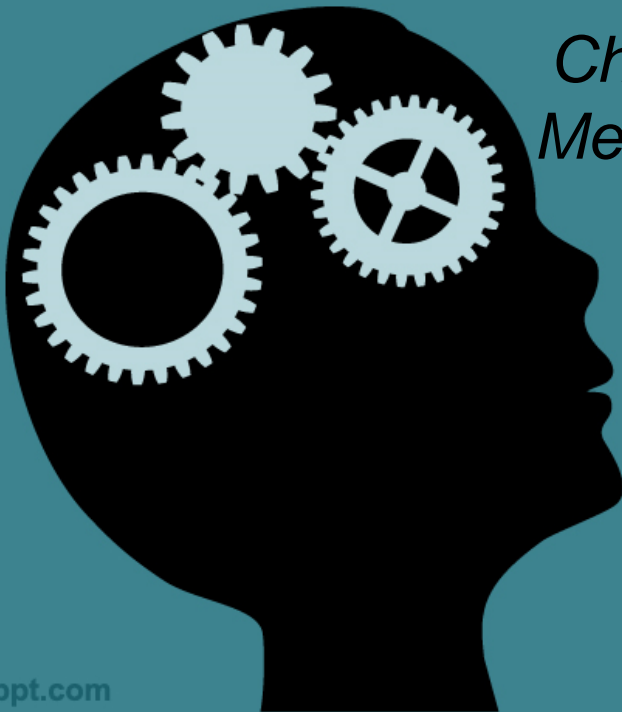


# Beyond Cognition: Guardianship for Functional Incapacity

Cynthia M.A. Geppert, MD, MA, PhD, MPH,  
MSBE, DPS

*Chief Consultation Psychiatry & Ethics New  
Mexico Veterans Affairs Health Care System*



# Objectives



By the end of the presentation the participant should be able to:

1. Distinguish unique aspects of mental health care.
2. Identify common misconceptions regarding the evaluation of decisional capacity.
3. Give examples of functional incapacity.
4. Critically reflect on whether cognitive criteria, while necessary, are sufficient for guardianship.

# Mental Health Care Ethics



- Branch of clinical ethics that relates to the knowledge, skills, and attitudes required for the compassionate and competent care of individuals with mental illness.
- Professionalism of mental health care providers.

# Differences in Mental Health Care: Power



# Police Powers



- Control function of psychiatry.
- Primarily protective of community from madness-induced violence.
- Social validation: “is the patient a danger to himself or others?”
- More legal than clinical.

# Parens Patriae



- Literally “Father of the country or people.”
- Beneficent action to protect those who cannot act in their own best interests.
- Therapeutic rather than protective.
- Political expression of compassion for mental illness.

# The Triumph of Dangerousness



- During the 1970s, the civil rights movement shifted commitment criteria from paternalism to police powers.
- Which is more protective of patients' rights depends on whether mentally ill can make rational and voluntary choices.

# Autonomy/Capacity is Contextual



- Suicidal or homicidal impulses, grave passive neglect, inability to function in the community are generally indication of global loss of self-determination.
- Purpose of involuntary treatment is to restore autonomy so that patient is ironically free to refuse care.



# Myth #1: Competence is Not Capacity



- Competence is a legal term. Decisional capacity is a clinical designation.
- Only a judge or other officer of the court can declare someone incompetent.
- Generally, the determination of competence is made on the basis of a clinician's assessment of a patient's decisional capacity.

# Myth #2: Only a Psychiatrist can Determine Decisional Capacity



- Any physician can make an assessment of a patient's decisional capacity.
- The primary physician is the first choice for making the assessment.
- Psychiatrists and psychologists have no special legal standing to determine "competence."
- Mental health professionals should be consulted on the assessment of capacity only when there is evidence of a mental disorder.

## Myth #3:

# A Person Who is Psychotic or Demented Cannot be Capable



- Numerous studies demonstrate that psychiatric illness impacts aspects of decisional capacity.
- Severely disorganized and demented patients will generally lack meaningful decisional capacity.
- Moderately demented and actively psychotic patients are not *a priori* decisionally incapable.
- Research shows that psychiatric patients can exercise decisional capacity and that their ability can be enhanced.

