Current PSYCHIATRY

Assessing decisional capacity in patients with substance use disorders

A skilled assessment is required to determine if patients can make decisions about their care

Ms. B, age 31, is brought to the emergency department (ED) via ambulance after emergency medical technicians used naloxone nasal spray to revive her following an overdose on heroin. She reports daily IV heroin use for the last 4 years as well as frequent use of other illicit substances, including marijuana and alprazolam, for which she does not have a prescription. She is unemployed, estranged from her family, and does not have stable housing. She refuses to be admitted to a drug rehabilitation facility for detoxification and asks to be immediately discharged.

How can you determine if Ms. B has the capacity to make decisions regarding her care?

NAPOCSKA/SHUTTERSTOCK

Walid Michel Nassif, MD
Director, Consultation-Liaison Service
Atlanta VA Medical Center
Decatur, Georgia
Assistant Professor
Department of Psychiatry and Behavioral Sciences
Emory University
Atlanta, Georgia

Decisional capacity is defined as a patient's ability to use information about an illness and the proposed treatment options to make a choice that is congruent with one's own values and preferences.[1] Determining whether a patient has adequate capacity to make decisions regarding their care is an inherent aspect of all clinician-patient interactions.

Published reports have focused on the challenges clinicians face when assessing decisional capacity in patients with psychiatric and cognitive disorders. However, there is little evidence about assessing decisional capacity in patients with substance use disorders (SUDs), even though increasing numbers of patients with SUDs are presenting to EDs[2] and being admitted as inpatients in general hospitals.[3] In this article, I discuss:

- the biologic basis for impaired decision-making in patients with SUDs

continued

Disclosure
The author reports no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.

Decisional capacity and SUDs

Clinical Point

Determination of decisional capacity in the clinical setting should be specific to an individual decision or set of decisions

Discuss this article at www.facebook.com/MDedgePsychiatry

- common substance use–related conditions that may impact a patient's decisional capacity
- the clinical challenges and legal considerations clinicians face when assessing decisional capacity in patients with SUDs
- how to assess decisional capacity in such patients.

Decisional capacity vs competence

"Capacity" and "competence" are not the same. Decisional capacity, which refers to the ability to make decisions, is a clinical construct that is determined by clinicians and is generally used in the acute clinical setting. Because cognition is the main determinant of capacity, conditions or treatments that affect cognition can impair an individual's decision-making capacity.[1] Decisional capacity is not a global concept but a decision-specific one, subject to fluctuations depending on the time and the nature of the decision at hand. Therefore, requests for determination of decisional capacity in the clinical setting should be specific to an individual decision or set of decisions.

In contrast, competence is an enduring legal determination of incapacitation, typically made by a probate judge. It refers to the ability of an individual to perform actions needed to put decisions into effect. Decisional capacity as assessed by a clinician often serves as the basis for petitions submitted for the purpose of competency adjudication by the judicial system.

A biologic basis for impaired decision-making?

Jeste and Saks[4] suggested that addiction itself is characterized by impaired decision-making because individuals keep using a substance despite experiencing recurrent physical, psychologic, or social problems caused or worsened by the substance. Several studies suggest there may be a biologic basis for impaired decision-making in these patients, even in the absence of severe psychiatric or cognitive disorders.

Bechara and Damasio[5] found that the decision-making impairment seen in some patients with SUDs was similar to that observed in patients who have lesions of the ventromedial prefrontal cortex. In both groups of patients, the impaired decision-making was characterized by a preference to opt for high immediate reward despite even higher future losses.

These deficits were also observed by Grant et al.[6] In this study, patients with SUDs displayed markedly impaired performance on the Gambling Task, which examines decisions that result in long-term losses that exceed short-term gains. However, patients with SUDs performed similarly to controls on the Wisconsin Card Sorting Test, which evaluates the ability to form abstract concepts and to shift from established response sets.

