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FINANCIAL AND PERSONAL COMPETENCY ASSESSMENTS FOR BRITISH COLUMBIA SENIORS

The best standard of care that physicians can follow in assessing competency is to do a thorough assessment focusing on the patient's ability to function and addressing the patient's unique needs.

ABSTRACT: Physicians in British Columbia are asked to do competency assessments but are given few guidelines to direct them. This paper gives a suggested format to physicians for both doing and charting competency evaluations under the present or "old" legislation. The key variables to assess are patients' present functioning and ability to make decisions regarding relevant issues within their own unique environments. Collateral information is regarded as an essential part of any assessment, and collaboration with other health-care professionals may be required in order to conduct a thorough review.

New guardianship legislation has been defined in four new Acts. The Representation Agreement Act provides a legal mechanism for adults (19 years of age or older) to name, in advance, a representative to make decisions for them if they cannot. Agreement can be made to authorize personal, health-care, and/or legal and financial directives. Specific triggers will be personally defined to allow the representative to begin to act. Safeguards will be built into the Act to protect vulnerable adults from abuse. The Health Care Consent and Care Facility Admission Act defines new mechanisms for dealing with adults who lack the capacity to consent. This will include provision for Temporary Standard Decision Makers for major health-care procedures or admissions to care facilities. It will also create new Health Care Review Boards to rule on objections to decisions when patients are deemed incapable. The new Adult Guardianship Act defines processes for, first, reviewing an adult's needs and, second, assessing an adult's capability of making decisions around needs. This Act includes provision to deal with neglect and abuse. Finally, the Public Guardian and Trustee Act defines a new and expanded role for the Office of the Public Trustee. In creating these four new Acts, three guiding principles were followed.

1. Adults who are capable may accept or refuse support as they see fit.
2. Adults who need support should be treated in the most effective and least intrusive way possible.
3. Substitute decision makers should

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not be named unless alternative supports have been tried or carefully considered.

It is expected that with implementation of the new legislation a clear new direction will be mandated. Until then, however, health-care professionals must work with the present laws (the Patient's Property Act and the Mental Health Act), which unfortunately do not define criteria for assessment of competency. Therefore, physicians are currently being asked to participate in legal competency assessments for older patients but are given few guidelines within which to work.

This paper briefly reviews some concepts from three publications that I have found useful in assisting me to direct competency assessments, discusses my own general principles for assessment, and outlines the types of questions I ask patients and their caregivers. These questions are included in a charting protocol that I recommend.

The procedures involved in the appointment of a committee under the Patient's Property Act of BC are well documented by McLellan et al.[1] A brief description of appropriate information for the medical affidavits is given, including date and place of examination, types of tests used and their results, diagnosis, prognosis, and a list of collateral informants and the information they provided. This paper also highlights the fact that physicians are asked to give only medical evidence toward a legal judgment. It is the director of a provincial mental-health unit or a judge in court who makes the final decision regarding the legal competency of the patient.

A position paper on financial and personal competency in the elderly was published by the Canadian Psychiatric Association (CPA) in 1989.[2] Guidelines are given regarding which issues should be assessed and which criteria should be considered in drawing final conclusions. It is emphasized that decisions regarding competency should be based on function, not diagnosis. A statement is made that the psychiatrist should, within the bounds of provincial law, "make recommendations which allow the patient to carry out life with the least restrictions possible". It is suggested that in the process of assessment the psychiatrist should consider whether or not the patient can safely manage at the poorest level of functioning when suffering from a condition that causes fluctuations in competency. This latter point is somewhat controversial. Consider the dilemmas involved in using this principle in the assessment of an alcoholic who functions well when sober but poorly when inebriated.

The paper recommends that, to be assessed as financially competent, patients need to "have realistic appreciation of their strengths and weaknesses, understand the nature of their assets and liabilities, have demonstrated ability to make sound decisions, use available resources appropriately and indicate a willingness to do so in the future". These abstract criteria would seem to have universal acceptability. However, in the final analysis, the decision depends on the thoroughness of the evaluation and the subjective conclusions of the evaluator. The subjectivity can be applauded for allowing for professional judgment to be exercised—or criticized for its potential for paternalism.

