

The Complexities of Cognitive Capacity

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People often assume that understanding mental capacity is simple and straightforward and that "measuring" cognitive abilities can be quickly accomplished. Actually, mental capacity is complex, multidimensional, and affected by many factors. People can be mentally incapacitated for a multitude of reasons, including cognitive impairment, psychosis, alcoholism, and severe developmental disabilities. *This TA Brief will specifically address the APS role in screening for lack of capacity due to cognitive impairment.*



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Ethical issues abound, including the essential duty to "do no harm" (see NAPSA Code of Ethics, 2002). Appropriate APS action or lack thereof inevitably depends upon whether or not the client in question has the ability to make informed decisions and consent to services. When a client lacks capacity and is at risk due to the actions of self or others, documentation of that person's limitations and an incapacity court ruling can facilitate APS prevention services to increase client safety. However, there are documented cases in which older adults have been unfairly judged to lack mental capacity and have inappropriately lost civil rights. Similarly, assuming that an APS client has capacity when that person does not can result in significant harm, including life-threatening situations. All professionals serving vulnerable adults carry a heavy responsibility to avoid premature and unsupported conclusions regarding a client's cognitive abilities.

APS administrators must insure that their staff is trained in the complexities of mental capacity, cognitive screening procedures and pitfalls, and the need to avoid inaccurate assumptions or conclusions regarding clients' abilities. Case-workers screen for cognitive loss when assessing client functioning, safety, and risks. However, workers are not trained to conduct capacity assessments due to the complexity of the task and the required materials, supervised testing experience, and credentials.

The NAPSRC provides monthly Technical Assistance (TA) Calls for state APS administrators on challenging subjects identified by them. The TA is designed to increase APS effectiveness in the secondary prevention of violence against older and vulnerable adults. This brief summarizes the information provided during the call on April 24, 2014.

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Critical decisions hinge on capacity, including emergency decisions, therefore caseworkers must understand: a) what mental capacity involves, b) indicators of cognitive loss, c) effective strategies for gathering and documenting capacity information, and d) indicated next steps when clients are in danger due to limited capacity. APS workers must also understand how their state law specifically defines capacity and practice accordingly.

Mental capacity is an evolving clinical and legal concept. Legally, one is or is not competent. All adults are presumed mentally competent unless and until a court having jurisdiction declares one incompetent. Clinically, one may function in the clearly competent range, clearly lack capacity, or function in that murky area of “mild to moderate cognitive loss.” Typically, the most challenging cases involve clients who struggle with cognitive losses while retaining fluctuating or partial abilities.

Mental capacity involves a number of different domains or abilities. Those often at issue in APS cases are a) ability to consent to release of information, investigation, evaluation or treatment procedures; b) capacity to manage finances and make financial decisions; and c) ability to manage Activities and Instrumental Activities of Daily Living. Current thinking is that capacity evaluations should assess specific domains, and that limited court orders should be requested and granted only for impaired domain(s). Professionals who gather and report information regarding an individual’s mental capacity are urged to avoid global descriptions when only limited impairments are present (ABA/ APA, 2008).

Brief one-time tests of cognition can lead to false readings for multiple reasons including the fact that many medical conditions cause temporary confusion and disorientation, including malnutrition, dehydration, illness, injury, trauma, crisis, and grief. Handicaps may also mask capacity. Distinguishing a physical disability, such stroke-related aphasia, from decisional incapacity is essential. Similarly, non-English speaking clients must be distinguished from those unable to converse due to dementia (see Ramsey-Klawnsnik, 2006 for a discussion of these issues).

Cognitive testing informs the capacity evaluation; it does not replace it.

Capacity screening is complex, especially when abilities fluctuate, communication barriers exist, and the screener lacks in-depth training and supervised experience. There are basically three procedures for assessing capacity: (1) interviewing, observing, and interacting with the client; (2) obtaining and analyzing collateral data, and (3) formal capacity evaluation including a clinical interview, functional assessments, review of medical record and/or physical examination with laboratory tests, medical tests of brain functioning, psychiatric evaluation, and cognitive testing that includes neuro-psychological testing. Cognitive testing informs the capacity evaluation; it does not replace it. Doing poorly on cognitive tests does not necessarily indicate incapacitation. Doing well on cognitive testing does not mean one has capacity either as there are causes beyond cognitive deficits that may render one incapacitated.