MacDonald et al[7] used a laboratory experiment and 2 field studies to test the hypothesis that alcohol affects attitudes and intentions toward drinking and driving. Their findings support the concept that alcohol intoxication decreases cognitive capacity such that people are more likely to attend to only the most salient cues.[7]

Whether the impairment documented in such studies is a contributing factor in addiction or is a result of addiction remains uncertain. While individuals with SUDs may have some level of impairment in decision-making in general, particularly in regard to their substance use, their decisional capacity on specific clinical decisions should be assessed carefully. In a study of 300 consecutive psychiatric consultations for decisional capacity at an urban hospital, Boettger et al[8] found that 41% were related to SUDs. Of these, 37% were found to have impaired decisional capacity.

Impaired decision-making in patients with SUDs may specifically pertain to choices related to their addiction, including[9]:

- consent for addiction treatment
- consistency in maintaining a choice of recovery
- changing values regarding treatment over time
- capacity to participate in addiction research involving the use of addictive substances.

It is important to recognize that this impairment may not necessarily translate into altered decisional capacity regarding

other health care decisions, such as consenting to surgery or other necessary medical interventions.[9]

Substance-related disorders that affect decisional capacity

Substance-related syndromes can affect mood, reality testing, and/or cognitive function, thereby directly impacting a patient's decisional capacity. Substance-related syndromes can be divided into 2 categories: 1) disorders resulting from the direct effects of the substance, and 2) secondary disorders resulting from/or associated with substance use.

Disorders resulting from the direct effects of the substance

Temporary/reversible incapacitation

• **Acute intoxication or intoxication delirium** may be the most frequent type of temporary incapacitation. It can result from toxic levels of licit or illicit substances; alcohol is likely the most frequent offending agent. Although some individuals who are intoxicated may appear to be alert, oriented, and able to engage in lengthy conversations, the majority do not possess adequate decisional capacity.[10]

• **Withdrawal delirium**, associated with long-standing alcohol, sedative-hypnotic, or barbiturate dependence, is typically prolonged, but usually resolves, either spontaneously or with treatment. Although most deliria resolve once the underlying etiology is corrected, vulnerable individuals may experience irreversible cognitive impairment and permanent decisional incapacitation.[11,12]

• **Severe substance-induced depressive disorders**, especially if accompanied by frank psychotic symptoms or severe depressive distortions of reality, may result in decisional incapacity. Substance abuse treatment that incorporates multiple strategies, sometimes in conjunction with pharmacotherapy to manage depression, should lead to sufficient recovery and restoration of decisional capacity.

• **Transient psychotic disorders** such as those associated with the use of stimulants are often treatable. Patients may recover decisional capacity spontaneously or with treatment.

Permanent incapacitation

• **Dementia** is associated with substance use, particularly alcohol use.[13] For a patient who develops dementia, no appreciable recovery can be expected, even with prolonged abstinence.

• **Persistent amnestic disorders** (eg, Korsakoff syndrome) resulting from undiagnosed or untreated severe thiamine deficiency (Wernicke's encephalopathy). Although an isolated Korsakoff syndrome consists primarily of anterograde amnesia, these patients may experience additional cognitive impairment resulting from years of alcohol consumption or associated with other neurodegenerative processes, and therefore are sufficiently impaired and lack decisional capacity. Even in the absence of such concomitant cognitive deficits, a very severe anterograde amnestic disorder directly impacts a patient's capacity to perform the necessary tasks required to give informed consent. The inability to consolidate information about new medical developments, treatments, and procedures, even when they are thoroughly explained by the medical team, can pose serious challenges. For example, a patient may protest to being taken to surgery because he/she does not recall signing a consent form the previous day.

• **Enduring severe and treatment-refractory psychotic disorders** associated with drug use, specifically stimulants, can result in permanent incapacitation similar to that seen in severe primary psychotic disorders (such as treatment-resistant schizophrenia).

