

Evaluating older adults' capacity and need for guardianship

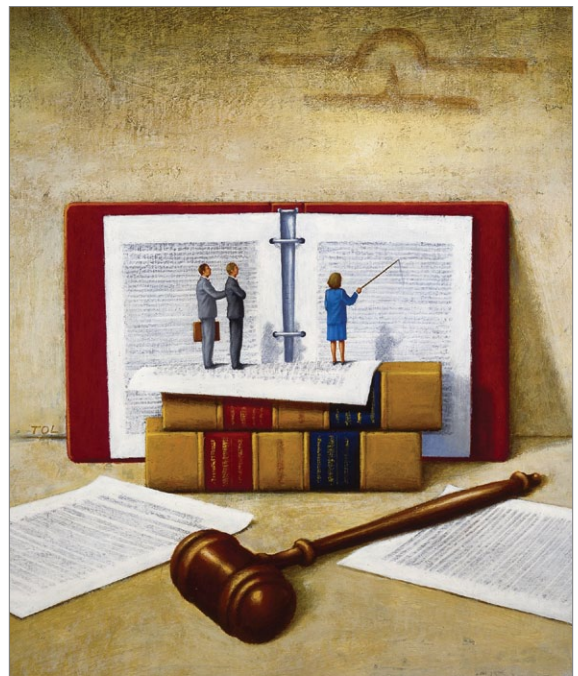
10 steps to ensure your assessments are thorough, accurate, and fair

Although forensic psychiatrists typically are consulted in complex legal matters, geriatric, consultation-liaison, and general psychiatrists are on the front lines of assessing capacity to give informed consent and need for guardianship. Psychiatrists often find such consultations daunting because residency training usually includes little to no formal training in performing psycho-legal assessments. Evaluating issues such as decision-making capacity, guardianship, and capacity to give informed consent requires a delicate balance between autonomy and beneficence. This article reviews 4 common legal issues in geriatric consultation—capacity evaluations, informed consent, guardianship, and elder abuse—and suggests a systematic approach to psycho-legal consultations in older adults.

Confidentiality and dual agency

Every psychiatrist should be familiar with basic principles of medical ethics as well as key aspects of local mental health law. Relevant ethical principles include autonomy, beneficence, confidentiality, and dual agency. A review of all these ethical issues is beyond the scope of this article, so here I highlight confidentiality and dual agency.

Confidentiality—the clinician's obligation not to disclose private medical information—is a legal as well as an ethical requirement. A psychiatrist who performs a psycho-legal evaluation must disclose to the patient the purpose of the evaluation, that a report will be prepared, and to whom it will be submitted. Exceptions to confidentiality include medical emergencies, mandatory reporting of abuse and infectious diseases, and the duty to protect (warning police



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Sherif Soliman, MD

Assistant Clinical Professor
Department of Psychiatry
Case Western Reserve University
Cleveland, OH
Northcoast Behavioral Healthcare
Northfield, OH



Psycho-legal evaluations

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‘Capacity’ refers to a patient’s ability to perform a specific task, and may be determined clinically



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Table 1

Criteria of 3 specific capacities

Capacity	Criteria
Capacity to give informed consent	<ul style="list-style-type: none"> Understand nature of illness and treatment Understand risks and benefits of treatment Understand treatment alternatives Understand risk of refusing treatment
Testamentary capacity	<ul style="list-style-type: none"> Understand that he/she is making a will Know the nature and extent of their property Understand the “natural objects” of their bounty and their claims upon them
Contractual capacity	<ul style="list-style-type: none"> Understand the transaction Act in a reasonable manner

Source: References 2-4

and the intended victim when a patient makes a threat).

Dual agency or dual role refers to serving as both a treating physician and a forensic evaluator. Although it is ideal to avoid serving in a dual role, sometimes it is impractical or impossible to avoid doing so, such as in guardianship or civil commitment evaluations, or in state forensic hospitals. In such cases, the psychiatrist must be aware of potential conflicts between clinical and forensic evaluations. A treating psychiatrist primarily serves his or her patient’s best interest, whereas a forensic psychiatrist primarily seeks truth.¹ A treating psychiatrist is at risk of consciously or unconsciously biasing his or her psycho-legal evaluation in favor of or against the patient/litigant, depending upon the psychiatrist’s countertransference. Further, performing a psycho-legal evaluation can cause problems in ongoing treatment. A psychiatrist who testifies that his or her fiercely independent patient needs a guardian or nursing home placement will experience significant challenges in continuing to work with that patient.

