Resource Document on Decisional Capacity Determinations in Consultation-Liaison Psychiatry: A Guide for the General Psychiatrist

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Introduction:

Consultation-Liaison Psychiatrists are experienced in responding to requests from medical services for the determination of decisional capacity (DC). General psychiatrists are occasionally called upon to perform decisional capacity determinations, especially when functioning in a consultation-liaison role. Some may not have extensive prior or current experience in decisional capacity determinations.

In recent years, there has been a significant amount of clinical research literature on DC, particularly in a consultation-liaison clinical context. As such, having a review of the recent literature leading to an evidence-based, standardized approach to DC determinations is of pragmatic value to the general psychiatrist.

The authors, all members of the APA Council on Consultation-Liaison Psychiatry, have reviewed the classic and emerging literature on DC in a consultation-liaison context, including clinical methodology, specific psychiatric and neurologic illnesses affecting DC, use of standardized rating instruments, and modification of clinical examination techniques for DC determinations. The authors of this resource document cover a sequence of nine topic areas pertinent to DC determinations, ordered in a way consistent with the conduct of a consultation-liaison interview of a DC case.

In each section, there is a review of the relevant literature for that topic, yielding a literature-informed and comprehensive proposed clinical methodology for DC determinations in the context of consultation-liaison psychiatric evaluations. The authors took this approach to DC to be a useful guide for general psychiatrists who have the occasional need to complete decisional capacity determinations when functioning in a consultation-liaison role.

We emphasize that the scope of this document is to provide evidence-based guidance on the determination of decisional capacity in a consultation-liaison setting where the common context of DC determination varies among: 1. consent to accept recommended treatments; 2. consent to refuse recommended treatments; 3. capacity to be discharged from the hospital against medical advice (AMA);

or 4. capacity to participate in discharge planning (recently referred to as dispositional capacity or capacity for abode).

In the consultation-liaison context, an additional type of decisional capacity determination is in the context of patient qualification for organ transplantation or major assistive device placement (e.g., left ventricular assist device (LVAD)) surgical procedures. This type of decision to accept a transplanted organ or an indefinite placement of a life-enhancing assistive device also involves a commitment to lifelong close medical follow-up and post-procedure clinical adherence. Due to the need for post-procedure adherence, this type of decision is more complex and "future oriented" than the "here and now" of decision making solely about a medical/surgical procedure.

In such cases, routine application of the elements of standard decisional capacity determinations are supplemented by considerations of commitment to ongoing future care and adherence therewith. This particular type of decisional capacity assessment is not addressed in this document, as such consultations are typically accomplished by consultation-liaison psychiatrists associated with organ transplant or cardiology services, respectively. Further details on decisional capacity determinations in these important areas are well described in the transplant psychiatry and cardiovascular psychiatry sections of the consultation-liaison psychiatry literature.

Similarly, the document does not address DC determinations that are common in a legal or forensic psychiatry context. These include assessment of capacity to testify at trial, ascertainment of psychiatric illness affecting criminal culpability, determination of capacity to execute a will, or detailed assessment of maternal competency for child custody proceedings. These particular areas of decisional capacity are robustly addressed in the forensic psychiatry literature and could be the topic of a similar guidance document for general psychiatrist written with a forensic psychiatry perspective.

In each of the following sections, a specific area of concern regarding an element of the decisional capacity determination is discussed and the supporting literature is cited. These sections conclude with recommendations to guide the general psychiatrist on how to address this particular area of a decisional capacity determination in the context of a consultation-liaison psychiatry evaluation.

This document thus serves as an item-by-item review of the various recommended elements of decisional capacity determinations in the consultation-liaison context. It allows all psychiatrists to have a common framework to guide them when periodically functioning in a consultation-liaison model to complete decisional capacity determinations using an evidence-based clinical method.

#1: Determine the type of decisional DC question.

Considering that a capacity determination is a functional assessment and a clinical determination about a specific decision, the first step is to determine the type of DC question. Common types of DC questions include informed consent, treatment refusal, requests to leave the hospital against medical advice (AMA), and capacity for participation in discharge planning (recently named as dispositional capacity or capacity for abode). In the case of some DC questions, such as informed consent, a full description is needed of the proposed intervention and its risks, benefits, side effects, and alternatives. In the case of dispositional capacity, additional consultation from occupational therapy, physical therapy, social work, and/or other disciplines may be indicated.