## Myth #4:

# Decisional Capacity is an all or nothing phenomenon



- Decisional capacity is a spectrum of ability.
- A patient may be unable to make financial decisions, but be able to make medical ones.
- Decisional capacity may fluctuate with the course of illness, treatment, nature of the decision and available social support.
- Thus assessments of decisional capacity also need to be ongoing processes.

# The Ability to Communicate



- A patient is able through verbal or non-verbal means to express his wishes.
- Very sensitive to education, culture and language.
- A patient with schizophrenia is able to converse sensibly that his antipsychotics are not working and he needs to lose weight, but unable to consistently exercise or adhere to medications.

# The Ability to comprehend



- The ability to understand the information presented such as the nature, risks, benefits, alternatives to and outcome of a proposed intervention.
- A depressed patient being consented for ECT is able to repeat the information the clinician, explains in his own words the procedure, what it will do to help him, and possible side effects.

# The capacity to reason



- The ability to rationally manipulate the facts given and arrive at a logical conclusion. The “Spock criterion.”
- A schizophrenic patient with delusions of persecution is able to tell an investigator that he would rather receive a medication that is effective 85% of the time than one that works 15% of the time.



# The capacity to Appreciate



- The ability to make authentic choices which reflect one's life history, culture, religion, values and prior significant decisions.
- A 55-year-old woman with depression, who has been an evangelical Christian, refuses medications because she believes they may change her beliefs, but agrees to counseling.



# Informed Refusal



- The sliding scale standard of capacity:
- As risk of a decision increases and/or benefits decrease, then the standard of determining capacity is more demanding.
- A lower-risk decision thus requires a less rigorous standard of decisional capacity.
- The decision is less complex AND the consequences less serious.

# Sliding Scale of Informed Refusal



## HIGH-RISK

- A 22-year-old man with Schizophrenia who has been victimized on the streets refuses placement in a group home because he believes the owner is in league with the devil.

## LOW-RISK

- A 34-year-old woman with borderline personality disorder who has a stable disability income and housing but has lost several jobs rejects offer of supported employment.

# Voluntarism: The forgotten capacity



- The ability to make free and authentic choices without internal or external coercion which prevents or impedes the exercise of self-determination.
- A veteran with post-traumatic stress disorder refuses a request from his primary care physician to participate in a research study.

# Domains of Voluntarism



## *Developmental Factors:*

Progressive emotional and intellectual maturity of young people to make medical decisions.

## *Illness-related considerations:*

Ambivalence & pessimism of depression, compulsive use & impulsive behaviors in SUD.

*Psychological Issues & cultural and religious values:* Family autonomy in Hispanic, Native American, Asian cultures

## *External Features & Pressures:*

Relationship with caregiver; economic burdens end-of-life care.

# Rationality and Reasoning



- A person can comprehend, yet be irrational.
- Individuals have the right, ethically and legally, to communicate irrational choices against their own best interest.
- Can an individual lack the higher order capacities of reasoning and appreciation and be capable of making high-stakes, great-risk life decisions: safety, medical care?

# Disorders with Partial, Fluctuating Capacity



- Substance-induced persisting dementia
- Substance-induced psychotic disorder
- Schizophrenia (when acute)
- Anorexia nervosa
- Major psychotic depression
- Bipolar (during episodes)
- Severe OCD without insight

# Ethics of Capacity Evaluation



- Should give the patient the best chance of demonstrating capacity (e.g., examine in morning).
- Should ensure capacity not reversible (e.g., B12, delirium).
- Should improve internal capacity if possible (antipsychotics, abstinence)
- Should bolster external capacity if feasible (social support, APS)

# The Hoarder



- Mr. F is a 64-year-old who comes into the emergency department of a local hospital covered in feces, having fallen multiple times in his cluttered house.
- On a screening cognitive examination he scores 28/30.
- His psychiatric assessment suggests obsessive compulsive disorder, hoarding type.



# Is He Capable?



- He has logical explanations for falls: his walker broke.
- The feces are the result of a new puppy and not being able to clean up.
- The neighbor at bedside says he usually is able to take care of himself.