4 common issues for older adults

Decision-making capacity. Although “capacity” and “competence” often are used interchangeably, “capacity” broadly refers to the ability to perform a specific task, whereas “competence” refers to the legally defined standard for performing a specific

task such as making a will. “Competence” is legally determined, whereas “capacity” may be determined clinically.

Capacity usually is task-specific rather than a general construct. The existence of physical or mental illness per se does not mean that a patient lacks capacity. Rather, capacity is determined by whether an individual has specific abilities, regardless of diagnosis. Specific capacities include the ability to give informed consent, manage finances, make a will, or enter into contracts (*Table 1*).²⁻⁴ Appelbaum and Gutheil describe 4 components for assessing specific capacity:

- communication of a choice
- factual understanding of the issues
- appreciation of the situation and its consequences
- rational manipulation of information.^{5,6}

Ability to communicate a choice refers to a patient’s ability to express his or her wishes in a reasonably stable manner. Factual understanding of the issues refers to an individual’s ability to understand the relevant facts before making a decision. Appreciation of the situation and its consequences refers to a person’s ability to rationally understand the effect of decisions. Appreciation is a higher level of understanding than mere factual understanding—eg, a delusional patient who believes himself immortal may intellectually understand that a surgical procedure carries a 50% mortality risk, but may be unable to appreciate the information as it relates

to him because he believes he is immortal. Rational manipulation of information refers to a patient's reasoning process and how the patient integrates data into his or her decision-making process.⁵

Informed consent. In my experience, capacity to give informed consent is the most commonly requested specific capacity assessment in general medical settings. Informed consent must be knowing, voluntary, and competent. All material information—information that would cause a reasonable person to accept or reject a proposed treatment—should be communicated to the patient. Informed consent requires an understanding of the patient's condition and indication for treatment, risks and benefits of and alternatives to treatment, and risks of declining treatment.^{2,3} Exceptions to informed consent include incompetence, medical emergencies, patient waiver of informed consent, and a limited therapeutic privilege (when a physician determines that the information would harm the patient).³

Several instruments can help clinicians assess patients' capacity to give informed consent. The benefits of using a structured instrument include:

- ensuring that specific information is covered during each evaluation
- systematically recording a patient's response.⁵

Disadvantages of using instruments include the fact that no instrument can take into account all aspects of a particular case, and some instruments are time-consuming and require training. Structured instruments can be a useful adjunct to the clinical interview in some cases, but should not substitute for it. In a review of 23 instruments for assessing decisional capacity to consent to treatment or clinical research, the MacArthur Competence Assessment Tool for Clinical Research and the MacArthur Competence Assessment Tool for Treatment had the most empirical support, although the authors noted that other instruments might be better suited to specific situations.⁷

Psychiatrists may be consulted when a patient refuses treatment or decides to leave the hospital against medical advice.

The key issue in both situations is whether the patient has capacity to refuse treatment.⁸ If there is evidence that the patient is mentally ill and poses an imminent risk of suicide or violence or is unable to provide for his or her basic needs, the psychiatrist should assess whether the patient meets criteria for civil commitment.

Many clinicians employ a "sliding scale" approach to competence, requiring a lower degree of competence for consenting to low-risk, high-benefit interventions and a greater degree of competence for higher-risk procedures.^{5,9} Family members often serve as informal surrogate decision makers for incapacitated patients, except when there is significant family discord or no family members are available.⁵

Guardianship. Guardians are appointed by courts to make decisions for individuals who have been found incompetent (wards). Although its purposes are beneficent, the guardianship system could do significant harm.¹⁰ Determining that an individual is incompetent is tantamount to depriving him or her of basic personhood. In many cases, the ward loses the ability to consent to or refuse medical care, manage his or her finances, enter into contracts, marry, and determine where he or she will live. On the other hand, failing to recognize incompetence can leave a vulnerable person in danger of physical deterioration, abuse, neglect, or exploitation.