Defining the specific question is critical because the patient may have intact DC in some areas but not others. This concept of "differential," decision-specific DC is sometimes modeled as the "DC gradient;" i.e., the higher the risk of the decision, the higher degree of DC needed for that specific decision. The

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most common reason for a DC evaluation is a patient's refusal of medical treatment. A common context for a DC evaluation request in a medical inpatient is the patient's refusal of medical treatment or recommended disposition, with dementia and/or delirium being common among decisionally incapacitated patients (1).

Recommendation:

- It is important to determine a specific question for DC in order to guide your psychiatric interview, to understand the risk involved, and to ascertain how it may influence the recommended workup.

#2: For informed consent decisions, a full description of the proposed intervention and its risks/benefits/side effects is necessary.

The doctrine of informed consent, including its corollary, the right to refuse treatment, is arguably the most important doctrine in medical ethics and health law (2). There are several essential components of informed consent. The consent is given in the absence of coercion or duress, and the person is provided information in a language understandable to him/her to allow for adequate comprehension. The person must have the capacity to understand the information and should be in a position to make and to authorize a choice about how to proceed. The degree of DC must be "proportional" to the clinical risks in making a meaningful decision; e.g., whether or not to accept the treatment offered or participate in a research study. Specific questions related to decisional capacity determinations for informed consent situations have emerged; e.g., what information should be disclosed, how much the person providing consent should understand, and how explicit consent should be (3).

Appelbaum and Grisso described four significant elements that comprise an accurate and effective way of assessing decisional capacity in their seminal 1988 article (4). The patient must be able to a) understand relevant information, b) appreciate the clinical circumstances, c) exhibit a rational process of decision making, and d) be able to communicate a consistent choice (4). In understanding the relevant information, the patient is able to show that he/she understands the illness and its prognosis and the risks and benefits of treatment options, including non-treatment. Several strategies can be employed to enhance a person's understanding in informed consent: additional simplified written information, extended discussions, audiovisual and multimedia programs, and test/feedback techniques, with particular attention to interventions that are accessible to persons with limited literacy and/or limited English proficiency (5).

To appreciate the situation and its consequences, the patient needs to recognize that his/her welfare is affected by the outcome of the decision and appreciate that he/she will benefit or suffer from the consequences of the decision. One can say that the patient is able to manipulate information "rationally" if he/she is using a logical thought process in his/her decision making, resulting in a persistent conclusion regarding a treatment decision. Finally, a patient is able to communicate a choice when he/she is able to express a consistent preference regarding a decision for or against a specific intervention.

Recommendation:

- Decisional capacity determinations in informed consent situations should include the four elements Appelbaum and Grisso described: understanding, appreciation, rationality, and communication of a consistent choice.

#3: Include a full, standardized psychiatric interview (including neurocognitive disorders workup) and review of collateral history in a DC determination consultation.

Decisional capacity should be assessed in the context of a standardized psychiatric interview and neurocognitive disorder workup. A thorough standardized psychiatric interview is critical for determining DC and identifying underlying conditions influencing DC, although some elements of the interview (e.g., family illness history, developmental history) are less important than in other interviews. The literature shows that neurocognitive disorders are common in impaired DC; hence, assessment for neurocognitive disorders is important in DC determinations. Boettger et al evaluated inpatient consults and found that the most common psychiatric diagnoses contributing to incapacity were cognitive disorders (54.1%), substance use disorders (37.2%), and psychotic disorders (25%) (6). Among other medical diagnoses, neurological disorders frequently contributed to decisional incapacity (6). Torke et al found that the most common neurologic reasons for impaired DC in hospitalized patients > 65 years old were Alzheimer's disease (39.4%) and delirium (19.0%) (7).

Specific Neurocognitive Disorders: Delirium

It is estimated that 11-42% of medical inpatients experience delirium at some time during hospitalization (8). The incidence is higher in post-surgical patients, in those with advanced age and pre-existing brain disease, and is likely under-diagnosed (8). While delirium is a cognitive disorder that is identified as a main source of decisional capacity consults, there is limited data looking at the correlation between delirium and decisional capacity (8, 9). The DSM-5 defines delirium as including disturbances in attention, cognition, and awareness that develop over a short period; that is a change from baseline; and that tends to fluctuate in severity throughout the day (10). By definition, there is evidence from history, physical examination, or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal, toxin exposure, or multiple etiologies (10). See # 9 for further details.

