COGNITIVE COMPETENCE AND DECISION-MAKING CAPACITY

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This essay is based upon a panel discussion at the 2020 Creighton Law Review Symposium and Tepoel Lecture entitled The 21st Century Trust: Evolution, Innovation, Adaptation. As the population of the United States shifts, resulting in a larger proportion of individuals living to age 65 and older, ensuring that these individuals are supported in terms of maintaining their decision-making independence when appropriate, is essential. There are normative age-related changes in both cognitive and physical functioning with age, but the impact on an individual’s decision-making is often nonexistent, minimal, or temporary. This essay includes information on normative age-related changes in cognition and the relation to capacity and competency. In addition, appropriate considerations for decisional capacity and evaluation of capacity are discussed, along with suggestions to support aging clients.

I. NORMATIVE COGNITIVE CHANGES AND THE IMPACT ON CAPACITY AND COMPETENCY

As people age, there are normal changes in many different cognitive abilities; some, such as processing speed, attention, and working memory tend to marginally decrease, while other abilities more related to experiences, such as verbal ability, tend to slightly increase or stay the same. These differential changes do not tend to negatively impact a person’s ability to function in everyday life and/or make decisions—if the cognitive changes experienced are within the realm of what is considered “normal.” In that regard, neither decision-making capacity nor competency should be negatively impacted. However, the distinction between capacity and competence should be clarified.

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Capacity is a term used in the psychological literature to refer to a person’s capabilities to make his/her own decisions; it is more about the autonomy of the individual. A functional assessment by a clinician that has some training in psychology or neuropsychology can be conducted to ensure that the person is capable of making his/her own decisions. This can obviously vary as a function of domain, such as health or financial-related decisions. These two domains are discussed and studied most often due to the relevance for aging individuals.

Competency, on the other hand, is a global assessment; it is not focused solely on decision-making for financial matters or decision-making for health or other domains. It is a global assessment that is a legal determination made by a judge in a court about whether someone has the mental capacity to decide in accordance with his/her own personal goals, concerns, and values. People are considered legally competent unless demonstrated otherwise by the court. Thus, competency is an absolute yes or no, whereas capacity can vary. This variability can occur over time, and/or as a function of domain, thus, capacity is a more flexible construct compared to competency. However, it is important to note that a person would not be deemed incompetent if he/she had capacity.

The other issue that makes competency particularly challenging is that it can also be an ethical issue – this is a global determination about whether someone is competent to make decisions for him/her-self. The decision has to be made with caution because, ultimately, it can vary depending upon the context, as is known from research on capacity. However, a competency decision cannot consider different contexts based upon domain or time. It is yes, the person has the ability, or no, the person does not. Because a person’s ability may be fluid, or change over time depending upon the source of the problem, a person’s inability may be temporary. This is one of the reasons why making a permanent legal determination of lack of capacity is difficult. Thus, many legal professionals are left to determine a person’s ability on singular occasions because more often than not, a person will not have lost his/her legal ability to make decisions.

The capacity versus competency distinction is important whenever a person is either temporarily or possibly permanently incapacitated. It is important to keep the person’s best interests in mind in terms of his/her goals, values, and what he/she is striving toward, as well as provide protection from potential abuse. Although, beyond the scope of the present consideration, abuse may occur from others that are interested in what the person may have in terms of his/her estates. From a psychological perspective, this capacity versus compe-
tency distinction is most often important when considering health and/or financial decision-making. In particular, it can be relevant in regard to estate planning, challenges to wills, trusts, donative transfers, and/or guardianships, along with other domains.

In order to determine whether a person is temporarily or permanently disabled, knowing the cause or source of the problem is important. This can relay information about the prognosis, whether the problem is temporary or permanent, if it will get better or worse, whether it could improve with treatment, etc. Answers to these types of questions can help determine whether this is an issue that might resolve over a period of time, or whether it will continue to get progressively worse. If there is a possibility for improvement, then attempting to temporarily delay decision-making for a period of time may be the best option.