It is critical that guardianship evaluations be conducted carefully. In a review of 298 guardianship cases from 3 states, Moye and colleagues¹¹ found that the quality of the reports was significantly better in Colorado, a state with guardianship reforms, but documentation of functional strengths and weaknesses was "particularly rare" in guardianship evaluations and prognosis often was not included. This information is relevant to judges, who need to determine which areas of function are impaired and how long the impairment is likely to last.

Guardianship evaluations often focus on general rather than specific capacity. In other words, often there is not a specific task such as consenting to surgery that the

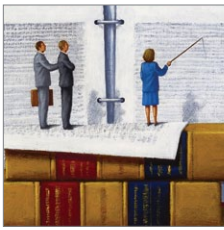
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A structured instrument can help you assess a patient's capacity to give informed consent

See this article at

CurrentPsychiatry.com

for a case study that illustrates a psycho-legal evaluation



Psycho-legal evaluations

Clinical Point

Identifying the legal issues and standards that apply to your patient's case will help focus your evaluation

Table 2

Signs of elder abuse: What to wlook for

Type of abuse Signs

Type of abuse	Signs
Physical	Bruises, burns (especially circular, suggesting cigarette burns), slap marks
Sexual	Unexplained sexually transmitted diseases, bruises in genital area, breasts, or anal area
Emotional	Withdrawal, new-onset depression
Financial	Sudden loss of property, unusual increase in spending, checks paid in large, round numbers, checks marked as gifts or loans
Neglect	Malnutrition, lack of medical care, poor hygiene, pressure ulcers

Source: Reference 13

alleged incompetent person needs to perform. Rather, the question is whether an individual can manage his or her finances or make treatment decisions in general. Appelbaum and Gutheil suggest considering 6 factors when assessing general capacity:

- awareness of the situation
- factual understanding of the issues
- appreciation of the likely consequences
- rational manipulation of information
- functioning in one's environment
- extent of demands on patient.⁵

The first 4 are closely related to the elements of specific capacity described above. Functioning in one's environment and extent of demands on the patient attempt to anticipate the tasks that an individual will need to perform. A patient with mild dementia may be unable to manage a complex estate but can handle a bank account and a fixed income. Similarly, it is important to consider the patient's support system. An impaired patient may function adequately with his wife's help but may lose the capacity to live independently if his wife dies or becomes impaired.

Traditionally, guardianship has resulted in a complete loss of decision-making ability. Several state legislatures have passed laws allowing for limited guardianship, although orders for limited guardianship remain underutilized.¹⁰ Limited guardianship delineates specific areas of incompetence and limits the guardian's decision-making authority to those areas while leaving intact the ward's ability to make all other decisions for himself or herself.

The use of less-restrictive alternatives to

guardianship—such as powers of attorney, durable powers of attorney, living wills, payees, and trusts—is increasing. A power of attorney allows a patient to authorize a specific individual to act on his or her behalf. The scope of the power of attorney can be limited, such as to manage finances or even to a specific transaction, such as selling a home or car. A durable power of attorney also allows an agent to make decisions on the patient's behalf but becomes active only when the patient becomes incompetent. It often is used to appoint an individual to make medical decisions on behalf of an incompetent patient. Living wills allow patients to determine what treatment they would like in the event they become incompetent.

Elder abuse. An estimated 1 to 2 million adults age >65 have been abused, exploited, or neglected.¹² Elder abuse includes physical abuse, neglect, emotional abuse, sexual abuse, and financial exploitation (including undue influence). Most states have mandatory reporting of elder abuse, although they vary regarding who must report and what the report must entail. Psychiatrists should be vigilant in looking for signs of elder abuse (Table 2),¹³ regardless of the reason for the consult.

10 tips for thorough evaluations

1. Consider the context of the consultation. This includes medical factors (such as the patient's condition, prognosis, relationship with the treatment team, and recommended course of treatment), legal factors (eg, pending litigation and relevant

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concerns arise. Human milk-feeding should be discontinued in infants with lamotrigine toxicity. Caution should be exercised when LAMICTAL is administered to a nursing woman.