Specific Neurocognitive Disorders: Major and Mild Neurocognitive Disorders (MNCDs, formerly Dementias)

Several studies have shown that patients with MNCDs/dementias of various etiologies experience impairment in DC when compared with age-matched elderly persons without any cognitive impairment (11). In one study by Karlawish et al (12), 48 patients with mild to moderate dementia due to Alzheimer's disease were tested with the MacArthur Competence Assessment Tool-Treatment (MacCAT-T) and scored lower on all four scales of understanding, appreciation, reasoning, and choice when compared to 102 family caregivers. Studies have also shown that patients with mild cognitive impairment may also experience problems in making competent decisions. Two studies by the same group (13, 14) utilized the Capacity to Consent to Treatment Instrument (CCTI) to compare patients that met criteria for MCI to normal subjects. In both studies, patients with MCI had lower scores on understanding, appreciation, and reasoning.

As part of the psychiatric interview, a workup for neurocognitive disorders should be included for all patients in DC consultation (15). This workup should include a Mini-Mental State Examination (MMSE) or Montreal Cognitive Assessment (MoCA). Kahn et al evaluated 52 patients with cognitive disorders on an inpatient medical consult service and found that an MMSE score lower than 24 was 83% sensitive

and 90% specific for finding impaired DC; an MMSE lower than 21 was 69% sensitive and 100% specific for finding impaired DC (16). In a study of 78 skilled nursing facility residents by Allen et al., better global cognitive ability (as determined by MMSE score) was correlated with the ability to understand the treatment situation and the ability to appreciate the consequences of their treatment choice (17).

Gurrera et al. conducted neuropsychological tests on 159 geriatric patients with and without significant cognitive impairment. Assessments included the MacArthur Competence Assessment Tool-Treatment (MacCAT-T) and 11 neuropsychological tests commonly used in the cognitive assessment of older individuals. They found that performance on neuropsychological assessments was correlated with DC performance (18). Burton et al found that impairment on a number of verbal abilities (verbal learning, memory, and fluency) during neuropsychological testing as well as global cognitive function correlated with diminished DC in a population of 110 hospice patients without chart evidence or history of cognitive impairment (19).

Substance Use Disorders

Substance use disorders are another area that can lead to impaired DC, particularly in the setting of substance intoxication or withdrawal and a substance-induced delirium. Unless there is significant acute decompensation, psychotic and bipolar or depressive disorders are less likely to lead to impaired DC, though these should be included in the differential and workup.

Studying DC empirically in the substance use disorders population is difficult since an individual while sober can perform well on standard capacity assessment tools but may have poor self-care and decision-making chronically due to neurocognitive changes of long-term substance use (20, 21). When using standard assessment measures such as MacCAT-T in patients with substance use disorders who are not currently intoxicated or withdrawing and do not have significant psychiatric co-morbidity (including neurocognitive disorders), rates of decisional incapacity are found to be low (16, 21, 22). Hazelton et al recommend delaying assessment of DC until acute effects of intoxication and delirium have resolved, considering evidence of impaired judgment, and differentiating cognitive deficits from poor insight and/or judgment (22).

Psychotic Disorders

Studies of patients with schizophrenia have found significant heterogeneity in DC when assessed by tools such as the MacCAT-T and MacCAT-CR (MacCAT version for clinical research) (23-26). A review of the DC literature found that five schizophrenia studies looked at association between severity of psychopathology and decisional capacity. These studies found that the psychopathology correlation with impaired DC was much lower than correlations between overall poor cognitive performance and impaired DC (26). Correlations between negative symptoms and impaired DC were stronger than for positive symptoms and impaired DC (26). In one study, decreased understanding was also correlated with severity of negative symptoms and of general psychopathology, but not with age, education, severity of positive or depressive symptoms, or level of insight (23).

Bipolar and Depressive Disorders

Bipolar disorder patients need to have their current mood state taken into account in DC determinations, with the likelihood of a finding of intact DC unless mania or severe depression is present. Capacity for research consent (regarded as requiring the highest level of DC) was studied in manic patients by Misra et al (27), who examined patients' ability to provide consent for three hypothetical research studies. Manic bipolar disorder patients performed worse than did non-manic

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bipolar disorder patients on the first trial, but by the third study consent there were no significant differences between the groups in understanding, suggesting that an iterative review of the consent process improved manic patients' performance (27). In contrast, another study found that 97% of patients admitted to a psychiatric unit during a manic episode were deemed to be incapable of making a treatment decision (28). Depressive episodes impair DC much less frequently than do manic episodes, as studies have consistently found low rates of impaired DC in depressed patients (6, 20, 21, 28-30), with decisional incapacity occurring in depressed patients who also demonstrated worse cognitive performance (29).