Relating competency and capacity back to cognitive functioning, decision-making capacity is not synonymous with cognitive ability. However, it is noteworthy that both working memory and verbal fluency, two abilities that experience normative age-related decline, have been implicated in ability to apply decision rules. Regardless, when the change is normative, the impact on daily life and functioning is minimal. Of concern to most is non-normative cognitive change representative in forms of dementia. Depending on the stage of dementia, this disease can negatively impact a person’s decision-making capacity. However, despite the increasing number of people with dementia, the majority of people will not experience dementia with age. Dementia is considered non-normative cognitive decline, much more extensive than what most people experience. In 2019, approximately 5.8 million Americans were living with Alzheimer’s disease, representing 10% of those aged 65+; these rates increase to 17% of those aged 75-84, and up to 32% of those aged 85+ years. These rates are similar for those experiencing mild cognitive impairment, which is also considered non-normative cognitive change; only approximately 15% of those with mild cognitive impairment will transition to dementia. If an individual has a diagnosis of dementia, it is important to consider the degree to which decision-making capacity may be impaired.


The normal age-related declines that we experience in different types of cognitive abilities is not sufficient to impair our ability to make decisions important to our everyday life and functioning and to live independently. Although there are changes, there are some abilities that plateau or even increase, such as crystalized abilities focused on language, comprehension, and experiences. Although decline occurs in some types of abilities, other abilities are retained or even increase, which can serve a compensatory function. There is a tendency to consider any aging person that exhibits trouble with cognitive functioning, whether it is memory, concentration, calculations, etc., must be exhibiting early signs of dementia. Maybe, but maybe not. It is very possible that even if his/her impairment is mild that there will not be a transition to full-blown dementia, and, in that regard, he/she may still be competent to make his/her own decisions.

Finally, if somebody has a very quick change—a significant change in cognitive functioning within a week or a few weeks’ worth of time, it is most likely not dementia, but may be delirium. Most people recover memory challenges they experienced as a result of delirium. Another consideration is cognitive or memory impairment due to depression, or another mental health issue. In this regard, mental health is usually treatable, suggesting that the impaired cognitive functioning may be temporary.

II. CONSIDERATION AND EVALUATION OF DECISIONAL CAPACITY

In the majority of the decision-making literature, regardless of the domain, the Four Component Model of Decisional Capacity is utilized.7 This model includes four different components/areas that are assessed in studies on decision-making capacity. The first is understanding, which is comprehension of the topic that is under discussion. Appreciation, the second component, involves having full knowledge about the risks, benefits, and significance of the situation. Regardless as to whether the topic is health-related or financial, being able to thoroughly understand the risks and the benefits to each of the various alternatives is essential to demonstrate appreciation. The third component is reasoning, being able to apply the decision to the current context. From the psychological perspective, there is a focus on whether the person can make rational decisions. Finally, being able to express a choice or indicate a preference in some way is the final

component. Even if a person lacks the ability to verbally communicate due to a temporary or permanent problem, if the person is able to somehow indicate a preference by pointing, nodding, blinking, etc., this can be helpful. When evaluating these components, it is important to consider whether someone was once able to do something that he/she is no longer capable of – the question is whether there has been a noticeable change in ability – and again, whether that change in ability is a permanent or temporary change. The fields of psychology and law may concentrate on different components due to the differential focus on what demonstrates capacity versus competency. To satisfy competency, the legal system may attend to understanding the topic and expressing a choice. Mental health professionals assessing capacity tend to concentrate on whether the person can appreciate the significance of the situation and engage in rational decision-making. This contrast is subtle but corresponds with the differences between capacity and competency.

Many practicing in law are confronted with making their own determinations about someone’s decision-making abilities while in the midst of a session. Thus, what can be done to determine if somebody is indeed competent or has decision-making capacity? It is important to be able to look for, observe, and interpret signs of diminished capacity. If signs of diminished capacity are detected, this does not translate into determining that the person should not be allowed to make decisions; however, this can serve as an initial indicator to reconsider whether this is an appropriate time to make decisions. It might be possible to temporarily postpone decision-making or slow down to allow the person the opportunity to make a decision under different circumstances whereby capacity may be improved.