Secondary disorders resulting from/or associated with substance use

• **Hepatic encephalopathy** may be seen in patients with advanced cirrhosis of the liver (due to hepatitis C resulting from IV drug use, and/or alcohol use). In late stages of cirrhosis, the confusional state patients experience may become severe and may no longer be reversible unless liver transplantation is available and successful. This would therefore constitute a basis for permanent decisional incapacitation.

continued

Clinical Point

Serious cognitive impairment can often be concealed by a superficially jovial or verbally skilled patient

Decisional capacity and SUDs

Clinical Point

It is critical to perform a cognitive evaluation and mental status examination in a medically compromised patient with an SUD

Box

Decisional capacity, substance use disorders, and the law

The legal system rarely views patients with substance use disorders (SUDs) as lacking decisional capacity in the absence of overt psychiatric or cognitive deficits. The penal system offers little if any mitigation of liability on account of addiction in civil or criminal cases. On the contrary, intoxication is an aggravating factor in such settings. Despite extensive literature that questions the "free will," accountability, and responsibility of patients with SUDs, the legal system takes an "all-or-none" approach to this issue. It assumes free choice and accountability for patients with SUDs, except when a clear superimposed psychiatric or cognitive disorder (such as psychosis or dementia) exists. Rarely, some jurisdictions may allow for mental health commitments on account of severe and persistent addictive behaviors that clearly pose a risk to the individual or to society, implicitly recognizing that incapacitation can result from severe addiction. Nevertheless, a finding of imminent or impending dangerousness is generally required for such commitments to be justified.

In other situations, individual health care settings may resort to local hospital policies that allow impaired patients with SUDs with a clearly altered mental status to be detained for the purpose of completing medical treatment. Presumably, discharge would occur when the medical and psychiatric acuity has resolved (often under the umbrella of a "Medical Hold" policy). Jain et al[14] suggested that although such commitment laws for patients with SUDs may be appealing to some people, especially family members, specific statutes and their implementation are highly variable; the deprivation of liberty raises ethical concerns; and outcome data are limited. Conversely, most states either do not have such legislation, or rarely enforce it.

- **Human immunodeficiency virus encephalitis or dementia** can result from IV drug use.

Clinical challenges

In intensive care settings, where a patient with a SUD may be treated for acute life-threatening intoxication or severe withdrawal delirium, an assumption of decisional incapacitation often exists as a result of medical acuity and impaired mentation. In these situations, treatment usually proceeds with consent obtained from next-of-kin, a guardian, or an administrative (hospital) authority when other substitute decision makers are unavailable or unwilling. In such cases, psychiatric consultation can play a dual role in documenting the patient's decisional capacity and also in contributing to the care of patients with SUDs.

It is critical to perform a cognitive evaluation and mental status examination in a medically compromised patient with an SUD. Unfortunately, serious cognitive disorders can often be concealed by a superficially jovial or verbally skilled patient, or by an uncooperative individual who refuses to engage in a thorough conversation with his/her clinicians. These scenarios present significant challenges and may result in missed opportunities for care or premature discharges. Negative countertransference by clinicians toward patients with SUDs may also promote poor outcomes. For difficult cases, legal and ethical consultations may help mitigate risk and guide management approaches (***Box***[14]).

How to assess decisional capacity

A direct conclusion of incapacity in an individual cannot be determined solely on the knowledge of the patient having a SUD-related clinical condition. (The possible exception to this may be a patient with severe dementia.) Evidence suggests that clinicians must conduct a specific assessment to determine the severity of the psychiatric or cognitive impairment and whether it directly impacts a patient's ability to:

- understand the decision at hand
- discuss its benefits and risks
- describe alternatives
- demonstrate an appreciation of the implications of treatment or lack thereof
- communicate a clear and consistent choice.

While most clinicians rely on a psychiatric interview (with or without a cognitive examination) to make these determinations, several instruments have been developed to aid these evaluations, such as the

MacArthur Competence Assessment Tool for Treatment (Mac-CAT-T).[15] In patients with potentially reversible incapacitating conditions, serial examinations over time, especially re-evaluation when a patient has achieved and maintained sobriety, may be necessary and helpful.

The ***Table*** offers a guide to assessing decisional capacity in a patient with an SUD.