Psychiatric Workup and Assessment for Neurological Illness

In addition to the psychiatric interview and neuropsychological testing, a thorough history (including accessing collateral history sources) is essential to obtain the time course of a patient's presentation, psychiatric history and treatment, and medical history, including any recent changes in medications or diagnoses.

When accomplishing hospital DC consultations, the psychiatrist is encouraged to thoroughly review the hospital chart (including notes from physicians, nurses, and allied health personnel) and to talk directly to the referring physician, ward nurses, and other treating personnel. Clinician descriptions of altered mental status will be typical in cases diagnosed with delirium, and having such documentation available before seeing the patient can increase the psychiatrist's suspicion of a diagnosis of delirium. Discussions with family members of the patient are highly recommended. While permission of a decisionally intact patient is required for the psychiatrist to disclose patient-specific information to family members, the psychiatrist is encouraged to seek information from family members. In the case of a decisionally incapable patient, the psychiatrist should disclose fully to the proxy decision maker, including the specifics of the neuropsychiatric illness resulting in impaired DC. Significant discrepancies between the patient's observations and those of collateral sources provide important information that can support a finding of impaired DC.

For certain presentations, quick bedside assessments such as the Confusion Assessment Method (CAM) for delirium, Hamilton Rating Scale for Depression (HAM-D) for depressive disorders, Young Mania Rating Scale (YMRS) for mania, and the Positive and Negative Syndrome Scale (PANSS) for psychosis can help elucidate diagnoses.

A focused physical examination can help differentiate between neurologic and psychiatric diagnoses, as well as shed light on underlying systemic medical conditions that may be contributing to delirium if present (31). Certain physical examination findings (e.g., asterixis, neurological findings, autonomic instability) may help to guide focused laboratory testing and neuroimaging inquiry. Focal or lateralized neurologic signs are more consistent with a primary neurologic (as opposed to psychiatric) disorder (31).

Targeted laboratory testing is helpful in identifying causes of delirium, the presence of substance use, certain medication toxicities, and other underlying causes of mood or cognition changes (31). Common laboratory tests include serum electrolytes, creatinine, glucose, calcium, complete blood count, and urinalysis and urine culture. Therapeutic drug levels, toxicology screen, liver associated enzymes, rapid plasma reagin (RPR), thyroid stimulating hormone (TSH), and vitamin levels are appropriate for specific clinical scenarios, particularly to rule out reversible causes of depressive disorders and neurocognitive impairment (31). Neuroimaging and lumbar puncture are usually reserved for patients with delirium and/or other cognitive impairment with an inconclusive initial workup. EEG testing is useful in patients with altered level of consciousness in order to rule out suspected non-convulsive/subclinical seizures, or

confirm the diagnosis of delirium; e.g., due to metabolic or infectious causes, that have characteristic EEG patterns (31).

Recommendations:

- A DC assessment should start with a full psychiatric interview, as several psychiatric diagnoses are associated with greater impairment in DC. Such workup includes a thorough history, interview, focused physical examination, laboratory testing, additional imaging and procedures where needed, and discussions with hospital staff and family members, if relevant and available.
- Cognitive assessments such as MMSE or MoCA, with additional testing as indicated (e.g., Hamilton Depression Rating Scale, Young Mania Rating Scale, Positive and Negative Symptoms Scale, neuropsychological testing) should be performed for any DC evaluation, since cognitive impairment is highly associated with DC impairment.
- Assumptions should not be made that all patients with psychiatric illnesses, including neurocognitive disorders, lack DC, nor that patients on psychiatric commitment order necessarily lack DC.
- Efforts should be made to determine underlying factors contributing to decisional incapacity, and to correct any reversible factors in efforts to restore DC.

