

# Competence and Health Law Issues in the Elderly

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R and C

# Objectives

- To increase the appreciation of Nova Scotia Health Law legislation
- Promote understanding of the components of completing competency assessments
- To increase comfort level in participating in (capacity) competency assessments

# Why Is This Important For You?

- *In NS, any physician* is qualified to give an opinion on competency:
  - ◆ Does not need to be a psychiatrist, geriatrician
  - ◆ The team can contribute greatly
- You have special knowledge related to discipline and training
- If 2 doctors opinions are needed, your input will be invaluable to them

# Why is This Important For You?

- Unprecedented growth in the number of seniors, trend even bigger in NS
  - ◆ 700 people turn 65 in NS every month
- Health professionals will be increasingly involved in the care of geriatric patients
- All team members will need to contribute to the competency assessment of patients they know well or who are new to them

## 5 Key Messages:

- 1) EPOA and substitute decision makers are for everyone! (talk to patients)
- 2) *Understanding & Appreciating* are the key elements in competency assessment
- 3) An MMSE is usually NOT enough
- 4) Home visit is ideal- But *always* get collateral
- 5) Least restrictive alternatives (aka. Will they accept help?)

# Clinical Highlights

- Review 3 common types of competence
- When should competency be addressed?
- Who assesses competency?
- How is competency addressed?

# Case: Mr. Frale

# Case: Mr. Frale

- 79 year old, widowed x8 years
- Known to the clinic you work in for 10 years
- Lives alone in small home
- Referral to your team from AP after neighbour called: concerns financial abuse by nephew. Not looking as neat in his appearance, and seems to be losing weight. Doesn't seem like his normal self. Sort of mixed up.

# Case: Mr. Frale

- WHAT SHOULD YOU DO?
- WHAT AREAS OF COMPETENCY NEED TO BE CONSIDERED?

# Competence / Capacity

- **financial**
- **personal care**
- **consent to treatment**
- sign out AMA
- testamentary
- marry
- parent
- fitness to stand trial
- fitness to instruct council
- responsibility for a crime
- be a witness
- enter into a contract
- assign POA

# Competency – The Definition

- Ability to make a decision
- Minimal cognitive capacity required to perform a recognized act

# Concepts of Capacity

## Necessary Components

- Ability to communicate choice
- **Understanding** the relevant information
- **Appreciating** the situation and its consequences
- **Manipulating** information rationally  
(Applebaum)

# Competence / Capacity

## ■ financial

- ◆ administer estate
  - ☞ manage property
  - ☞ enter contract
  - ☞ make will
  - ☞ be corporate partner
  - ☞ act as trustee
  - ☞ assign POA

## ■ personal care

- ◆ take care of oneself
  - ☞ shelter
  - ☞ food
  - ☞ clothing
  - ☞ safe, secure environment
  - ☞ ADLs
  - ☞ medical treatment

# Financial Assessment

- Assets, income, expenses, debt
- Corroboration by collateral
- History of management of finances in past
- Need for support in same

MacKay, MJ. C J Psychiatry 1989; 34:829-832

# Financial assessment

- ◆ Implications if poor judgment used
- ◆ If fluctuating competence, should be safe during poorest level of function
- ◆ Delusions/ hallucinations that would impair competency
- ◆ Patient's preference for estate management

Mackay, MJ. C J Psychiatry 1989; 34:829-832

# Personal Care Competence

- Health, nutrition, ADLs, hazards
- Appreciation of strengths and weaknesses
- Willing to make use of supports if necessary
- History of poor judgment resulting in harm to self or others

# Personal Care competence

- ◆ If fluctuating competence, should be safe during poorest level
- ◆ Delusions/hallucinations that would impair capacity

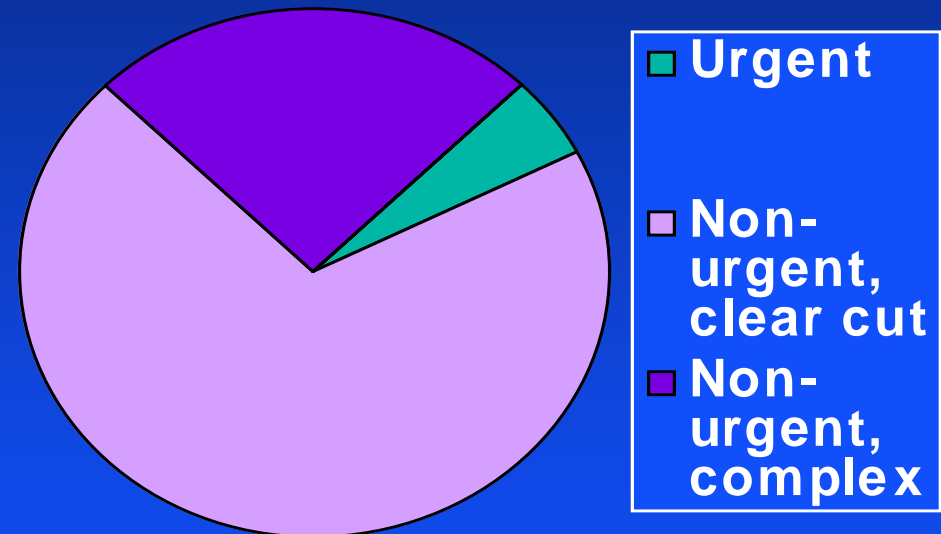
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# Competency for Treatment Decisions

