# The Adult at Risk: clinical approaches

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# Objectives

- To outline clinical approaches to the adult at risk in the community
- To review the principles of capacity/competency
- To briefly discuss the IPTA
- To provide an overview of the roles of Adult Protection, the Registry of Motor Vehicles, and the Public Trustee

# At risk

- Definitions: ‘susceptible to harm’, ‘in peril’ or ‘in danger’
- The concept of risk involves an element of uncertainty: the possibility of harm is presumed, but not a definite outcome
- Quantifying risk is often difficult – objective measures are often inadequate, and clinical judgment becomes the standard

# Risk and competency

- Risk intervention by Dept of Health services (Mental Health, Adult Protection) occurs only when the person at risk is felt to have compromised capacity or competency
- Types of capacity include:
  - Consent to treatment
  - Personal care
  - Financial

# Assessment of Risk: suicide

- The risk assessment most familiar to mental health clinicians is determining suicide risk
- Population-based risk factors have been identified, but standardized risk assessments have low predictive value for completed suicide
- Individual clinicians have different clinical approaches and thresholds for intervention

# Involuntary Psychiatric Treatment

- IPTA guiding principle: treatment and related services are to be offered in the least-restrictive manner and environment with the goal of having the person continue to <u>live in the community</u> or return to the person's home surroundings at the earliest possible time

# Involuntary admission

- That a person, as a result of a mental disorder,
- (i) is threatening or attempting to cause serious harm to self or another or has recently done so OR
- (ii) as the result of the mental disorder, the person is likely to suffer serious physical impairment or serious mental deterioration, or both; and
- **And** the person would benefit from psychiatric inpatient treatment in a psychiatric facility and is not suitable for voluntary admission

# Definition of Mental Disorder

- “Mental disorder" means a substantial disorder of behaviour, thought, mood, perception, orientation or <u>memory</u> that severely impairs judgement, behaviour, capacity to recognize reality or the ability to meet the ordinary demands of life, <u>in respect of which psychiatric treatment is advisable</u>

# When to admit to psychiatry?

- Is dementia the most responsible diagnosis?
- Does the patient have a psychiatric illness that is likely to benefit from treatment in hospital?
  - Examples:  depression, psychosis
- Can the same treatments be offered in the community (including a nursing home)?

# When to admit continued

- If admission would be beneficial and the patient is refusing admission, is there evidence of risk that would justify the use of the IPTA?

# Problems with psychiatric admission

- Often the main issue is inability to live in the community due to dementia, which cannot be effectively ‘treated’
- In many centers, elderly patients with dementia are on general psychiatric wards with younger patients who may have very different needs
- Stigma may lead to difficulties in classification of these patients, and discharge becomes impossible

# Other Common Types of Risk in the Elderly

- Abuse: according to the MCC, 4% of surveyed seniors reported abuse
- Other risks can be broadly conceptualized as those affecting personal care
- Neglect: a syndrome of habitual lack of care, often arising from dementia. Usually involves a number of potential risks to the individual.

# Personal care

- Personal care refers to the person's ability to carry out tasks needed to maintain a functional standard of living, and can be divided into activities of daily living (ADL's) such as dressing, eating, ambulating, toileting and hygiene, and instrumental activities of daily living (IADL's) such as housework, shopping, preparing meals, and so on.

# IADL risks

- Occur at the early stages of dementia
- Often related to problems with planning and organizing (executive function)
- Examples include:
  - Driving
  - Finance management
  - Medical condition management (meds, appts)
  - Household management (stoves, etc.)

# ADL risks

- May occur at later stages of dementia
- Related to basic motor activities such as ambulation and toileting
- Examples include:
  - Falls
  - Wandering
  - Skin breakdown due to poor hygiene

# Competency

- It is important to distinguish between competency, which is a legal decision, and capacity, a clinical term.
- “An ability to understand and process information, make decisions, and carry out related tasks in a manner consistent with and protective of a set of values demonstrated over a period of time.” (Merrick and Yesner, 1995)

# Canadian Psychiatric Association criteria

- 1. Is there evidence the person may not be adequately caring for himself or herself?
- 2. Does he/she have a realistic appreciation of his/her strength and weaknesses?
- 3. If he/she cannot function independently, are they willing to make use of available resources?
- 4. Is there evidence of impairment of judgment, which resulted in accidents?

# Canadian Psychiatric Association criteria continued

- 5. If there is a fluctuating level of competence, is the person safe at the lowest level of function?
- 6. Are there delusions or hallucinations that would impair their capacity to care for themselves?

# Ethical Issues

- Autonomy refers to a person's ability for self-determination and independence. An incompetent person has their autonomy compromised, but capacity occurs on a continuum.
- The health care team may need to act for a patient's own good (beneficence) even if it compromises his autonomy.

# Adult Protection Act

- To provide a means whereby adults who lack the ability to care and fend adequately for themselves can be protected from abuse and neglect by providing them with access to services

# Guiding principle

- The welfare of the adult in need of protection is the paramount consideration.