#4: For informed consent cases, if there is evidence of cognitive impairment, modify the consent process to facilitate understanding and optimize patient performance

In cases where a patient's DC is judged to be marginal based on routine clinical assessment, modifications of the informed consent process and/or use of assistive devices may permit some patients to enhance their understanding of clinical decisions, and thus be able to preserve their autonomy to a greater degree. When reasonable and available, as an act of patient empowerment, the psychiatrist could endeavor to avail him/herself of these additional techniques to maximize the patient's ability to maintain autonomy and articulate treatment preferences. If modifications of the assessment and/or consent process are used for a final decision regarding DC, the modifications in examination technique should be included in the consultation report (e.g., "The interview was conducted with an interpreter and with the use of videos demonstrating the proposed surgical procedure to improve the patient's demonstrated understanding").

In their discussion of assessing DC for informed consent, Jeste and Saks state that explicit assessment is needed when the treatment or study involves more than minimal risk and the treatment or protocol is specifically intended for a population that is reasonably expected to have diminished DC (20). Patients with cognitive impairments due to a variety of psychiatric and medical illnesses, including MNCD/dementia, psychotic disorders, brain metastases, and multiple sclerosis fall into the latter category (19, 20, 29, 32-34).

Initial interventions to help enhance DC in these populations include performing the evaluation in the patient's native language and identifying and correcting potentially treatable conditions such as delirium or depressive disorder (11, 20, 29). In addition, evidence indicates that there are methods by which the consent process can be modified to facilitate understanding and enhance DC in individuals with cognitive impairment (11, 20, 32, 33, 35-39)

Dunn and Jeste reviewed 34 published studies of interventions across specialties designed to improve subject understanding of informed consent (36). Of these, 25 out of 34 studies reviewed found that

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subjects' understanding or recall showed improvement with various interventions. More highly structured and more uniform consent processes; better organized, shorter, and more readable consent forms; and simplified and illustrated formats all improved subjects' understanding. Corrected feedback, multiple learning trials, ''advance organizers'' (which alert subjects to information about to be presented), and summaries of information also enhanced understanding.

Modification of DC assessments and consent processes, depending on the type of cognitive impairment, is indicated in a variety of illnesses. In a study on multiple sclerosis, interventions such as cueing and repetition helped patients with diminished cognitive function to display understanding equivalent to the control group (32). Similarly, in a review of informed consent challenges in adults with impaired cognition due to major neurocognitive disorders, modifying consent procedures with variables such as timing (i.e., completing informed consent procedures in the A.M. to avoid the effects of "sun-downing"), providing corrective feedback, and modifying consent content to plain language were useful in enhancing capacity (35).

Research has also shown that modifying consent processes is also helpful for patients with cognitive impairments associated with psychosis and bipolar disorder (20, 36-39). In a study of errors in informed consent in patients with schizophrenia or schizoaffective disorder, administration of the MacCAT-CR along with informed consent processes found that cognitive deficits, particularly recall of disclosed information, were seen in 65.6% of patients. Interventions such as iterative disclosure of the information, corrective feedback, and emphasis of key points helped improve recall (37). In a similar study, patients with schizophrenia and bipolar disorder were found to have worse scores on the MacCAT-CR secondary to neurocognitive deficits compared with healthy controls, which in turn significantly correlated with impaired DC. Repeating the missed information improved the level of understanding in all groups (39). Lastly, patients with schizophrenia randomized to multimedia consent procedures had improved scores on the MacCAT-CR and the University of California San Diego Brief Assessment for Capacity to Consent (UBACC) when compared with patients randomized to written consent (38).

Recommendations:

- Informed consent procedures can be modified to maximize cognitive domains such as understanding, reasoning, and recall in patients with cognitive impairments.
- Multimedia and other new technologies should be explored as methods to improve informed consent procedures for patients with cognitive impairment and could lead to improved performance by patients with marginal DC based on clinical assessment using routine methodology.

#5: When assessing DC for informed consent, address the primary elements of DC separately

While legislation about informed consent varies across jurisdictions, there are consistent legal and ethical principles that guide this process in most Western countries. In general, patients with the capacity, have autonomy and the right to make their own treatment decisions. Treating clinicians must assess whether their patients are capable to accept or decline treatments and interventions when they are proposed. When clinicians suspect that a patient is not capable of consent, then a substitute decision maker is usually sought to make this decision on the patient's behalf. While this assessment is usually implicit in the clinical encounter, given the legal and ethical importance of decisional capacity and provision of informed consent, a structured approach can assist with evaluation and documentation.

