arbd network

Examination of reasoning (dysexecutive syndrome) in capacity assessment

In the context of ARBD

1

arbd network

Main Presenting features
Reasoning problems (dysexecutive syndrome)

- The ability to concentrate [1]
- Sorting information (short term memory) [2]
- Problems in reasoning [3] and problem solving difficulties [4] and explaining actions and reasons [5]
- Understand complex information and concepts and difficulty in acquiring drink refusal strategies [6]
- The to change from one stream of thought to another (difficulty in following complex discussions)[5]
- Proneness to make impulsive decisions [7]
- Understanding risk related to actions and decisions [8]
- Reduced organisational skills, planning and organizing arrangements[9]
- Poor compliance to treatment programs [10]
- Lower confidence [11]
- Breakdown of interpersonal relationships [12] (Problems with empathy, social cognition)
- Apathy [12]
- Lack of insight[13]

2

arbd network

Frontal paradox

as described by clinical psychologists

- Can perform tasks which are externally prompted by an assessor
  - Can perform adequately in well-structured office-based tasks: clearly set out
- Lack the ability to self-initiate those tasks when they are not cued to do so.
- Testing can fail to reveal the greater effort that is required by people with executive deficits; they may perform normally but be exhausted by it
- Difficulties with 'complex behavioural organisation in non-routine situations'
  - Cannot cope with ill-structured tasks that occur in everyday life, where the task requirements are less clearly defined and there are no clear rules.
- Problems with long-term 'rule maintenance' may go undetected because the testing process is short
- There are few demands on social cognition within the context of a psychological assessment.

3

arbd network

Syndrome of environmental dependency[1]

The person has significant dysexecutive problems e.g., memory problems, difficulty in complex thinking and problems with anticipation, planning

Patient relies on current environmental (social and physical) cues in order to accomplish goals or tasks

In reality: A disorder in personal autonomy as a consequence of their cognitive damage that is more evidence in a less structured environment

It is important to gain a coroborative history of the individual regarding his/her ability to cope in a less structured environment

4

arbd network

Consider John in an acute ward/nursing home or residential home:

Encouraged/helped to get up in the morning
Guided in keeping room tidy/bed made
Laundry managed
Told when meals are ready
Told where they can and cannot go
Escorted and supervised in activities
Medication monitored/supervised
Arguments/antisocial behaviour contained/prevented
Finances managed

No need for self initiation
Prompted/cued activity
No need for long term planning or
Evidence of rule maintenance
Little cognitive effort required
Social interactions supervised and boundaries controlled
Impulsive behaviour curtailed

Have we considered the influence of his environment in our MCA?
Do we have information regarding how he coped (or can cope) in a less structured environment?

5

arbd network

Principles of the Mental Capacity Act

- Assume that the individual can make decisions
- Demonstrate that you have tried to help the person make decisions
- Capacity is decision specific
- Demonstrate evidence of mental impairment

Determine if the degree of mental impairment compromises the capacity regarding the specific decision

- Examine the ability of the individual to memorize the information
- Examine the individual's ability to understand the information
- Examine the individual's ability to weigh up information
- Demonstrate that the individual can communicate decisions

6

arbd network

Make sure the individual has all the relevant information required to make a decision

- Make sure that the person can repeat information that you have given. Get her to summarise.
- If in an institution: Get carers to re-inforce information.
- Check that the person has written information.
- NB: the person might be able to use working memory to make a decision but not have the memory to be able to carry out the decision. This is accepted as a 'memory problem' by the CoP.
- Test memory within interview and revisit a couple of hours /day later and test memory of content of the interview.

7

arbd network

Care Needs Decisions

test their understanding

Questions to check understanding:

Most important thing is:

Do not rely on asking if the person understands! (they may not understand that they do not understand!)

Some helpful questions

What is wrong with you that means you need help? (Including cognitive problems; awareness of nature and severity)

What is the role alcohol has played in developing your problems?

What are the particular practical issues with which you need help?

How much help do you need?

Who is going to help you?

How is the help going to be organised? (How are you going to action the plans you have?)

