

Diminished Capacity

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Diminished Capacity CLE: Chief Justice's

Commission on Professionalism

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Client with diminished capacity (rule1.14)

When the lawyer reasonably believes the **client has diminished capacity, the lawyer may take reasonably necessary protective action** including consulting with individuals or entities that have the ability to protect the client and, in appropriate cases, seek the appointment of a guardian *ad litem*, conservator or guardian

When the client is a minor or suffers from diminished mental capacity, maintaining the ordinary client-lawyer relationship may not be possible... A severely incapacitated person may have no power to make legally binding decisions. Nevertheless, the **client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being.**

Rule 1.14 cont.

In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: The client's **ability to articulate reasoning** leading to a decision, **variability** of state of mind and ability to **appreciate consequences** of the decision, the substantive **fairness** of a decision, and the **consistency of a decision** with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician

Diminished Capacity

- Diminished: mental/emotional impairment(s) that limit or prohibit practical functioning and/or decision-making. Must consider norms and “baseline”
- Capacity: ability to make, communicate, or implement important decisions or needs. Can be global or situation/skill-specific, permanent or transient
- Relevant to criminal proceedings (competency, responsibility, mitigation), civil/probate matters, education and training, custody, health and medical consent and decisions, rights

Capacity-competence

Understand nature and object of proceedings

Understand “concerns-charges” and implications thereof

Factual understanding of proceedings

Aware of parties involved and their role

Ability to assist in their “advocacy-defense”

Flags

- **Reports** of parents, spouse, children, family, teachers, of decreased functioning.
Teachers/professionals more objective
- **Observed** odd speech, variable attention/arousal, disorganized, poor hygiene/grooming, forgetful, impulsive, delusional
- Relevant **records**: school or work, medical reports, psychiatric, test scores, legal
- **Decisions or actions** are clearly contrary to client's welfare or prior *patterns* of behavior or judgment

Probing questions

Do you know the purpose of our meeting?

What does a guardianship mean to you?

What concerns would you have about someone having authority with you?

Why would your family *think* you need help?

Tell me about yourself, your daily routine

Reasons to consult

- When there is an important capacity question that might be clarified by specialized assessment *and* information cannot be more readily obtained
- “It ain’t brain surgery”. Can be a time and logistical hassle, costs somebody, stress for examinee, causes delays
- Court usually appreciates structured, normative, functional/diagnostic information from an unbiased source

Impairments

- Can be **global/enduring** (severe developmental conditions, head trauma, dementias) or **specific/transient** (ischemic strokes, drug-induced, acute psychosis, concussive, epilepsy)
- Symptoms can (and often do) fluctuate and might respond to treatment (e.g., addiction, mania, “sundowning”, catatonia, NPH).

Executive function

Diffuse intellectual skills (metacognition) needed to plan, attend to, organize, prioritize, and execute tasks

Includes working memory, mental flexibility, and self-control

Autism, dementias, head trauma, ADHD, drug toxicity, mania degrade EF

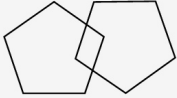
Primarily (though not exclusively) involves brain frontal lobes

Evaluation Process

- Review records: referral from Court, prior assessments if any, medical, school, legal
- Interview and observe “client” (proposed ward, defendant, patient)
- Consult with family, parent, caregivers
- Consider formal test scores and other objective and subjective data (e.g., MMSE, MOCA, DRS)
- Report to Court or attorney succinct findings and opinions addressing nature, degree, and persistence of impairment **and** impact on essential skills (communication, self-care, literacy, money mgt., insight, impulse control, executive functions, *etc.*)

Screening Tool: The Mini-Mental State Examination (MMSE)

Patient _____ Examiner _____ Date _____

Maximum	Score	
		Orientation
5		• What is the (year) (season) (date) (day) (month)?
5		• Where are we (state) (country) (town) (hospital) (floor)?
		Registration
3		• Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat until he/she learns all 3. Count trials and record. Trials _____
		Attention and Calculation
5		• Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively spell "world" backward.
		Recall
3		• Ask for the 3 objects repeated above. Give 1 point for each correct answer.
		Language
2		• Name a pencil and watch.
1		• Repeat the following "No ifs, ands or buts."
3		• Follow a 3-stage command: "Take a paper in your hand, fold it in half and put it on the floor."
1		• Read and obey the following CLOSE YOUR EYES.
1		• Write a sentence.
1		• Copy the design shown. 