There are cognitive, emotional, and behavioral signs of diminished capacity. Short-term memory loss, communication difficulties, comprehension problems, lack of mental flexibility, calculation errors, and/or overall disorientation may be cognitive indicators of diminished capacity. Emotional signs include various forms of distress and/or inappropriate or quickly changing emotions. Grief, recent changes in health status or diagnoses, amongst other changes, in one’s personal life can cause stress that can temporarily diminish one’s capacity. Finally, behavioral signs can include poor hygiene or grooming, presence of delusions or hallucinations, and/or new needs for assistance with activities or instrumental activities of daily living. With any of these signs, the emphasis is on noticeable differences from previous encounters with the same individual. Looking for these signs in clients and being able to observe and interpret is important, particularly in regard to whether the sign(s) may be something short-term that might resolve. In addition, keeping a note of signs observed and
then looking for them the next time you interact with the person can be really helpful.

Observations of signs should also be made while considering the following: a person’s abilities rather than his/her cooperation, whether there is a change from prior history, being sensitive to potential age-based stereotypes (e.g., trouble concentrating translating into an assumption about dementia), and the potential impact of other mitigating factors. Even in instances where there are some signs present, it may or may not impact the decision currently under consideration. Various mitigating factors, such as stress, temporary medical conditions, normal fluctuations, and sensory changes could impact an individual. If there has been a recent significant change in vision or hearing for an individual, he/she might still be adapting to using new device(s), such as new hearing aids, and might seem very disoriented or disagreeable. Other mitigating factors can include socioeconomic status and cultural differences, which may impact the degree to which people engage in making decisions on their own versus integrating others.

If a lawyer makes a judgment that further evaluation is needed to determine decision-making capacity, this will likely lead to a psychological/psychiatric evaluation. This evaluation will include: 1) a clinical interview, which assesses global cognitive ability and values/preferences; 2) objective tests to assess functional abilities, cognitive functioning, and psychopathologies/psychiatric illnesses; and 3) collateral interview(s) with person(s) close to the individual. In regard to functional abilities, this will assess what the individual is physically able to do on his/her own, such as take care of him/herself (ADLs\textsuperscript{8} and IADLs\textsuperscript{9}), in terms of his/her physical body – feeding him/herself, grooming, etc., and managing his/her independent lifestyle including finances, medications, getting to appointments, etc. Cognitive assessments examine attention, language, memory, visual perception, speed of processing, executive functioning, etc. Finally, with some aging individuals collateral interviews will be completed with people who are close to the aging individual to get their perspective on abilities, changes in ability, and whether the changes have been slow or quick. This clinical evaluation will show where a person falls on the continuum, but it will not provide a definitive judgment as to whether someone is competent or not. The placement on the continuum may vary

\textsuperscript{8} ADLs stands for Activities of Daily Living. These include self-care activities such as bathing, continence, grooming, dressing oneself, eating, etc.

\textsuperscript{9} IADLs stands for Instrumental Activities of Daily Living. These activities have more of a cognitive component such as medication and financial management, shopping, using transportation, making and attending appointments, housekeeping, preparing food, etc.
based upon time or domain. However, when, in terms of the legal perspective, it has to be an absolute yes or no, a clinical assessment can be used in the court to help make a competency judgment. In the court, the person is either deemed competent to make decisions for him/herself on any domain or he/she is deemed incompetent to make decisions for him/herself on any domain.

The American Bar Association and the American Psychological Association have been in collaboration with one another regarding this issue since 2001. Handbooks to support both lawyers and psychologists regarding capacity have been produced. In the algorithm for lawyers, the flowchart guides one to first consider if there are observational signs of diminished capacity. If so, then mitigating factors should be taken into account. If mitigating factors are present, it is recommended to revisit signs of diminished capacity at a later time. If mitigating factors are not present, then the lawyer needs to consider the transaction to be completed and make a legal judgment regarding whether the person is intact, has mild problems, more than mild problems, or severe problems. If the person is intact, this means that there is no or very minimal evidence of diminished capacity. In this case, the lawyer proceeds as he/she always would. When mild problems (e.g., some evidence of diminished capacity but not enough to interfere with the proposed transaction) are detected, the lawyer may proceed or consider suggesting a medical referral, clinical consultation, or evaluation. This may depend upon the lawyer's comfort level and/or history with the client. When the legal judgment is more than mild or severe, it is unlikely that the transaction will proceed exactly as initially intended. This suggests that there is substantial evidence of diminished capacity (i.e., more than mild). In this regard, consultation with a neuropsychologist or a clinical psychologist would be recommended in most circumstances. In some instances the transaction may proceed with caution. In all cases of severe problems, the transaction will not continue, and the lawyer may decline/withdraw representation or at least request protective action for the client until a formal capacity assessment has occurred.