In a model written by Stephen Anderer, the standard for incompetency or incapacity is defined as a functional inability, as well as the inability to make or communicate decisions.[3] The inability to make or communicate decisions is caused by a demonstrated psychiatric or medical disorder or disability. Anderer believes a basic principle of competency is its inherent interactive nature. That is, the patient's external environment and changing personal skills influence capacity at any point in time. Thus the patient's use of resources, external and internal, should be considered in determining competency status.

In 1991, the BC Public Trustee's Office created an ad hoc multidisciplinary committee to draft a standardized financial competency assessment for the certificate process. The resulting assessment process was similar to the Anderer model. It was never formally mandated, but was piloted within the mental health system. The modification of this process, along with the CPA position paper criteria, forms the basis of my own approach to competency assessments and is also the approach that I recommend to colleagues. My approach involves two components: general principles and charting protocols.

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General principles for assessment of competency

1. Find out if the patient has already named a general power of attorney with durability and if this alone might suffice, rather than requiring a committeeship of finance. If no power of attorney exists or if there is a concern that the power of attorney might not be appropriate, it is then wise to write down what the problem is as stated and to consider whether there is a less restrictive approach than committeeship that would help the patient. The same principle applies in assessing competency of person. Is there a way to help without a committee being appointed?

2. Do not rush to assess a patient unless a decision is needed to protect him or her immediately. Take the time to get a complete picture. Consider if the patient is acutely confused and if treatment of the confusion should be attempted before assessment of competency begins.

3. Maximize patient communication. Use professionally trained translators

when necessary. If the patient has a hearing aid, make sure it is working. When assessing writing skills, make certain that the patient can see what you are asking him or her to complete.

4. Interview the patient personally. Try to ensure that he or she is as comfortable as possible. This includes assessing the patient in a normal context, at home when appropriate. If the interview must be done in a hospital or clinic, assure patient privacy by using a quiet room apart from other people. If a caregiver is present, make certain the caregiver does not try to answer questions for the patient.

5. Assess the patient's strengths, not just weaknesses. The strengths may outweigh the weaknesses and tip the decision toward competency.

6. Remember that functioning is key. As with all geriatric care, it is not the diagnosis but the patient's functioning that is of greatest importance. Diagnosis is important here only in terms of prognosis with respect to functioning.

7. Look at a problem from more than one viewpoint. Collateral information is essential. Multiple opinions help to clarify the image and put it into a proper perspective. It is important to document who gives the collateral information, along with what is said.

8. If in doubt, ask for help. It may be impossible for a physician to give a clear opinion without assistance from other health-care professionals. At all stages of assessment, if questions arise that you are unsure of, ask for help. The Public Trustee's Office can be invaluable. At times, physician colleagues may help, either formally, by giving second opinions, or informally, by listening to a verbal case review and giving comments.

9. Hold high respect for the personal rights and value systems of the patient. Inform the patient in a simple, clear, nonthreatening way about the nature of the assessment and its conclusions. When a patient has difficulty expressing personal wishes now, search for what his or her wishes were in the past when the person was more independent. Try to include a statement about these in the final conclusions or special recommendations.

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Suggested protocol for charting financial competency assessments

1. Kind of assessment
   State what kind of assessment this is (competency of finance or person or both).
2. Reason for referral
   State the problems that led to the referral and from whom the information was obtained.
3. Patient's reaction
   State briefly how the patient was informed about the nature of the assessment and what his or her response was.
4. Functional ability
   A. In the patient interview, ask about the following issues and chart answers.
   (i) What is your income?
   (ii) What are your assets? (property, bank accounts, investments)
   (iii) What are your expenses?
   (iv) Do you have debts?
   (v) Can you write a cheque? (Have the patient demonstrate this ability.)
   (vi) How do you pay your bills?
   (vii) Who, if anyone, helps with your finances? Whom do you trust and why? Who is available within your social network to help?
   (viii) What are your personal strengths?
   (ix) Do you have any legal actions that you are involved with at the present time?
   B. In collateral interviews, ask about the patient's history of functioning with respect to the same issues that the patient interview has enquired about. Always indicate the source of information.
   Summary of functional ability
   On the basis of the patient interview and collateral information, draw conclusions regarding the patient's present functional ability.
5. Decision-making ability
   A. In the patient interview, ask the patient about the following issues and chart answers.
   (i) Does the patient recognize financial problems and needs?
   (ii) Does the patient understand the nature of the problems that were noted on the referral? (Confront the patient directly about these with direct questioning, being careful not to be offensive. For example, if you know from collateral information that the patient has not been paying the rent but the patient does not mention this, say that you understand from information given to you that this is the case and you wonder if the patient can comment on this.)
   (iii) Does the patient know about potential solutions for problems or how to satisfy financial needs?
   (iv) Does the patient understand personal risks involved in financial management? Are there others at risk because of personal decisions regarding finances?
   (v) Does the patient ask for help? If not, why not?
   B. In collateral interviews, note collateral information regarding the patient's past recent history of ability