Recommendations:

- When obtaining informed consent, clinicians should evaluate each of the four domains of DC for the proposed treatment or intervention. Each domain has been associated with patient and clinician tasks, as well as suggested questions for clinical assessment (40).
- When obtaining informed consent, clinicians should determine whether the patient can (40):
    - Communicate a choice
        - Patient task: clearly indicate a preferred treatment
        - Clinician approach: ask patient to indicate a treatment choice
    - Understand the relevant information
        - Patient task: grasp the fundamental meaning of information communicated by the physician
        - Clinician approach: encourage the patient to paraphrase disclosed information regarding medical condition and treatment
    - Appreciate the situation and its consequences
        - Patient task: acknowledge their medical condition and the likely consequences of treatment options
        - Clinician approach: ask the patient to describe views of their medical condition, proposed treatments, and likely consequences of accepting or declining each of these options
    - Reason about treatment options
        - Patient task: Engage in a rational process of manipulating the relevant information
        - Clinician approach: ask the patient to compare the treatment options and potential consequences, and offer reasons why their choice is the best one for them

#6: Consider using DC-specific instruments to supplement the clinical interview

In general, the determination of whether a patient has decisional capacity for medical treatment has been based on clinical assessment and judgment. However, research suggests that there is often poor inter-rater reliability among clinicians about DC. Moreover, clinicians often do not recognize incapacity, when compared to expert rating and/or a standardized assessment (41-43). The use of a DC standard assessment instrument remains more common in a research setting than in routine clinical care and use of these DC-specific assessment instruments is not considered "essential" to the contemporary standard of care. Numerous structured instruments have been developed to assist clinicians with DC assessments, although no one is considered to be a "gold standard" (for reviews see 25, 44, 45).

These instruments vary in the specific domains of DC they assess. Some assess all four of the classic DC domains (understanding, appreciation, reasoning, expressing a consistent choice), while others assess only two or three domains. Furthermore, the instruments vary in the way that they assess these domains. Several use predetermined situations or vignettes to determine the patient's ability to demonstrate DC, while others can be modified to include information about the patient's specific clinical situation and the decision to be made. All require a structured or semi-structured interview, and none provide a dichotomous reductionistic decision about whether a patient has DC or not. Rather, they help clinicians to assess separate domains in a structured manner as part of an overall evaluation. Evidence suggests that utilization of a DC assessment instrument may increase the reliability of decisional capacity assessments among clinicians, as well as agreement with expert raters (46-48).

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DC specific instruments differ in the ways that they have been evaluated (e.g., how and whether data on inter-rater and test-re-test reliability, external and predictive validity, and consistency have been measured and published), as well as the populations (e.g., healthy controls, medical or psychiatric inpatients, patients with known cognitive or neurological impairment) on whom they have been studied. These limitations have been highlighted in the literature on this topic and identified as an area where further research is greatly needed.

Recommendations:

- DC instruments can *supplement*, but do not *replace*, clinical assessment and judgment in the determination of decisional capacity. When utilizing a DC specific instrument, clinicians should:
    - o Have the relevant training required for its administration, which varies among instruments
    - o Consider the purpose of using the instrument, with some being more appropriate for screening of DC and others being more appropriate for a comprehensive assessment
    - o Be aware of the domains of DC assessed by the specific instrument and acknowledge that there is often a lack of consistency among instruments in how they define each domain
    - o Use a DC instrument that can incorporate the specific medical treatment decision being proposed

#7: Modify the assessment for cases of determining dispositional capacity, as opposed to DC for informed consent

Requests for DC evaluations go beyond informed consent for a treatment or procedure, or participation in research. They can include threats to leave the hospital against medical advice, ability to care for self if discharged, ability to manage finances, testamentary capacity, and maternal competency (capacity to care adequately for a newborn without assistance) (49), among others. Bourgeois, et al, in their review article in 2017, introduced the concept of "dispositional capacity" to care for self post-discharge as a subtype of DC that is supplemented with an in-vivo demonstration of self-management skills (15).

Determination of the patient's capacity to live independently is quite broad and includes almost all areas of functioning. Factors that influence dispositional capacity according to Bourgeois et al include age and stage of the illness, sensory capacities, mobility, and the ability to perform activities of daily living and instrumental activities of daily living (15). Evaluating the patient's cognitive capacity and presence of psychiatric disorders and social factors such as housing status and status of social support are essential in the overall assessment. Therefore, a comprehensive assessment of a patient's capacity to live independently necessarily involves a multidisciplinary team involving psychiatry/psychology, medical/surgical staff, nursing and social work and all other staff involved in the care of the patient.