III. SUPPORTING AGING CLIENTS

In cases of diminished capacity, whether temporary or progressive, lawyers can support aging clients to enhance capacity; this may be particularly relevant when mitigating factors are present or only mild problems may be evident. These techniques may also be used in

cases of more substantial diminished capacity to simply support the client, even if the transaction does not proceed. To foster trust and confidence with clients, ensuring confidentiality is essential. Demonstrating respect and encouragement, providing additional time to make decisions, and supporting continued participation in decision-making (regardless of legal determinations of competency) can also enhance client capacity. Extending the amount of time, even over multiple sessions, can be particularly helpful, especially in cases of mild concern that might temporarily resolve themselves over time. In this case, at the beginning of the next session, decisions made in the prior session could be briefly revisited to ensure no changes are desired before continuing. Being mindful of sensory changes, particularly in regard to vision and hearing, is also important to enhance client capacity. It is essential that the client can hear and understand what is being spoken and communicated.

In regard to cognitive impairments, adaptations can be made. Again, approximately 15% of people with mild cognitive impairment progress to dementia, but the majority of them do not. Also, less than 10% of people aged 65+ have mild cognitive impairment, whereas this number increases to approximately 15% of those aged 75 to 85, and 30% of those aged 85 and older. Depending upon the individual, and possibly the day, mild cognitive impairment may place someone in the mild or more than mild designation. The cognitive impairment may be permanent or temporary. Thus, simplifying as much as possible, slowing the pace, and allowing sufficient time to make decisions (when appropriate) is necessary. Providing additional cues and rephrasing may also help. Finally, strengthening client engagement in decision-making is encouraged.11 Even in instances where there is a power of attorney involved, or a guardianship, or someone has been deemed incompetent to make decisions, they can and should be included in those decision-making processes to the extent that they can.

In conclusion, there are various strategies to support aging clients. It is essential to keep in mind that some instances of diminished capacity are temporary, and mitigating factors can be influential. Further, the majority of aging clients will not have dementia, so utilizing strategies to support those experiencing normative changes and/or mitigating factors is essential to maintaining a positive relationship with clients. Looking for, observing, and interpreting potential signs of diminished capacity are important, and should be regularly attended to in all adults, but particularly in aging adults when mitigating factors may be present. These indicators might be temporary or

permanent. Additional suggestions include asking and encouraging clients to consider advanced care planning, such as living wills and advanced directives.\(^{12}\) There are dementia-specific advanced directives available to consider care at each stage of dementia. There are many options in regard to who an individual may want to make healthcare and/or financially-related decisions in the event that he/she is temporarily or permanently unable to do so. In that regard, completing planning documents by the time a person is 50 or 60 and then revisiting it every five years to make sure that his/her wishes have not changed can be helpful. Finally, another form of planning is to offer the option for shared decision making and, when necessary, integrating powers of attorney, either globally or specifically for health or financial-related decisions.\(^{13}\) Advanced planning can also be discussed in regard to guardianship if a person would ever need that. Regardless, all named individuals should be those that will adhere to advanced planning documents and keep the person’s goals, values, etc. in mind. It is always important, regardless of a person’s legal competence, to include him/her to the maximum extent possible in decision-making.

\(^{12}\) Jane deLima Thomas et al., *Advance Care Planning in Cognitively Impaired Older Adults*, 66 J. AM. GERIATRICS SOC’Y 1469 (2018).