# Adults in Need of Protection

- A victim of physical abuse, sexual abuse, mental cruelty or a combination thereof, who is incapable of protecting himself by reason of physical disability or mental infirmity
- OR……

# Or, more relevantly…

- A person who is <u>not receiving adequate care and attention</u>, is <u>incapable of caring adequately for himself</u> by reason of <u>physical disability or mental infirmity</u>, and <u>refuses, delays or is unable</u> to make provision for his adequate care and attention

# Duty to report

- Every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection shall report that information to the Minister.
- No action lies against a person who gives information under subsection (1) unless the giving of the information is done maliciously or without reasonable and probable cause.

# Order of the Court

- If the court finds that a person is an adult in need of protection and either
  - not mentally competent to decide whether or not to accept the assistance of the Minister; or
  - refusing the assistance by reason of duress,

the court can authorize the Minister to provide the adult with services, including placement in a facility approved by the Minister

# Lifespan of the orders

- The court orders are in effect for six months
- If renewed, the renewal is in place for six months

# When to call adult protection?

- Is dementia the most responsible diagnosis? (While the CPA guidelines allow for psychosis, most AP cases appear to be dementia-related.)
- Is admission to a psychiatric facility unlikely to improve the person’s ability to care for themselves?
- Is the person both incapable of caring for himself and unable to appreciate the implications of their deficits?

# A typical pathway

- A person with dementia living in the community (often alone) is identified as having deficits in self-care (neglect)
- The person is refusing assistance/placement
- They lack insight into the problems they are having (note: an OT assessment is often helpful to quantify the problems)
- A physician (not necessarily a psychiatrist) fills out a medical form
- At some point in the path, AP referral is made

# Special case: Alcohol abuse

- 22% of those over age 65 drink four or more times per week
- 15% of seniors presenting to ER services have alcohol abuse
- Alcohol use can lead to persisting cognitive impairment which may improve with prolonged sobriety
- Addiction treatment services are run by the local health authorities

# Driving

- Although morbidity and mortality rates related to MVA's have declined, the rates for those over 65 continue to rise
- SAFEDRIVE mnemonic: Safety record, Attentional skills, Family report, Ethanol, Drugs, Reaction time, Intellectual impairment, Vision/visuospatial function, Executive function

# CCCDTD Guidelines: Driving

- Published by the 2006 Canadian Consensus Conference on the Diagnosis and Treatment of Dementia
- Driving is contraindicated in persons who, for cognitive reasons, have an inability to independently perform multiple IADL's (e.g., medication management, banking, shopping, telephone use, cooking) or any of the ADL's (e.g., toileting, dressing).

# CCCDTD cont.

- No single test should be used as a sole determinant of driving ability. Abnormalities on tests such as the MMSE, clock drawing and Trails B should result in further testing
- The driving ability of persons with earlier stages of dementia should be tested on an individual basis.

# CCCDTD cont.

- A health professional-based comprehensive off- and on-road driving evaluation is the fairest method of individual testing.
- In places where comprehensive off and on-road driving evaluations are not available, clinicians must rely on their own judgment.
- For persons deemed safe to drive, reassessment of their ability to drive should take place every 6 to 12 months.

# *The Motor Vehicle Act*

- Section 279 (1) C  Immediate suspension or revocation by Registrar when the Registrar has reason to believe :

"that such person is incompetent to drive a motor vehicle or is afflicted with mental or physical infirmities or disabilities rendering it unsafe for such person to drive a motor vehicle upon the highways"

# *The Motor Vehicle Act*

Section 280 of the Motor Vehicle Act:

The Registrar can demand a person submit a medical report from a family doctor or specialist; participate in a re-examination; submit a vision report

The Registrar can suspend a person's license for not complying with the demand

# *Suspensions*

- The person is entitled to a hearing under Section 280 (2) of the Motor Vehicle Act
- The person will be advised what they need to do to for hearing
- It can be a letter of explanation; new medical information; an in-person review; a re- examination; an assessment by the Driving Evaluation program, an assessment by Addiction Services

# *Demands*

- Allow person to keep license but make a demand for something in 30-60 days
- Demand medical reports/ demand re-exam;  demand vision report; combination of above
- Outcome of demand will determine next step -  suspend; ask for more, no further action

## *What is mandatory?*

- Legislation for doctors to report is voluntary - Sec 279 (7) of the Motor Vehicle Act;
- Doctors are protected for reporting under section 279 (9)
- There is no age based testing for seniors in the province
- The correct measure for fitness to drive is functional ability; not age

# *Licensing authority responsibilities*

- Create awareness about driver licensing decision making
- Work in partnership with agencies to build resource networks for those who can no longer drive
- Make evidence based decisions where possible and develop best practices in conjunction with other jurisdictions

# *Lingering Questions....*

- How will we prepare for baby boomers who want to keep driving?
- Many drivers already self limit their driving - only drive during the day, do not drive in bad weather or on the highways and do not drive in rush hour; is this working and is this enough?
- How do we become proactive in dealing with at-risk drivers rather than reactive?
- How can we identify drivers of any age who have driving limitations?