8.4 Pediatric Use: LAMICTAL is indicated for adjunctive therapy in patients ≥ 2 years of age for partial seizures, the generalized seizures of Lennox-Gastaut syndrome, and primary generalized tonic-clonic seizures.

Safety and efficacy of LAMICTAL, used as adjunctive treatment for partial seizures, were not demonstrated in a small randomized, double-blind, placebo-controlled, withdrawal study in very young pediatric patients (1 to 24 months of age). LAMICTAL was associated with an increased risk for infectious adverse reactions (LAMICTAL 37%, placebo 5%), and respiratory adverse reactions (LAMICTAL 26%, placebo 5%). Infectious adverse reactions included: bronchiolitis, bronchitis, ear infection, eye infection, otitis externa, pharyngitis, urinary tract infection, and viral infection. Respiratory adverse reactions included nasal congestion, cough, and apnea.

Safety and effectiveness in patients below the age of 18 years with Bipolar Disorder has not been established.

8.5 Geriatric Use: Clinical studies of LAMICTAL for epilepsy and in Bipolar Disorder did not include sufficient numbers of subjects 65 years of age and over to determine whether they respond differently from younger subjects or exhibit a different safety profile than that of younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

8.6 Patients With Hepatic Impairment: Experience in patients with hepatic impairment is limited. Based on a clinical pharmacology study in 24 patients with mild, moderate, and severe liver impairment [see *Clinical Pharmacology* (12.3) of full prescribing information], the following general recommendations can be made. No dosage adjustment is needed in patients with mild liver impairment. Initial, escalation, and maintenance doses should generally be reduced by approximately 25% in patients with moderate and severe liver impairment without ascites and 50% in patients with severe liver impairment with ascites. Escalation and maintenance doses may be adjusted according to clinical response [see *Dosage and Administration* (2.1) of full prescribing information].

8.7 Patients With Renal Impairment: Lamotrigine is metabolized mainly by glucuronic acid conjugation, with the majority of the metabolites being recovered in the urine. In a small study comparing a single dose of lamotrigine in patients with varying degrees of renal impairment with healthy volunteers, the plasma half-life of lamotrigine was significantly longer in the patients with renal impairment [see *Clinical Pharmacology* (12.3) of full prescribing information].

Initial doses of LAMICTAL should be based on patients' AED regimens; reduced maintenance doses may be effective for patients with significant renal impairment. Few patients with severe

renal impairment have been evaluated during chronic treatment with LAMICTAL. Because there is inadequate experience in this population, LAMICTAL should be used with caution in these patients [see *Dosage and Administration* (2.1) of full prescribing information].

10 OVERDOSAGE

10.1 Human Overdose Experience: Overdoses involving quantities up to 15 g have been reported for LAMICTAL, some of which have been fatal. Overdose has resulted in ataxia, nystagmus, increased seizures, decreased level of consciousness, coma, and intraventricular conduction delay.

10.2 Management of Overdose: There are no specific antidotes for lamotrigine. Following a suspected overdose, hospitalization of the patient is advised. General supportive care is indicated, including frequent monitoring of vital signs and close observation of the patient. If indicated, emesis should be induced; usual precautions should be taken to protect the airway. It should be kept in mind that lamotrigine is rapidly absorbed [see *Clinical Pharmacology* (12.3) of full prescribing information]. It is uncertain whether hemodialysis is an effective means of removing lamotrigine from the blood. In 6 renal failure patients, about 20% of the amount of lamotrigine in the body was removed by hemodialysis during a 4-hour session. A Poison Control Center should be contacted for information on the management of overdose of LAMICTAL.



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legal standards for issues such as guardianship), and psychosocial issues (eg, the patient's current support structure and family conflicts).

2. Identify the legal issue and any relevant legal standards. The legal standard will inform you of the issues you need to address in the evaluation. If an attorney has consulted you, ask him or her to provide the legal standard.

3. Gather relevant collateral information, which may include interviews with family members or a review of financial or medical records.