_____ **Total Score**

ASSESS level of consciousness along a continuum _____

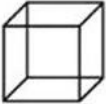
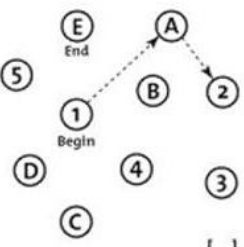
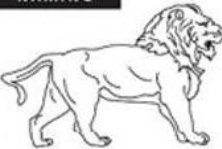
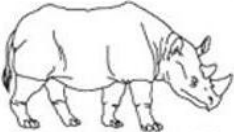
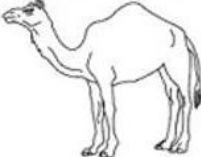
Alert Drowsy Stupor Coma

"Mini-Mental State." A Practical Method for Grading the Cognitive State of Patients for the Clinician. *Journal of Psychiatric Research*, 12(3): 189-198, 1973.
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more information on reverse →

MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME : _____
 Education : _____ Date of birth : _____
 Sex : _____ DATE : _____

VISUOSPATIAL / EXECUTIVE		 Copy cube <input type="checkbox"/>	Draw CLOCK (Ten past eleven) (3 points) <input type="checkbox"/> Contour <input type="checkbox"/> Numbers <input type="checkbox"/> Hands	POINTS ____/5			
							
NAMING							
 <input type="checkbox"/>		 <input type="checkbox"/>		 <input type="checkbox"/>			
MEMORY							
Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.		FACE	VELVET	CHURCH	DAISY	RED	No points
		1st trial	2nd trial				
ATTENTION							
Read list of digits (1 digit/sec). Subject has to repeat them in the forward order [] 2 1 8 5 4 Subject has to repeat them in the backward order [] 7 4 2					____/2		
Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors [] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B					____/1		
Serial 7 subtraction starting at 100 [] 93 [] 86 [] 79 [] 72 [] 65 4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt					____/3		
LANGUAGE							
Repeat: I only know that John is the one to help today. [] The cat always hid under the couch when dogs were in the room. []					____/2		
Fluency / Name maximum number of words in one minute that begin with the letter F [] _____ (N ≥ 11 words)					____/1		
Abstraction Similarity between e.g. banana - orange = fruit [] train - bicycle [] watch - ruler					____/2		
DELAYED RECALL		FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
Has to recall words WITH NO CUE		[]	[]	[]	[]	[]	
Optional Category cue							
Multiple choice cue							
ORIENTATION							
[] Date		[] Month	[] Year	[] Day	[] Place	[] City	____/6
© Z. Nasreddine MD Version November 7, 2004		Normal ≥ 26 / 30		TOTAL		____/30	
www.mocatest.org				Add 1 point if ≤ 12 yr edu			

Brain development

Early growth of social-emotional cortices (limbic midbrain, orbital frontal). Need for reward and stimulation, reactive and irritable, attend to social cues

Later developing cognitive control cortices (dorsolateral frontal). Reduced impulses, regulates emotions, planning, resists pressure

65% of 11-13 yo admit to crime when questioned

20% of 18-24 yo admit

Cases

Several cases have opined that child/adolescent brain development and neuroscience relevant to adjudication:

Roper v. Simmons (2005) banned juvenile death penalty

Graham v. Florida (2010) no life without parole for non-homicide offense

Miller v. Alabama (2012) lack decisional capacity, vulnerable to influence, moral character not developed, “no irrebuttable depravity”

JBD v. North Carolina (2011) juveniles have different perception of legal system, police custody, *Miranda*

Mild cognitive impairment (MCI)

