Decisional Capacity with SCI/D Veterans

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At the conclusion of this activity, the participant will be able to:

1. Delineate 4 main criteria for decisional capacity
2. Identify various causes of impaired decisional capacity
3. Understand the complexity of assessment of decisional capacity
Capacity vs. Competence

- **Capacity** refers to one’s ability to make a meaningful decision about circumstance or participation
  - Financial, medical, independent living, research
  - Accept, reject, or select among alternatives

- **Competence** is a legal determination made in a court of law
Implications for SCI/D Veterans and Providers

- Clinical, legal, ethical implications
- Autonomy should be respected
- May elicit moral/ethical dilemmas for providers
- Impacts options for treatment, discharge planning, management of VA financial funds
Capacity Criteria

1. **Evidence of a choice:** ability to communicate a choice, and do so consistently
2. **Understanding:** Comprehend treatment-related information – disorder, treatment options, risks/benefits
3. **Appreciation:** Have insight into disorder and possibility of treatment benefits
4. **Reasoning:** Use logic and reasoning to compare treatment alternatives
Manage money and assets consistent with values and self-interest

Declarative knowledge
- Describe financial concepts

Procedural knowledge
- Describe process of financial management

Judgment sufficient to make sound financial decisions consistent with prior decisions
Potential Causes of Impaired Capacity

- Altered mental status/delirium
- Dementia/Cognitive Dysfunction
- MS
- ALS
- Parkinson’s Disease
- Infection/medical complications
- TBI
- End of life changes
- Medication side effects/illicit substances
- Psychiatric Illness
- Impaired intellectual functioning
Facts about Capacity

- It may not be a permanent state
- Presence of a disability alone doesn’t indicate lack of capacity
- Disagreeing with your physician doesn’t necessarily mean you lack capacity
- People are allowed to make poor decisions!
- Lack of capacity isn’t always obvious
More Facts about Capacity

- Approx. $\frac{1}{2}$ of persons with Alzheimer’s disease have capacity
- Common demographic variables don’t determine capacity
- Diagnosis or neuropsychological impairment doesn’t equal lack of capacity
When to Question Capacity

- Immediate risk of harming self or other
- Mental status changes; cognitive decline
- Signs/concern of exploitation
- Decisions are incomprehensible to provider
- Veteran repeatedly changes his/her mind
- Veteran consents immediately and uncritically to every treatment proposed
- Veteran declines immediately to every treatment proposed or doesn’t care about decision
Spinal cord injury itself doesn’t impact capacity, but associated conditions can:

- MS: processing speed, attention, memory
- ALS: memory, executive, behavioral
- Moderate – severe TBI: attention, memory, executive
- CVA: memory, language, executive, spatial

These disorders may require additional treatments, clinical trials, etc. that can impact QOL
**Capacity and SCI/D**

- Disability status and capacity
  - Can the blind manage finances?
  - Can someone dependent for care make decisions?
  - If you can’t physically sign a contract, can you proceed?
Psychological Factors

- Depression may lead to apathy, cognitive complaints
- Psychosis, mania/bipolar, delusional beliefs may impact executive functioning, reasoning, appreciation
- Anxiety may lead to avoidance/in-action
- Crisis may reflect temporary incapacity

*Capacity may still be retained even in the most severe mental health cases*
How to Assess

* Record review
* Person-Centered clinical interview
* Instruments
  * Aid to Capacity Evaluation (ACE)
  * MacArthur Competence Assessment Tool
  * Capacity to Consent to Treatment Instrument
  * Independent Living Skills
* Collateral Information
* Neuropsychological Assessment battery
  * Attention, memory, language, executive functioning, psych/personality inventories
How to Assess

- Elicit information about *their own* medical/financial/independent living circumstances

- Provide clinical vignettes with a hypothetical medical problem

- Can they follow capacity criteria?
  - Choice, understanding, appreciation, reasoning
Limitations with Assessment

- Mini-mental status exams may miss impairment
- Neutral or hypothetical stimuli (i.e. “what is a will”, “how do you know the price of the house if fair”) may capture knowledge and intellectual factors, but fail to account for person’s actual circumstances or judgment
Interventions

* Present information with multiple learning trials and summaries of information through multiple methods (verbal, written)
* Allow time to process information and have veteran paraphrase back
* Provide viable options for choice
* Involve trusted persons
Advance Directives

* Written statement executed by adult with decisional capacity regarding wishes about nature and extent of future medical care should they *lack* decisional capacity
  * Living will specifies preferences for life-sustaining treatment

* Durable Power of Attorney: identifies person(s) to make decisions on their behalf

* Surrogate Decision-Making
  * No advance directives on file
  * Family/loved ones
  * Court-appointed guardian or conservator
Aid to Capacity Evaluation

Questions can move from complex to simplified

* **Medical Condition**
  * What problems are you having now?
  * What problem is bothering you the most?
  * Do you have [XXXX] problem?

* **Proposed Treatment**
  * What is the treatment for [XXXX]
  * What else can we do to help you?
  * Can you have [proposed treatment]
ACE, cont.

- Alternatives
- Options of refusing treatment
- Consequences of accepting proposed treatment
- Consequences of refusing proposed treatment
ACE, cont.

* Impact of Depression
  * Do you think you’re being punished?
  * Do you have any hope for the future?
  * Do you deserve to be treated?

* Impact of Psychosis
  * Is anyone trying to hurt/harm you?
  * Do you trust your doctor?
62 y.o. AA male h/o

- C4 ASIA D tetraplegia 2/2 recent fall
- Bipolar I disorder
- Polysubstance use d/o (MJ, ETOH, cocaine)

- Evaluated 2/2 poor compliance with therapies, emotional lability, possible hypomanic state
Case 1, cont

- Mental status
  - Tangential, racing, illogical thoughts
  - Aggressive and inappropriate with staff
  - Denied changes in mood, no insight into symptoms

- ACE exam
  - Medical Condition
    - Knows he has SCI, lack of appreciation of deficits
    - Limited used of UE & LE; states he can live independently
    - Refuses PT/OT: “Ill figure it out when I go home”
Proposed Treatment (PT/OT)
* Fluctuates w/ recognition that he can’t stand, transfer
* Says PT/OT is useless, wouldn’t need any help at home

Alternatives
* None identified
* Refuses SNF (no need)

Option to refuse treatment
Consequences of accepting proposed treatment
Consequences of refusing proposed treatment
* Does not identify any; doesn’t appreciate consequences proposed by examiner
* Says no need for POA/decision maker “I wouldn’t ever be unconscious”
Case 1, cont.

* Cognitive Functioning
  * MoCA blind = 11/22
    * Impaired attention, memory (0/5 delay), executive
  * Unable to develop sound plan for discharge

Does veteran have decisional capacity?
41 y.o. Hispanic male with SCI/D 2/2 cerebral cavernous malformations

+ personality changes
+ behavioral issues
+ cognitive deficits (PS, attn, executive)
+ slow response style
Case #2, cont

ACE exam

Medical Condition
* Able to explain current medical status, palliative wound care

Proposed Treatment
* Can describe palliative care, wound care process

Alternatives
* Knows he needs to quit smoking for addl options

Options of refusing treatment
* Knows it’s his right to refuse care

Consequences of accepting proposed treatment

Consequences of refusing proposed treatment
* Understands this, knows he will need LTC
References

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