to make decisions and indicate from whom the collateral information was obtained.

Summary regarding decision-making ability

From information obtained in both patient interviews and from collateral sources, comment on the nature or quality of decision-making that the patient has been demonstrating.

6. Medical/psychiatric evaluation
   Document a general medical psychiatric review including the following:
   (i) relevant personal history
   (ii) relevant medical and psychiatric history
   (iii) communication skills with respect to hearing, seeing, reading, and writing
   (iv) a complete mental status examination including appearance, behavior, mood, thought process, thought content, perception, and a standardized cognitive assessment (e.g., Folstein Mini-Mental Status Examination). Add comments regarding specific mental-status abnormalities or strengths that are relevant to functioning in a competent fashion. Orientation and memory are particularly important variables. Delusions may or may not interfere with competency, depending on their relation to specific decisions made.
   (v) psychiatric diagnoses and medical diagnoses
   (vi) a brief statement of relevant medical-care needs
   (vii) prognosis with respect to psychiatric and medical problems in terms of effects on overall functioning, with and without treatment
7. Final opinion
   Based on the evidence from the assessment and using the CPA criteria, state your opinion with respect to the patient's competency status. Give a simple explanation of how you came to that conclusion. Include a statement regarding your prognosis for competency in the future based on your prognosis for the patient's diagnosis.
8. Special recommendations
   State any special recommendations based on the assessment. This may include such things as early review because the patient's prognosis may be one of improvement, or special concerns regarding family conflicts that might interfere with family assistance.

Suggested protocol for charting personal competency assessments

Managing one's person is an even more complicated and vague concept than managing one's finances. It refers to making decisions about personal welfare and living circumstances. This may include planning for health-care needs, choosing a place to live and with whom to associate, providing for personal nourishment, and ensuring personal safety. Unfortunately, in BC, there is at present no legal definition of partial or specific competencies with respect to personal decisions. Personal competency is given a global definition.

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In doing personal competency assessments, follow the same kind of general principles and charting protocol described for financial competency assessments. Revise the questions regarding functioning according to personal decision-making issues. Ask about:

(i) food shopping, food preservation, and cooking
(ii) what medications the patient is taking or what medical treatments are required and how these are arranged. Ask the names of physicians involved in care.
(iii) where the patient wishes to live now and in the future and why. Is the present housing situation adequate for needs?
(iv) what assistance the patient requires to carry out basic activities of daily living including personal hygiene, dressing, ambulation, nutrition, housekeeping, medical and transportation needs
(v) personal safety issues, recognition of hazards, and handling of simple problems

When reviewing the patient's decision-making abilities, ask directly about the problems noted on the referral and then focus on these problems to ask what the patient needs. Does the patient understand risks and alternatives? Does the patient ask for help? If the situation becomes more complex in the future, how would that affect decisions? Whom does the patient trust now and whom would he or she trust in the future to help make decisions about personal welfare?

Conclusions

The role physicians will play in the assessment of competency, once the new legislation has been implemented, has yet to be defined. Until then, physicians must develop their own personal approach to assessment using the Patient's Property Act and Mental Health Act to assess competency. The best standard of care that physicians can follow is to do a thorough assessment, focus on function as the key principle of assessment, and address the patient's unique needs. Finally, it is important for the physician to document both the process and content of the assessment accurately and to give some explanation of how the conclusions were drawn in order to be both credible and fair as an evaluator.

References

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