ASSESSING COMPETENCE

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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

MMSE ‘norms’ by Age and Educational Level

MMSE SCORES

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

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 (see syllabus)

Neuropsychological Testing

- 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*

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

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 *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.
- 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)