While DC for financial matters is less common in the general hospital, this issue may surface occasionally. Marson, et alproposed a conceptual model to be used for determining financial capacity that contains three elements. These include *declarative knowledge*, which is the ability to describe facts, concepts, and events related to financial activities (knowledge of currency, concepts such as interest rate or loans, and personal financial data); *procedural knowledge*, which is the ability to carry out motor based, overlearned practical financial skills and routines (such as making change and writing checks); and *judgment,* which is the ability to make financial decisions with self-interest, in both every day and novel or ambiguous situations (50).

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Determining maternal competency is a challenge and making an error has serious consequences, in either direction, considering the interests of the patient (mother) and the child. Maternal competency determinations may include involvement with the court system as well as social agencies, such as child protective services. When formal judicial system involvement is included in maternal competency determinations, it is common to have the opinion of a forensic psychiatrist. When the general psychiatrist functions in a consultation-liaison role, maternal competency determinations are often related to the focal question of whether the mother of a newborn is capable of caring for the infant. The protocol recommended by Nair and Morrison for maternal competency determinations is as follows: 1. examination of the mother; 2. direct observation of mother with the child; and 3. review of reports of the multi-disciplinary staff directly involved with the mother's and/or the child's care. The mother needs to be advised of the lack of confidentiality of the assessment and should be asked about her plans for herself or the baby (49).

Recommendations:

- Dispositional capacity determinations should not be limited to a psychiatric evaluation.
- Dispositional capacity determinations should be comprehensive and involve all the disciplines involved in the disposition of the patient.

#8: Write a summary of diagnosis, formulation, and DC status specific to the consultation question.

DC and dispositional capacity determinations are an important part of clinical psychiatric practice with ethical and medico-legal implications for patient care. The literature, including recent reviews, provides guidance for a framework for DC determinations (4, 11, 51-53). The literature on DC in specific illness states associates many psychiatric (and neurologic) illnesses with impaired DC (6, 7, 9, 14, 16-19, 23, 24, 29, 32-34, 54-58). Therefore, it is appropriate and literature-supported to integrate a standard approach to decisional and dispositional capacity cases. It is shown in the literature that patients with impaired DC and/or dispositional capacity have a high rate neurocognitive disorders; less commonly, other psychiatric illness(es) may be associated with impaired DC/dispositional capacity, as has been discussed earlier in this document (6, 7, 9, 14, 16-19, 23, 24, 29, 32-34, 51, 54-58).

Consultation-liaison and general psychiatrists should not limit their consultations to a sole focus on the "capacity question(s)." Rather, psychiatrists should conduct comprehensive assessments for the various psychiatric illnesses (e.g., neurocognitive disorder, psychotic disorder, substance use disorder) as well as the various purely social variables (sometimes in the absence of explicit psychiatric illness) that may be present in the patient on whom decisional and/or dispositional capacity questions arise in the context of medical and surgical care.

Recommendations:

- Implement an integrated approach to decisional and/or dispositional capacity cases in the context of a comprehensive consultation-liaison psychiatry evaluation that should include several elements (4, 11, 51-53).
- Ascertain the type of capacity concern (i.e., informed consent re interventions vs global treatment refusal vs AMA (DC) vs capacity for independent function (dispositional capacity)); many patients may need evaluation for both types of decisions simultaneously, depending on the complexity of the case

- Perform a standardized consultation-liaison psychiatry interview, including a neurocognitive disorders workup (e.g., standard cognitive rating scale, relevant laboratory studies to elucidate reversible causes of neurocognitive disorders, consideration of neuroimaging). To quantitate depressive symptoms, use a Hamilton Depression Rating Scale or other standardized rating scales
- Formulate a psychiatric diagnosis(es) (or "no psychiatric illness" if none is found), with diagnostic summary and proposed additional assessment (e.g., neuroimaging, laboratory) and recommended clinical intervention(s)
- For informed consent for medical/surgical procedure(s), have the patient provide a full description of the proposed procedure and its risks/benefits/side effects. If there is clinical evidence of cognitive impairment, modify the consent process to facilitate patient performance.
- Separately address the four Appelbaum and Grisso factors pertinent to the proposed intervention (understanding, appreciation, rationality, communication of choice for or against intervention) to ascertain which one(s) are impaired in the finding of impaired decisional capacity.
- Consider DC-specific instruments, if the clinician is experienced in their use and they are readily available
- For dispositional capacity/social function assessments, consider supplementing a standard consultation-liaison psychiatry interview with an in vivo assessment using OT/other supplemental assessments
- Provide a concise summary of case diagnosis(es) and clinical formulation
- Place the decisional capacity status in a context specific to the question(s) at hand
- Comment on whether treatment could change decisional capacity findings
- Describe "differential capacity" findings (e.g., if a patient could choose a substitute decision maker even if not able to consent/refuse surgery *per se*)