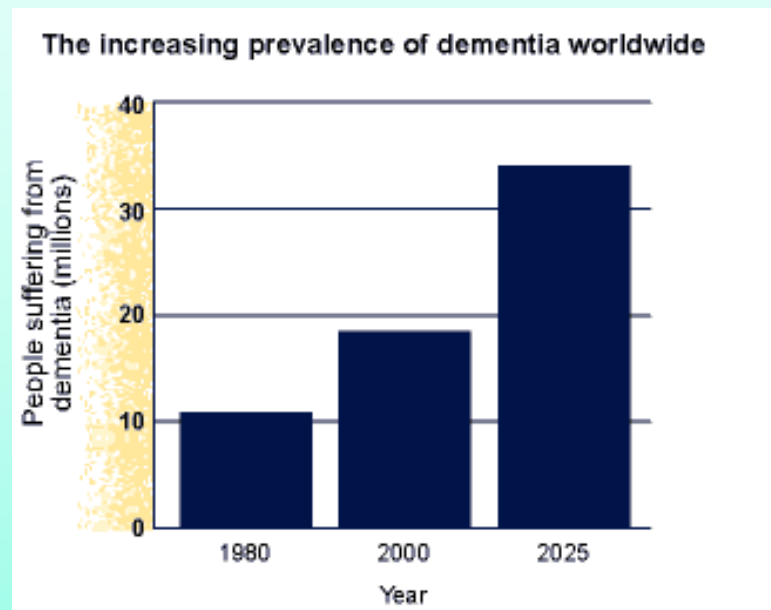
- *Some* evident problems with memory but not actual dementia
- 75% in preclinical stage of dementia. Many have MCI due to stress/anxiety, depression, physical illness (HTN) or overload (i.e., interference vs decay)
- 15% of older adults experience MCI
- Extensive research on MCI currently
- Not enough evidence to recommend specific treatments (except psychiatric and lifestyle changes).

Dementia

Progressive deterioration of intellect, behavior and personality due to diffuse brain disease, especially affecting the cerebral cortex and hippocampus.

Dementia is a *symptom* of disease rather than a single disease entity

Dementia

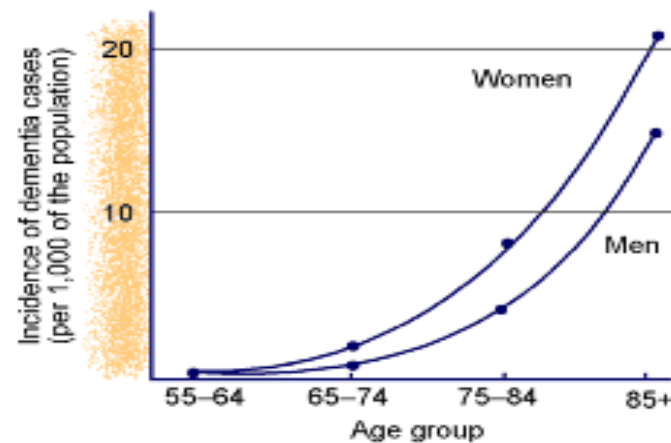


Dementia can occur at any age, **more common among elderly**, 40% of long-term psychiatric in-patients over 65. ~5million in US

Prevalence between 50 and 70 years is about 1-5%, by 80 ~20%, approaching 90 years reaches 50%.

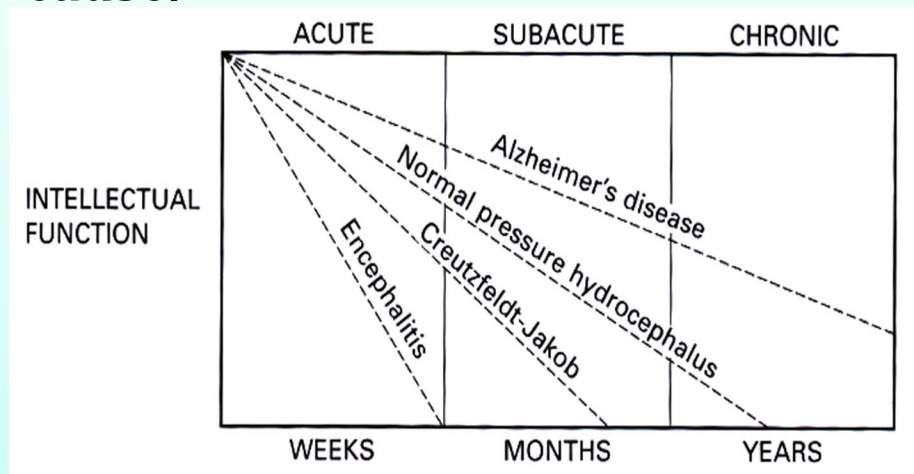
Annual incidence rate is 190/100 000 persons.