8

arbd network

Care Needs Decisions

check their ability to weigh up information

- How are they balancing the pros and cons of support required?
- Why would you not want support?
- Are reasons weighty enough to balance against the need for support?
- What happens if you do not get support ?
- How are you going to manage the potential problems/
  - Deteriorating mental and physical health
  - Financial
  - Fire
  - Trauma

9

arbd network

Problems in understanding and weighing up

1. Memory difficulties: the individual does not remember the nature and severity of risk
2. Understanding the risk profile : He/she cannot manage to conceptualise or understand risk (do they know that they can suffer from malnutrition, run out of money due to problems with planning or the risk of financial abuse)
3. The person maybe highly suggestible and maybe under the 'influence 'of someone else (e.g. financial abuse)
4. Dysexecutive apathy: He/she may be suffering from significant apathy, with lack of spontaneity and ability to change in behaviour due to brain damage. She just wants to maintain the status-quo irrespective of risk.
5. Anosognosia: Frontal lobe damage can be associated with the Jean not being aware of their cognitive/physical problems even though they are explained

10

arbd network

Important points to take home
with regard to dysexecutive syndrome and capacity assessment

1. Dysexecutive syndrome is common, very difficult to test and recognise, is insidious and can be disabling.
2. It is essential to undertake assessments of reasoning, planning, conceptualizing, risk assessment, long term rule maintenance and organizational skills in terms of a capacity assessment, **with planned questions** regarding understanding and weighing up.
3. Failure to identify lack of insight and associated apathy due to organic brain damage may often be missed or not considered as important in the assessment of capacity.
4. Is the environment in which you are assessing an individual likely to affect the individual's responses and behaviour? Can you generalize your findings to less structured circumstances? Do you need to assess in different environments, do you have corroborative histories?
5. Beware of memory problems. Check tat the individual can remember the decisions they have made so that they can carry them out.

11

arbd network

Full presentation on Capacity:

ARBD Network

www.ARBD.net

12

arbd network

13

arbd network

Jean

- 46 year unmarried old female nurse, living in her own house
- 10-15 years of increasing heavy drinking, drinking at least a bottle of sherry each day
- Lost her job and increased drinking
  - Admitted onto GIT ward with history of convulsions, evidence of neglect and possible financial abuse
  - Confused and disorientated
  - Denied any problems
- Physically stabilised and referred to ARBD team

14

arbd network

Most important

Through these questions we may have some understanding and appreciate why Jean has made the decision that she has other than just a problem with potential smoking.

Can we find a way of helping her which she is likely to accept?

Examples might be:

regular visits, helping her with her cash, helping her to do shopping, helping her manage her alcohol consumption and enabling her to smoke

15

arbd network

Some thoughts about Jean's situation

Possible indicators of dysexecutive syndrome to consider….

- When assessed prior to going home did we assess her ability to cope in real world situation: did we cater for the frontal paradox?
- Apathetic ?
- Memory loss?
- Suggestible ?
- Lack of risk awareness ?
- Is she overly Impulsive?

Is this because she is mentally impaired?

Has the impairment impinged upon her capacity to make decisions about her care?

16

arbd network

Jean

- Transferred to residential home under DoLs
- Recovery was slow but settled in very well
- Routine developed, helped staff around the home
- Over the next 18 months:
- Went out to shops with staff, visited home with staff
- She increasingly demanded to go home
- DoLs not renewed

17

arbd network

When interviewed

P: I was praying that you would come and get me.
C: Why did you not contact us?
P: Don't know…
C: Why did you give him all your money?
P: He said he would look after it.
C: Why did you start drinking again?
P: Don't know, I don't even want to drink.
C: There is no food in the fridge…when did you last eat?
P: Haven't been hungry
C: When did you last go out?
P: Hmmm…not sure

She refused to come back into residential care or have people in the house because she could not smoke

18

arbd network

Jean

- Before transfer home:
  - BIA noted: Abstinent, Able to self-cater
- Went home with treatment plan and support
- Stopped complying with treatment plan and started refusing support
- We visited her: Neglected state, Weight loss, House dirty, , Little food in fridge, apparent 'neighbours' had taken all her money

19

arbd network

Anosognosia

- A 44 year old lady in a nursing home
- Admitted as a consequence of malnutrition/starvation and long-standing alcohol misuse.
- Significant memory problems
- Fairly profound frontal dysfunction (reasoning problems; dysexecutive syndrome)
- Peripheral neuropathy
  - Unsteady gait
  - Can walk with a zimmer for about ten metres
  - Needs on-going close mobility support
  - Unable to co-ordinate own dressing and anything more than simple motor movements.

20

arbd network

Q. Do you think you have any problems at all?
A No
Q. Are you physically well?
A. Yes
Q. Do you have any memory problems?
A. No
Q. Can you walk perfectly well?
A. Yes
Q. Are you ill?
A. No
Q. You have a Zimmer?
A. Yes...stops people walking into me.
Q. Can you run?
A Yes
Q Why do you use a Zimmer?
A Lots of old people around and it pushes them out of the way.

Conversation extracted from notes taken at interview

- Rinn et al 2002

A preliminary study of individuals in treatment for alcohol dependence found that participants who were judged by clinicians to have more denial regarding their addiction exhibited worse performance on tests of executive functioning, memory, and processing speed than their counterparts who were thought to have less

21