#9. Conduct repeated assessments in patients at high risk for fluctuating DC

After addressing Items #1-#8, the psychiatrist should consider the possibility of fluctuations in DC over time. Delirium is the psychiatric illness most typically associated with fluctuating cognitive status, and thus DC, in the near term. Cognitive status can also fluctuate in major neurocognitive disorders. Fluctuating DC is particularly likely when delirium occurs superimposed on a pre-existing major neurocognitive disorder (6, 7, 9, 11-17, 19, 58). When the psychiatrist's assessment results in a diagnosis of delirium, major neurocognitive disorder, or both, given the propensity for fluctuating cognitive status, the DC determination is thus only valid for the clinical decision in question at hand at the time of assessment.

A specific challenge encountered in delirium cases is the patient who experiences "lucid intervals" during an episode of delirium with fluctuating cognitive status. During such lucid intervals, the patient may demonstrate intact DC. This represents a clinical and ethical challenge, in that the patient may later (during a period of greater cognitive impairment) not recall the earlier informed consent discussion during which he/she appeared to have been able to capably manage. This is difficult to study prospectively, so a literature-informed pragmatic approach is recommended.

During the course of an episode of delirium, a lucid interval with intact DC can be a fortuitous time to engage the patient in discussions regarding goals of care, patient preferences, and advance directives. Recall that the patient must be "competent" (i.e., of intact decisional capacity) to choose a proxy or

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surrogate decision maker, who is then empowered only when the patient's DC is impaired. This way, if the delirium worsens and the patient loses DC, the medical team and surrogate decision maker have more contemporary information regarding the patient's own preferences if major decisions regarding resuscitation, intubation, and other medical and surgical interventions need to be made during a time of patient decisional incapacity.

There will be cases where patients *without* delirium on assessment, who are initially assessed has having intact DC, will later develop delirium during hospitalization (58-60). This is often reflected in acute onset of cognitive fluctuations with changes in decisional capacity status. Such cases can thereafter be managed with the approach detailed above.

Recommendations:

- When managing a case of delirium, assessment of cognitive status serially (e.g., using MoCA or MMSE and other structured standardized cognitive assessments) as part of each encounter can establish a practical clinical database that substantiates the fluctuating nature of cognitive status in delirium.
- If, with such serial follow-up assessments, a patient demonstrates fluctuating DC, then great caution needs to be used if a patient appears to have intact DC during what is later determined to have been a lucid interval.
- The psychiatrist should ascertain whether there are medical/surgical procedures proposed later in the hospital course that differ from the procedure that occasioned the initial decisional capacity assessment since a decisional capacity assessment is specific to a particular proposed clinical intervention.
- When communicating with surrogate decision makers, once a periodicity of cognitive and decisional capacity status has been demonstrated, the surrogate decision maker should be fully informed of the patient's fluctuating condition. This allows the surrogate to be more empowered in the role of decision maker. It is helpful to explicitly diagnose the condition of delirium and provide psychoeducation to both the patient and surrogate regarding the impact of delirium on decisional capacity.
- Other clinicians managing delirium cases are advised to also assess cognitive status and DC at each encounter. This approach helps to further document the variable cognitive and DC status during a delirium episode.
- Communication regarding cognitive and DC status with other clinicians throughout a delirium case is important to assure that continued delirium precautions and pharmacological/non-pharmacological management continue throughout a delirium episode.
- In cases with new-onset delirium, another physician or a nurse managing the patient may first identify these fluctuations and may discern a change in DC status, if not necessarily a diagnosis of delirium, per se. This should prompt the psychiatrist to reassess the patient and DC determination (including a repeat of standardized cognitive assessments as above).
- Upon recovery from an episode of delirium, the patient should have cognitive status and decisional capacity status assessed and documented at that time. Cognitive status and, thus, decisional capacity may be decreased from the pre-delirium state, even upon recovery from the acute delirium episode.

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