- Understand?
  - ◆ The condition for which treatment is proposed
  - ◆ The nature and purpose of the treatment
  - ◆ Risks in undergoing treatment
  - ◆ Risks in not undergoing the treatment
- Whether or not his (her) ability to consent is affected by the condition

# Levels of assessment

- Urgent
  - ◆ e.g. life-threatening injury
- Non-urgent, clear cut
  - ◆ e.g. obvious dementia
- Non-urgent, complex
  - ◆ e.g. early dementia
  - ◆ relevant health care professionals' assessments helpful
  - ◆ fewer consults; more time



# Functional Abilities in Decision Making

- Ability to *express* a choice
- Ability to *understand* information relevant to decision making
- Ability to *appreciate* the significance of that information (including consequences)
- Ability to *reason* with relevant information to weigh options

# Ability to express a choice

## ■ Decreased ability:

- ◆ Expressive aphasia
  - ☞ look for a consistent message
  - ☞ try nonverbal techniques
- ◆ Poor memory- inability to make consistent choice
- ◆ Depression (ambivalence)

# Ability to understand information

- Impaired comprehension:

- ◆ Receptive aphasia

- ◆ Poor attention span

- ◆ Psychiatric

- ☞ denial

- ☞ delusions

# Ability to appreciate consequences / reason

- Depression - delusions of punishment, hopelessness
- Frontal lobe damage
  - ◆ evaluating consequences
  - ◆ insight into significance of problem
  - ◆ mental flexibility to adapt to changes
  - ◆ memory problems not necessarily prominent

# Law and Medicine

- Competence is a legal judgment
- Past view: competent or not competent
- Current view: concept of a continuum of competence
  - ◆ limited guardianship
  - ◆ segregation of competencies
  - ◆ least restrictive alternative

# Competency-to assess or not to assess...

- Presumption of competence
- Cognitive deficits alone are not sufficient basis for incompetence
- Person is allowed to make a “poor” decision

## When not to assess ...

- Is formal assessment necessary?
  - ◆ 15% of referrals dismissed
    - ☞ motive not in best interest of patient
    - ☞ misunderstanding of legal consequences of potential assessment
    - ☞ another alternative available that would better serve the person's interest
  - ◆ Incompetent person willing to accept help may not need to be formally declared incompetent

# Remember...

- Competency assessment places person's fundamental rights and freedoms at risk, particularly the right of liberty
- It should focus on the needs of the patient and not others and should only be used as a last resort
  - ◆ incompetence route can be highly coercive way of advocating services and professionalizing care

# Competency Assessment Guidelines

- Standardized assessment and criteria is the goal
- One-shot assessments should be the rare exception

# Overview of assessment-

## Who should assess?

- Family medicine, Psychiatry, Geriatric Medicine
- Neuropsychology
- Social work
- RN
- OT / PT
- Other team members

- Principle:

- ◆ weigh the tenuous balance of person's autonomy against the need to act in that person's interest

# Competency Assessment

- Is the referral specific?
- Talk to referral source / family
- Explain purpose to patient

# Competency Assessment

## ■ Mental status

- ◆ orientation (to pay bills)
- ◆ memory (keep track of financial transactions)
- ◆ concentration
- ◆ simple and complex calculations
- ◆ delusions / hallucinations
- ◆ insight
- ◆ judgment
- ◆ intellect

# Cognitive Assessment

- The following tests are useful:
  - ◆ MMSE
    - ☞ Recall
    - ☞ Concentration
  - ◆ Clock drawing
  - ◆ “F” words / animals in 60 seconds
  - ◆ Similarities
  - ◆ Trails B
  - ◆ Frontal assessment battery

Mr. Frale

# Interview: Financial Competence

## ■ Assets, income

- ☞ Unaware of \$200,000 in savings, he thinks it may be \$2000, Neighbor knows its Down to \$100,000
- ☞ Unaware of pensions, “I’m too old to get them”

## ■ Debts, expenses

- ☞ Nephew insists on “helping”
- ☞ Thinks he pays \$10 for electricity once or twice a year, unsure of phone cost
- ☞ Unpaid bills

# Mr. Frale : Finances

- Thinks he can manage his money
- Trusts Bruno

# Mr. Frale:

## Financial competence

- Collateral, history of money management
- Does he accept need for support? - no
- Delusions or hallucinations that may impair decisions? -no
- Patient's preference
  
- CONCLUSION?