The exponential increase in the prevalence of dementia by age group in men and women



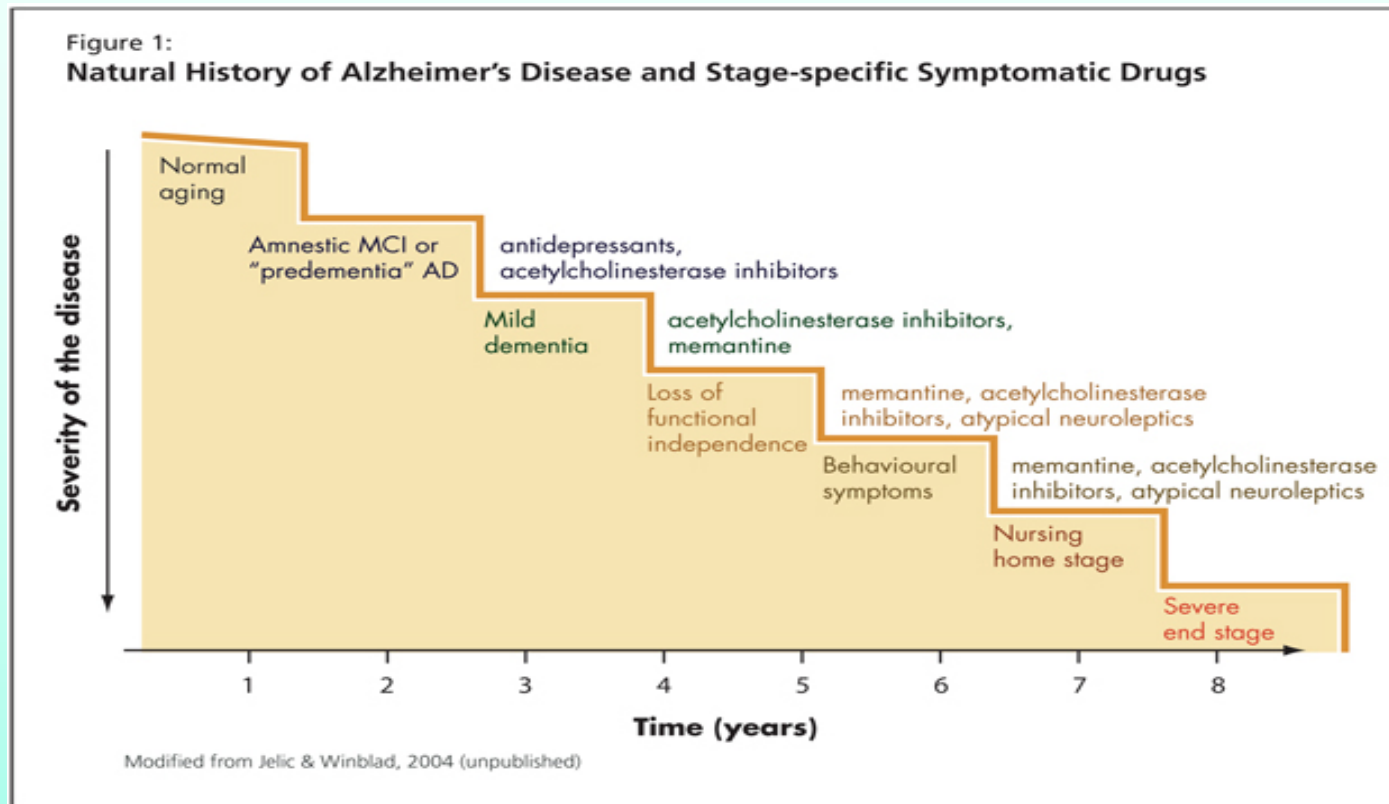
Clinical course:

Rate of progression depends on underlying cause.



The duration and progression helps establish the cause of dementia: Alzheimer's disease is slowly progressive over years, encephalitis rapid over weeks. Dementia due to CVA occurs 'stroke by stroke'.

Progression of AD



Hard cases

Drug-related, history or active addiction

Fluctuating mental illness (schizophrenia, bipolar) and treatment noncompliance

Minimal cognitive impairment (MCI) and early dementia

Localized strokes

Eccentricity

The image features a repeating pattern of colorful speech bubbles on a teal background. Each bubble is a different color (red, yellow, pink, white, and light blue) and contains a dark blue question mark. The bubbles are scattered across the frame, creating a dense, textured effect. In the center of the image, the word "QUESTIONS" is written in a white, serif, all-caps font, with a slight shadow effect behind the letters.

QUESTIONS