The most effective APS cognitive screening tool is interviewing, interacting and observing the client. When doing so, it is important to build rapport through non-threatening conversation. Be alert for language, disability, and cultural barriers to effective communication. Consider if the client is in a situation in which he or she can perform up to ability. Avoid forming judgments about cognition when clients are in situations that adversely affect functioning, such as health or personal crises. Consider: *Am I seeing this client at his or her best? Is the functioning displayed typical for this person? Is the client experiencing pain, fear, hunger, or other conditions that adversely affect cognition?*

Home visits provide a wealth of data about an individual's functional ability and cognitive status. Observing the performance of routine task such as opening the mail, taking medication, preparing food, or answering the phone provides essential information. When observing, attend especially to problem-solving abilities – is the individual able to meet his or her basic needs? Consider: Does the client's appearance and functioning suggest that the person is alert; oriented to self, place, and time; able to understand and complete activities of daily living? Use clues in the environment. For example, displayed photos provide opportunity to inquire about those depicted. Does the client recognize them? Can he name them and indicate the relationship? A man who explains that his seven grandchildren are in the photo and proceeds to provide their names and places of residence demonstrates important cognitive skills. Contrast this to a man who seems confused by the photo and guesses that relatives are depicted but is uncertain. "Natural assessments" of this type are less threatening, and often more effective, than brief screening tests. Furthermore, they facilitate rapport and assessing client needs and supports, in addition to cognitive status.

Avoid global conclusions based upon limited data. Observation and interaction over time are necessary for full assessment, especially when disabilities or communication barriers exist. Reliable history and collateral data are essential. Evaluate collateral data being alert for inaccuracies and ulterior motives. Consider: Is collateral data consistent with the caseworker's observations of client functioning? Ask professionals to specifically describe cognitive limitations and to provide relevant diagnoses, dates of diagnoses, medications prescribed, domains affected by the loss, the degree of impairment, functional abilities, and care needs. Request written statements that contain the basis for opinions and describe recommended care plans.

Formal evaluation is warranted when observations and collateral data suggest cognitive loss and safety risks. Payment challenges and lack of available clinicians confront many APS systems. More fortunate locales have established agreements with qualified evaluators. There is no standard test battery for cognitive evaluations. The evaluator must determine appropriate tests to employ. The APA/ABA (2008, p. 7) urges the use of "functional assessments that describe task-specific deficits." Validated, normed, and accepted measures should be employed. The clinician must be qualified, trained, and authorized to administer, score, and interpret tests utilized and must ascertain if hearing loss, fatigue, language differences, and other factors skew the client's performance. When requesting an evaluation, provide relevant background data and the specific domain(s) in question.

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In summary, use caution in drawing conclusions about a client’s mental capacity. Assess at times ideal for the client using multiple methods. Observe and document client statements, appearance, behaviors, home environment, functional abilities, and limitations but avoid premature conclusions or statements regarding the cause of problems observed. Arranging a court-appointed trustworthy decision-maker for clients lacking cognitive ability is important in preventing further maltreatment. Equally important is protecting the rights of those able to make informed decisions. If it appears that clients have been unfairly judged as incompetent, document abilities observed and seek an evaluation of cognitive and functional status.

Quality supervision is essential in cases involving questionable client capacity. Individual cases must be addressed in accordance with ethics, state law, jurisdictional standards of practice, sound professional judgment, and careful consideration of the involved facts. If there are concerns about specific cases, consultation with clinical, legal, or other experts may be needed.

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References

- American Bar Association (ABA) and American Psychological Association (APA). 2008. *Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists*. Washington, DC: ABA and APA.
- NAPSA. (2002). *Adult Protective Services Ethical Principles and Best Practice Guidelines*. National Adult Protective Services Association.
- Ramsey-Klawnsnik, H. (2006). Complexities of mental capacity. *Victimization of the Elderly and Disabled*, 9(1), 1 - 2, 15 - 16.

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