Table

How to assess decisional capacity in a patient with an SUD

Clarify the specific question for which the patient's decisional capacity must be assessed
Ensure the patient has been duly informed of his/her clinical condition by the treating team and presented in relevant terms with treatment options, including alternatives and risks of no treatment
Conduct a thorough psychiatric assessment and establish the presence or absence of any additional psychiatric disorders beyond the SUD
Perform a cognitive examination, determining the presence or absence or cognitive impairment. Consider mental status fluctuations by carefully reviewing other clinicians' observations in the hours or days preceding your examination
Review medical conditions, vitals, laboratory workup, and all administered medications in order to track factors that could be impacting the patient's mental state
Determine the extent to which the patient is capable of understanding his/her condition, appreciating the impact of treatment or lack thereof, reasoning through the available information, and consistently communicating a choice in this regard

SUD: substance use disorder

Who should conduct the assessment?

Mental health professionals—usually psychiatrists or psychologists—are consulted when there is uncertainty about a patient's decisional capacity, and when a more thorough mental status examination is warranted to formulate an informed opinion.[16] Unfortunately, this typically occurs only if a patient refuses treatment or demands to be discharged before treatment has been completed, or there is a high level of risk to the patient or others after discharge.

In acute settings, when a patient consents to treatment, a psychiatric consultation regarding decisional capacity is rarely requested. While it is often tempting for medical or surgical teams to proceed with an intervention in a cooperative patient who willingly signs a consent form without a formal assessment of his/her decisional capacity, doing so raises challenging ethical and legal questions in the event of an adverse outcome. It is therefore prudent to strongly recommend that medical and surgical colleagues obtain a psychiatric consultation when an individual's decisional capacity is uncertain, especially when a patient is known to have a psychiatric or neurocognitive disorder, or exhibits evidence of recent mental status changes. In cases of potentially reversible impairment (eg, delirium, psychosis, or acute anxiety), targeted interventions may help restore capacity and allow treatment to proceed.

No jurisdictions mandate that the determination of decisional capacity should be made exclusively by a mental health professional. Any treating health care professional (usually the attending physician) can make a determination of decisional capacity in scenarios where there is no overt evidence the patient has a mental or cognitive disorder and the patient is communicating clear and reasoned choices, or when a patient is profoundly impaired and no meaningful communication can take place.

CASE CONTINUED

The emergency physician requests a psychiatric consultation. You assess Ms. B's decisional capacity using the Mac-CAT-T along with a standard psychiatric evaluation. Her score of 14 reflects that she is able to understand the risks associated with her opioid use, and although irritated by engaging in such a discussion, is capable of reasoning through the various medical and psychosocial aspects of her addiction, and shows moderate appreciation of the impact of her choices on her future and that of significant others. The psychiatric evaluation fails to elicit any substantial mood, anxiety, or psychotic disorders associated with/or resulting from her addiction, and her cognitive examination is within normal limits. She does

Current PSYCHIATRY
MDedge.com/psychiatry

Clinical Point

In cases of potentially reversible impairment, targeted interventions may help restore capacity and allow treatment to proceed

Decisional capacity and SUDs

Clinical Point

Primary or secondary conditions related to substance use can affect a patient's decisional capacity

Related Resources

- Tan SY. Determining patients' decisional capacity. Clinical Psychiatry News. https://www.mdedge.com/psychiatry/article/137939/practice-management/determining-patients-decisional-capacity. Published May 10, 2017.
- Sorrentino R. Performing capacity evaluations: What's expected from your consult. Current Psychiatry. 2014;13(1):41-44.

Drug Brand Names

Alprazolam • Xanax
Naloxone nasal spray • Narcan

not exhibit severe withdrawal and is not delirious on examination. Finally, she did not harbor thoughts of intentional harm to self or others and is not deemed imminently dangerous.

You document that in your opinion, despite Ms. B's unfortunate choices and questionable judgment, she does have the capacity to make informed decisions regarding her care and could be released against medical advice if she so chooses, while providing her with information about available resources should she decide to seek rehabilitation in the future.

