious practitioner may make the determination under item 6 ONLY.)*
4. (Proposed) conservatee *(name)*:
   a. I last saw the (proposed) conservatee on *(date)*:
   b. The (proposed) conservatee ☐ is ☐ is NOT a patient under my continuing treatment.

ABILITY TO ATTEND COURT HEARING

5. A court hearing on the petition for appointment of a conservator is set for the date indicated in item A above. *(Complete a or b.)*
   a. ☐ The proposed conservatee is able to attend the court hearing.
   b. ☐ Because of medical inability, the proposed conservatee is NOT able to attend the court hearing *(check all items below that apply)*
      (1) ☐ on the date set *(see date in box in item A above)*.
      (2) ☐ for the foreseeable future.
      (3) ☐ until *(date)*:
      (4) **Supporting facts** *(State facts in the space below or check this box ☐ and state the facts in Attachment 5)*:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date:

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (Name):	CASE NUMBER:
☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	

6. EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS

Note to practitioner: This form is *not* a rating scale. It is intended to assist you in recording your impressions of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.

(Instructions for items 6A–6C): Check the appropriate designation as follows: a = no apparent impairment; b = moderate impairment; c = major impairment; d = so impaired as to be incapable of being assessed; e = I have no opinion.)

A. Alertness and attention

(1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)
a ☐ b ☐ c ☐ d ☐ e ☐

(2) Orientation (types of orientation impaired)
a ☐ b ☐ c ☐ d ☐ e ☐ Person
a ☐ b ☐ c ☐ d ☐ e ☐ Time (day, date, month, season, year)
a ☐ b ☐ c ☐ d ☐ e ☐ Place (address, town, state)
a ☐ b ☐ c ☐ d ☐ e ☐ Situation ("Why am I here?")

(3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)
a ☐ b ☐ c ☐ d ☐ e ☐

B. Information processing. Ability to:

(1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)
I. Short-term memory a ☐ b ☐ c ☐ d ☐ e ☐
II Long-term memory a ☐ b ☐ c ☐ d ☐ e ☐
III Immediate recall a ☐ b ☐ c ☐ d ☐ e ☐

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)
a ☐ b ☐ c ☐ d ☐ e ☐

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)
a ☐ b ☐ c ☐ d ☐ e ☐

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)
a ☐ b ☐ c ☐ d ☐ e ☐

(5) Reason using abstract concepts. (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)
a ☐ b ☐ c ☐ d ☐ e ☐

(6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)
a ☐ b ☐ c ☐ d ☐ e ☐

(7) Reason logically.
a ☐ b ☐ c ☐ d ☐ e ☐

C. Thought disorders

(1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)
a ☐ b ☐ c ☐ d ☐ e ☐

(2) Hallucinations (auditory, visual, olfactory)
a ☐ b ☐ c ☐ d ☐ e ☐

(3) Delusions (demonstrably false belief maintained without or against reason or evidence)
a ☐ b ☐ c ☐ d ☐ e ☐

(4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior).
a ☐ b ☐ c ☐ d ☐ e ☐

(Continued on next page)

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (Name): ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

6. *(continued)*

D. **Ability to modulate mood and affect.** The (proposed) conservatee ☐ has ☐ does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. *(If so, complete remainder of item 6D.)* ☐ I have no opinion.

***(Instructions for item 6D:** Check the degree of impairment of each inappropriate mood state (if any) as follows: **a** = mildly inappropriate; **b** = moderately inappropriate; **c** = severely inappropriate.)*

Anger	a ☐	b ☐	c ☐	Euphoria	a ☐	b ☐	c ☐	Helplessness	a ☐	b ☐	c ☐
Anxiety	a ☐	b ☐	c ☐	Depression	a ☐	b ☐	c ☐	Apathy	a ☐	b ☐	c ☐
Fear	a ☐	b ☐	c ☐	Hopelessness	a ☐	b ☐	c ☐	Indifference	a ☐	b ☐	c ☐
Panic	a ☐	b ☐	c ☐	Despair	a ☐	b ☐	c ☐				

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6A–6D

(1) ☐ do NOT vary substantially in frequency, severity, or duration.

(2) ☐ do vary substantially in frequency, severity, or duration *(explain; continue on Attachment 6E if necessary):*

F. ☐ *(Optional)* Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is ☐ stated below ☐ stated in Attachment 6F.

ABILITY TO CONSENT TO MEDICAL TREATMENT

7. Based on the information above, it is my opinion that the (proposed) conservatee

a. ☐ has the capacity to give informed consent to any form of medical treatment. This opinion is limited to medical consent capacity.

b. ☐ lacks the capacity to give informed consent to any form of medical treatment because he or she is **either** (1) unable to respond knowingly and intelligently regarding medical treatment **or** (2) unable to participate in a treatment decision by means of a rational thought process, **or both**. The deficits in the mental functions described in item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

(Declarant must initial here if item 7b applies: _____.)

8. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

Print This Form

For your protection and privacy, please press the Clear This Form button after you have printed the form.

Clear This Form

Reporting duty

- A report to APS is required by state law if you conclude self neglect in a patient if not already done by medical social workers

When is a "Guardian" Necessary?

If the individual is compromised or lacks capacity (*clinical examples: Dementia, TBI victim, mental retardation, mental illness), this needs to be documented, and this typically begins an involved process.

In short, the delegation of someone over the individual in question; such as a Durable Power of Attorney (DPOA), or in more extreme cases, a "Guardian."

The level of involvement of this "Guardian" depends on the need, but it can be for health care decisions, medical and financial concerns.

This "Guardian" is assigned control over decision making, with the idea that the "Guardian" will act in the best interest of the compromised individual.

Types of Conservatorships

- A probate conservatorship is a court proceeding where a judge appoints a responsible person (called a conservator) to care for another adult who cannot care for him/herself or his/her finances (called a conservatee).
  - ***A conservator of the person*** cares for and protects a person when the judge decides that the person can't do it.

    A conservator of the estate handles the conservatee's financial matters – like paying bills and collecting a person's income – if the judge decides the conservatee can't do it.

- An LPS conservatorship gives legal authority to a conservator to make certain decisions for a seriously mentally ill (grave disability with DSM dx) person who is unable to take care of him/ herself). Controls Finances, Medications, Locked unit.

Least Restrictive Alternative

What level of supervision is needed:

- Medication supervision
- Live with family
- 24 hour in home care
- Board and Care
- Full residential care
- Guardianship

Examples of recommendations for help with financial issues

- *Bill paying services*
- *Utility company third party notification*
- *Shared bank accounts (with family member)*
- *Durable Power of Attorney for finances*
- *Trusts*
- *Representative Payee*
- *Adult protective services*

Conclusion of Assessing Cognitive Function

- **Prognosis**
- **Recommendations**
- Explicit statement about capacity and need for a Guardian/conservatorship, and if the patient can meaningfully participate in the legal proceedings.

DOCUMENTATION OF THE ASSESSMENT- "U-ARE……"

- **U=** understanding. The patient is able to express in their own words the information regarding the risks and benefits of the situation.
- **A**=appreciation. The patient accepts that the facts presented apply to them, and they know the benefits of the treatment.
- **R**=reasoning. The patient can compare options, infer how a choice will impact them, and can offer logical consistency
- **E**=expressing a choice. The patient can communicate a consistent decision about treatment.

Documentation

- Put a dated, timed note in the chart, including the following:
  - Nature of decision being evaluated
  - State of the patient: alert? Cooperative?, etc
  - Documentation of a basic MSE, e.g. MOCA
  - Instrument s used, if any, for the assessment, including representation of questions asked, and significant patient responses. Completed form can go in chart.
  - Areas of concern identified, and how you will address them
  - Are deficits intermittent, reversible, permanent
  - Your assessment of capacity and reasoning behind it
- **Recommendations:**
  Further evaluation, treatment, advocating services, plan for future needs, request a conservatorship (general, specific?)

Template?

- **Capacity Conclusions**
- *The results of clinical interview previously described, combined with reports of staff and family, and considered in light of the mental status testing reported above support the following findings.*
- ***Financial Capacity: Given Mr. XX's*** *moderate to severe impairments in memory, executive function, and on direct assessment of financial capacities (check writing test), it is the examiner's opinion that Mr. XX does not have capacity to manage simple or complex finances independently.*
- ***Capacity to Manage His Person: Given Mr. XX****'s moderate to severe impairments in memory and executive function, and on direct assessment of executive functioning tasks, it is this examiner's opinion that Mr. XX is currently at significant risk for harm to himself. He has limited insight into his abilities . Mr. XX needs the structure of 24-hour care at the present time and for the foreseeable future.*

Still uncomfortable?

- If you are uncomfortable with the ethics of the decision of a capacitated patient, or the ethics of imposing a particular decision on an incapacitated patient, consult the Ethics Committee to discuss it further

Recommended

- **Judicial Determination of Capacity of Older Adults in Guardianship Proceedings**
  - **http://www.apa.org/pi/aging/resources/guides/judges-diminished.pdf**
- **Assessment of Older Adults With Diminished Capacity: A Handbook for Psychologists**
  - http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf

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