4. Explain the purpose of the examination and the limits of confidentiality.

5. Perform a focused psychiatric evaluation, paying special attention to cognitive functioning, reasoning, and unusual thought content such as delusional beliefs.

6. Perform an interview specific to the referral issue.

7. Consider using a relevant assessment instrument.

8. Consider psychological testing, laboratory testing, imaging, or further medical evaluation. These assessments can help determine the diagnosis, the cause of any deficits in capacity, and whether any deficits are reversible.

9. Determine what opinions you are able to render. Limit opinions and remember that it may be appropriate to decline to address certain issues if there is insufficient information or if the issue is outside your area of expertise.

10. Prepare a written report. Consider the audience. Minimize the use of medical jargon and define all medical terms. State your opinions clearly and with reasonable medical

certainty (in most jurisdictions, this means more likely than not). State the basis for all opinions.

For a case study that provides an example of a psycho-legal evaluation of a geriatric patient, see this article at CurrentPsychiatry.com.

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Related Resources

- American Academy of Psychiatry and the Law. www.aapl.org.
- American Bar Association Commission on Law and Aging. www.americanbar.org/groups/law_aging.html.
- National Center on Elder Abuse. www.ncea.aoa.gov.

Disclosure

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Clinical Point

It may be appropriate to decline to address certain issues if you lack information or the issue is outside your area of expertise

Bottom Line

Psychiatrists who care for geriatric patients must be familiar with common legal issues such as decision-making capacity, informed consent, guardianship, and elder abuse. A systematic approach to these evaluations includes identifying relevant legal standards, performing an interview specific to the patient's legal issue, and considering using an assessment instrument and additional psychological and medical testing.

Case study: Unfaithfully yours?

Mr. A, age 75, recently started taking a dopaminergic agonist to treat Parkinson's disease. He says he wants to divorce his wife of 35 years because of "scandalous affairs" she allegedly engaged in. His wife reports that he has been accusing her of having affairs with various men, including a man who recently painted their house.

On evaluation, Mr. A's Mini-Mental State Examination score is 30/30. He has no signs of depression and his sleep patterns have not changed. There have been no changes in his spending patterns, although he no longer gives his wife money for grocery shopping, telling her to get money from her "boyfriends." He is adamant about this decision, saying, "It's my money and I can do with it as I please. This is still a free country, isn't it?"

He says he has \$70,000 in his individual retirement account, \$20,000 in his bank account, and receives a pension of \$1,785 per month. He estimates that his home is worth \$200,000. His financial records essentially are consistent with his reports. He is able to perform basic calculations without difficulty and is aware of his monthly expenses. He describes his relationship with his wife by saying, "It was fine until she started screwing around."

When asked about the likely consequences of his decision, he shrugs and says, "I guess she'll have to get money from her boyfriends. I don't really care who she sees as long as they stay away from me." He denies having thoughts of harming his wife or her alleged "boyfriends."

He recognizes that his wife might divorce him, leaving him alone.

When I ask Mr. A if it is possible he is mistaken in his belief that his wife is having affairs, he says, "No, doctor. You don't know her." When I ask how he knows she is having affairs, he says that the painter started looking at him "funny" and that the busboy at a restaurant they frequent called his wife "dear." He believes his wife is having sexual relations with both of these men.

Does Mr. A require a guardian? I opine that Mr. A requires a guardian of estate (to manage his property) but not a guardian of person because he is capable of making decisions about his medical care and other personal decisions. He is failing to care for his wife because of his delusional jealousy. Although cognitively intact, he is unable to appreciate the consequences of his actions or rationally manipulate information because of his delusional thinking. He believes he is "cutting off" an unfaithful spouse when, in fact, there is no evidence that she has been unfaithful. His inability to rationally manipulate information is demonstrated by the fact that he uses innocuous facts such as a busboy calling his elderly wife "dear" to support his delusion that she was having affairs.

I note that his psychosis is reversible because it is likely due to his antiparkinsonian regimen. However, he declines both a dose reduction in his medication and antipsychotic treatment. I note that should his psychosis resolve, he may regain financial decision-making capacity.