# Disposition?



- The psychiatrist evaluating the patient says he is decisionally capable and not depressed.
- The intern is very upset and says this is grave passive neglect.
- Is it?
- Medically, he has minor problems that respond quickly.
- Social work offers home health care, but patient refuses anyone to come to his home.
- Should APS be called?

# The Drinker



- Mr. B is a 43-year-old who has drunk up to a liter of alcohol a day since he was 11.
- He may have an anxiety disorder, but is not sober long enough to diagnose.
- He is in the hospital for weeks with withdrawal and cirrhosis, during which time incapable due to delirium.
- He tries/wants to leave but neither the hospital nor his parents think he is safe.

# Discharge?



- With weeks of good nursing and medical care, nutrition, lactulose, and SOBRIETY, mentation improves to point patient can be discharged - still guarded capacity.
- Patient can do his own ADLs, so does not meet criteria for nursing home.
- Is not a danger to himself or others, can care for himself with parental help.

# Home



- Mr. B is sober for several months at home with parents and goes to treatment twice.
- He then goes back to his own apartment, relapses for weeks and then comes back to the hospital in similar condition.
- He must consent to enter residential treatment and has broken no laws.
- Under NM mental health code he does not meet criteria for involuntary admission.

**Mr. B's Parents want to become his guardians to keep him from drinking.**



If a guardianship petition was filed, would the judge grant?

# Miss A Doesn't Eat



- Miss A is a 25-year-old college honor student.
- She has had anorexia nervosa since the age of 16.
- She has been repeatedly admitted to the hospital with weights as low as 78 pounds.
- Once she gains enough weight, the hospital must discharge her.

# Miss A



- Miss A has been through and failed numerous outpatient and residential eating disorder programs.
- She has had comprehensive neuropsychological testing which shows she is of high intelligence and has generalized anxiety but no serious or major cognitive impairment.
- She is well-groomed and articulate.



# Should Miss A Have A Guardian?



Miss A eats 1000 calories a day.

She no longer has periods, she has osteoporosis.

She thinks she is fat despite others' view.

She exercises 6 hours a day.

She graduates from college with honors.



# Functional Capacity



- Not grossly incompetent, but subtle impairment.
- Impairment may be in appreciation/voluntarism, not cognitive.
- Patient may be able to communicate coherently, organize facts, confabulate/rationalize.
- Interferes with independent functioning, but can seem capable in structured setting.
- Patient has partial insight into safety concerns and provides plausible solution to problem.

# Capacity Criteria Compared



## Cognitive Criteria

- Can be measured and quantified with neuropsychological testing.
- More objective and consistent finding
- More legal safeguards
- Covers limited range of diagnoses/deficits

## Functional Criteria

- Difficult to measure or quantify even with a comprehensive psychiatric assessment.
- Subjective-better with experience and training
- More potential for exploitation/manipulation
- Applies to more disorders/impairments

# Differences in Behavioral Health Care: Vulnerability



# Vulnerability



“A universal and ongoing human experience. The awareness of being wounded and the potential for same gnaws at our sense of security. We are capable of being hurt at many levels: physical, mental, emotional and spiritual. . . . Our greatest vulnerability centers on assaults from within and without that threaten our integrity and dignity as persons.” *McGovern, 1998.*



# Respect for Vulnerability

- Be aware of subtle forms of coercion in therapeutic interactions.
- Monitor boundary crossings and violations.
- Understand own motivations and biases.
- Vigilance against dual relationships and conflicts of interests.
- Neither overestimate capacity nor underestimate impairment.

# Domains of Vulnerability



## Biological

Psychosis  
Cognitive  
Impairment  
Mood lability  
Addiction  
Medical Illness

## Psychologica |

Anxiety  
Depression  
Grief  
Fear  
Anger

## Social

Stigma  
Lack of social  
support  
Homeless  
Poverty  
Unemployment

# Last Thoughts for Reflective Inquiry



- If the brain/mind is the organ of thinking and deciding, what if it is broken?
- If emotions/will are what allows humans to make their way in the world, what if they are disturbed or co-opted?