An increasingly common scenario

Decisional capacity assessment in patients with SUDs is an increasingly common reason for psychiatric consultations. Primary and secondary conditions related to substance use can affect a patient's decisional capacity on a temporary or permanent basis. The same principles that guide the assessment of decisional capacity in patients with other psychiatric or cognitive disorders should be applied to compromised individuals with SUDs. In challenging cases, a skilled psychiatric evaluation that is supported by a thorough cognitive examination and, when required, complemented by a legal or ethical consultation, can help clinicians make safe and judicious decisions.

References

1. Karlawish K. Assessment of decision-making capacity in adults. UpToDate. https://www.uptodate.com/contents/assessment-of-decision-making-capacity-in-adults. Updated July 2019. Accessed August 19, 2019.
2. Owens PL, Mutter R, Stocks C. Mental health and substance abuse-related emergency department visits among adults, 2007. HCUP Statistical Brief #92. https://www.ncbi.nlm.nih.gov/books/NBK52659/pdf/Bookshelf_NBK52659.pdf. Published July 2010. Accessed August 19, 2019.
3. Smothers BA, Yahr HT. Alcohol use disorder and illicit drug use in admissions to general hospitals in the United States. Am J Addict. 2005;14(3):256-267.
4. Jeste DV, Saks E. Decisional capacity in mental illness and substance use disorders: empirical database and policy implications. Behav Sci Law. 2006;24(4):607-628.
5. Bechara A, Damasio H. Decision-making and addiction (part I): impaired activation of somatic states in substance dependent individuals when pondering decisions with negative future consequences. Neuropsychologia. 2002;40(10):1675-1689.
6. Grant S, Contoreggi C, London ED. Drug abusers show impaired performance in a laboratory test of decision making. Neuropsychologia. 2000;38(8):1180-1187.
7. MacDonald TK, Zanna MP, Fong GT. Decision making in altered states: effects of alcohol on attitudes toward drinking and driving. J Pers Soc Psychol. 1995;68(6):973-985.
8. Boettger S, Bergman M, Jenewein J, et al. Assessment of decisional capacity: prevalence of medical illness and psychiatric comorbidities. Palliat Support Care. 2015;13(5):1275-1281.
9. Charland LC. Chapter 6: Decision-making capacity and responsibility in addiction. In: Poland J, Graham G. Addiction and responsibility. Cambridge, MA: MIT Press Scholarship Online; 2011:139-158.
10. Martel ML, Klein LR, Miner JR, et al. A brief assessment of capacity to consent instrument in acutely intoxicated emergency department patients. Am J Emerg Med. 2018;36(1):18-23.
11. MacLullich AM, Beaglehole A, Hall RJ, et al. Delirium and long-term cognitive impairment. Int Rev Psychiatry. 2009;21(1):30-42.
12. Pandharipande PP, Girard TD, Jackson JC, et al. Long-term cognitive impairment after critical illness. N Engl J Med. 2013;369(14):1306-1316.
13. Rehm J, Hasan OSM, Black SE, et al. Alcohol use and dementia: a systematic scoping review. Alzheimers Res Ther. 2019;11(1):1.
14. Jain A, Christopher P, Appelbaum PS. Civil commitment for opioid and other substance use disorders: does it work? Psychiatr Serv. 2018;69(4):374-376.
15. Grisso T, Appelbaum PS. Chapter 6: Using the MacArthur competence assessment tool – treatment. In: Grisso T, Appelbaum PS. Assessing competence to consent to treatment: a guide for physicians and other health professionals. New York, NY: Oxford University Press; 1998:101-126.
16. Hazelton LD, Sterns GL, Chisholm T. Decision-making capacity and alcohol abuse: clinical and ethical considerations in personal care choices. Gen Hosp Psychiatry. 2003;25(2):130-135.

Bottom Line

Assessing the decisional capacity of a patient with a substance use disorder can be challenging. Primary or secondary conditions related to substance use can affect a patient's decisional capacity on a temporary or permanent basis. A skilled psychiatric evaluation that includes a thorough cognitive examination and is complemented by legal or ethical consultation can help in making judicious decisions.