# Mr. Frale:

## Personal Care Competence

### ■ Health Deficits:

- ◆ Parkinson's disease - harder to walk, falls
- ◆ COPD - stopped smoking
- ◆ ?dementia - memory decline X 3 years, forgets pills

# Personal Care Competence

## ■ Functional deficits:

- ◆ Lives alone
- ◆ Mrs. Goodhart sometimes bakes
- ◆ Cooks soup on wood stove, losing weight
- ◆ Cleans?
- ◆ Independent ADLs but poor hygiene
- ◆ Drives to grocery store in mornings
- ◆ ER - minor traumas

# Personal Care - Interview

- Admits he needs help with his pills – its hard to keep track
- Says he gets some meals on his own but appreciates neighbor's cooking
- Admits to falls but says he always manages to get the help he needs or will get to ER
- Agrees to have someone in the home who would help him organize pills, clean

# Personal Care Competence

- History of poor judgment resulting in harm - no
- Delusions that would impair capacity- no
- Appreciate his own strengths & weaknesses - yes
- Willing to use supports – yes
  
- CONCLUSION?

# Competency Assessment

- Consider extra data
  - ◆ Home visit
  - ◆ Collateral re: finances, personal care and function.
  - ◆ Neuropsychology
  - ◆ OT assessment of function
- Is condition permanent or temporary?
  - ◆ Re-evaluate if temporary

# Presumption of Capacity

- In Nova Scotia, each person is presumed to have capacity to make his/her own decisions
- This includes decisions for and against recommended medical treatment.
- Except in very limited circumstances, no one can make decisions for a competent individual.

# Substitute Decision Makers

- Medical decisions, hierarchy
  - ◆ Person authorized under Medical Consent Act
  - ◆ Court appointed guardian
  - ◆ Spouse or common law partner, is cohabitating in conjugal relationship
  - ◆ Adult child
  - ◆ Parent
  - ◆ Adult sibling
  - ◆ Any other adult next of kin
  - ◆ Public Trustee
- Financial decisions
  - ◆ POA (enduring)
  - ◆ Not NOK

# Substitute Decision Makers cont'd

- SDM shall make a decision in relation to a specific medical treatment
  - ◆ In accordance with the patient's prior capable informed expressed wishes; OR
  - ◆ In the absence of a prior capable informed expressed wish, in accordance with what the SDM believes to be in the patient's best interests

# Power of Attorney Act 1988

- Authorizes person to act on your behalf
  - ◆ general
  - ◆ specific
- Duration
  - ◆ standard
  - ◆ enduring POA

# Hospitals Act-Amended

- Psychiatrist must assess:
  - ◆ capacity to consent to treatment in psychiatric facility
  - ◆ financial competence when necessary in a psychiatric facility
  - ◆ no provision for personal care competence
- For the purpose of a person in a hospital the attending physician may now comment on capacity to consent to treatment and financial competency

# Hospitals Act-Amended

- Incompetence without a judge
- Lasts for duration of hospitalization only

# Incompetent Person's Act

- “Insane person” or “lunatic”
- Requires medical evidence from one *medical practitioner*; often two obtained
- Judge must declare person incompetent, then appoint a guardian
- Guardian of estate and person

# Adult Protection Act 1986

- “In need of protection”

- ◆ Victim of abuse +/- mental cruelty incapable of protecting themselves *by reason of physical disability or mental infirmity*

OR

- ◆ Not receiving adequate attention or incapable of caring adequately for themselves *by reason of physical disability or mental infirmity*
- ? Where they live, duration of 6 months

# Summary

If we have a patient who is not competent and has no:

- ◆ Person authorized under the Medical Consent Act
- ◆ Court appointed guardian
- We must rely on Next of Kin
  - ◆ As outlined in the amended Act

## 5 Key Messages to Remember:

- 1) EPOA and substitute decision makers are for everyone! (talk to patients)
- 2) *Understanding & Appreciating* are the key elements in competency assessment
- 3) An MMSE is usually NOT enough
- 4) Home visit is ideal- *Always* get collateral
- 5) Hard vs soft approach to incompetency (aka. Will they accept help?)

# REFERENCES

- Chisholm, T. “Financial and Personal Care Competences”. Shared slides. May 2003
- Hickey, C. “Challenging Capacity Evaluations”. Shared slides, Feb 2006.
- MacKay, M.J. “Financial and Personal Competence in the Elderly”. C.J. Psychiatry, 1989, 34:829-832.
- Bosma, M. “Geriatric Psychiatry Curriculum: A Series of Case Based Interactive Teaching Modules.” Shared slides. June 2006