# *How are Decisions Determined?*

- The Registrar has discretionary authority under the Motor Vehicle Act.
- Medical standards are utilized in decision making from the CCMTA (Canadian Council of Motor Transport Administrators) and the CMA (Canadian Medical Association).
- Information provided by the treating physicians is taken into consideration.
- Medical Advisory Committee is consulted in more complex cases.

# *Suspensions*

- When a client's license is suspended, the client's case will be reviewed if they supply favorable medical information and/or participate in a re-examination.
- If it appears the medical situation will not improve, the client is advised of their right to a hearing (either written or in-person) to explain why the suspension should not remain in effect.
- Hearing is conducted by the Deputy Registrar at the request of the client. Typically, wait times for hearings do not exceed two weeks and a decision is rendered in writing within one week of the hearing being held.

# *Permanent Revocation*

- After the client has had their hearing, the decision could be:
  - deferred pending the provisions of additional medical information and/or or a successful re-examination; or
  - to permanently revoke the license.
- The client's only recourse at this point is through the NS Supreme Court.

# Challenges Ahead

- Rural demographic
- Men will stop driving 6 years before death; women will stop driving 10 years before death - how will their transportation needs be met?
- High incidence of chronic illness and disability - Compared to other Canadians, Nova Scotians have particularly high rates of chronic illness and the country's highest reported use of disability days. (source: GPI Atlantic Report 2002).
- Evidence-based information is still being developed.

# When to call registry of motor vehicles?

- Is there evidence of impairment (due to cognitive reasons) in at least one ADL or more than one IADL?
- Are there abnormalities on cognitive testing?
- Do family and others report problems with driving?
- Is there reason to suspect the person will not comply with advice to stop driving?

# Financial competency

- The basic principles involved in financial and personal care competency are similar:  does the person have deficits, do they appreciate their deficits, is there evidence of harm, and is the person willing to accept assistance?

# Financial Risks

- Inability to pay bills
  - Financial equivalent of neglect
  - This may go undetected if bills are being paid through direct withdrawal
- Financial abuse by family members or others
  - Can be difficult to prevent or act upon:  not the responsibility of Adult Protection

# Power of Attorney

- Power of Attorney is a legal document that allows others to make financial or other decisions for another person.
- To remain valid when a person is incompetent, it must be <u>enduring.</u>
- All older patients should be encouraged to make arrangements for someone to have power of attorney while they are capable of signing the necessary forms.

# Public Trustee

- Reports to the Minister of Justice, but independent corporation: 2 lawyers
- Administers estates of deceased persons
- May consent to medical treatment of a mentally incompetent hospital patient when consent cannot be obtained from the patient's guardian, spouse or next-of-kin
- May represent incompetent persons in lawsuits

# Public Trustee continued

- Manages estates of incompetent persons who need services of a trustee, guardian, or attorney
  - If the person has no NOK or POA, and is not an adult in need of protection, the public trustee could potentially become involved
  - The person’s own estate would pay for the guardianship application ($2000 or so)
  - HOWEVER they are more likely to become involved with inpatients under the Hospitals Act

# Public Trustee continued

- Does not investigate financial abuse
  - In other provinces, public guardian fulfills that role
  - If fraud or theft is suspected, police may be a better option
- Recently hired staff to act as SDM for CTO's
- Can be appointed at the time of an AP order

# When to call the Public Trustee?

- Is the person incompetent?
- Are they an inpatient? (More common scenario, although outpatient is not impossible)
- Is there no other person available to manage the estate (esp POA)?
- Have the police been called to investigate fraud or theft?

# Mrs. J. (a composite character)

- 87 year old woman with anxiety and chronic depression
- Referred by Geriatric Day Hospital Program
  - Told them she did not want to come back and left prematurely
  - Concerns about home safety

# Mrs. J. continued

- Seen by psychiatry in 1990’s for auditory hallucinations and delusional beliefs
- Started on risperidone with good response
- MMSE in 1996 27/30
- Prior admission to NSH in 1970’s, and outpatient treatment

# Mrs. J. continued

- Admitted to internal medicine in 2006 with pneumonia
- Lifelong history of anxiety, demanding behavior: alcohol abuse 30 years ago
- Multiple medical problems including TIA’s, OA, HTN, GI bleed, GERD, hypothyroidism

# Mrs. J’s current issues

- Not eating healthy meals
- Possibly giving money to neighbor
- Scared to be alone: numerous physical complaints, calls to family, visits to ER
- Still driving, daughter concerned
- Refusing to move from current apt
- Not willing to accept HCNS services

# Issues continued

- Independent for ADL’s, but requiring assistance for laundry, shopping, wants her daughter to do these things for her: otherwise, neglects them
- Takes multiple over the counter meds such as Gravol despite being told not to do so
- Family burned out
- No POA

# Mrs. J. continued

- MSE:
  - Somewhat frail-looking
  - Very talkative, ‘feisty’
  - Affective lability
  - No psychosis
  - Says she sometimes thinks of jumping in the river
  - MMSE 21/30, FAB 5/18

# Discussion.

# Thank you.

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