ABA CoLAP Senior Lawyer Committee Working Paper on Cognitive Impairment and Cognitive Decline

Introduction

All of our brains go through changes as a normal part of aging. What changes the least are our powers of recognition – "I know it when I see it." What may actually get better – at least up to a point -- is our vocabulary, our abstract reasoning (the ability to see concepts and relationships), our emotional stability and that elusive thing called "wisdom."

Inevitably, there are important cognitive functions that do, to varying degrees, erode over time. Our general cognitive processing (especially of new or novel things) slows; long-term retrieval of information takes longer; learning new information is more challenging; multi-tasking is significantly affected (although no one does this as well as they think they do!); and our spatial memory deteriorates. Cognitive impairment and predictable cognitive decline is not synonymous with a mental illness. None of these things should significantly interfere with our ability to "function normally." And, in spite of what was once thought, as brain cells die, new ones develop – albeit at a slower pace.

I. General Observations of Cognitive Functioning In Adulthood

Declines in both **motor** and **mental** speed of processing constitute the greatest change in function associated with aging. Age-related declines in working memory place limits on other complex cognitive skills, including learning and recall of new information. As we age, the physical size of our brain cells begin to shrink. Connections between neurons (synapses) begin to function more poorly and eventually die; and fewer neurotransmitters (chemical messengers) are produced.

- In our twenties and thirties, our cognitive functioning is arguably at its peak, although there is evidence of the beginning of neuronal shrinking by the mid 20's.
- As early as our 30's, a small amount of brain volume has been lost. Although there is no apparent loss of cognition in any broad sense, sophisticated testing can detect small declines.
- In our forties, our loss of brain volume continues, and may begin to accelerate. Most will notice the slowing of mental processing; and most will note that short-term memory tasks are more challenging.
- In our fifties, an accelerated loss of brain volume begins. Changes in memory and other cognitions become more noticeable. These changes may involve processing speed, multi-tasking, attention to detail, visuospatial processing and the ability to place an event in time and place.

- In our sixties, no surprise, our brain volume continues to shrink. The hippocampus and the amygdala are particularly affected, and these are the parts of the brain that are integral in the integration and formation of short-term memory. Other changes perhaps first noticed in the fifties may become more pronounced. Processing speed slows further; it takes us longer to learn new information or master complex mental tasks; it becomes more difficult to maintain concentration and tune-out distractions; "senior moments" become more common.
- In our seventies and beyond, people vary widely in their cognitive abilities. Many remain sharp until a very advanced age, while others begin to show the wear and tear of life and diseases.

II. Dementia

There are at least 70 causes of dementia, including brain tumors, head injuries, nutrition deficiencies, infections, drug reactions and thyroid related disorders. Some are reversible but many are not. The most common causes of dementia are Alzheimer's, Vascular Dementia, and Alcoholic Dementia and Lewy Body Dementia.

Age, family history, genetics, lifestyle, diseases, and accidents are the most common risk factors for all type of dementias. The greatest known risk factor for Alzheimer's is advancing age. The age at onset is typically after 65, and the likelihood of developing Alzheimer's doubles every five years after the age of 65. After age 85, the risk reaches nearly 50%.

No single lifestyle factor has been conclusively shown to reduce the risk of Alzheimer's. Evidence suggests, however, that the factors that put you at risk for heart disease may also increase the chance of Alzheimer's and Vascular Dementia. These factors include lack of exercise, smoking, high blood pressure, high cholesterol and poorly controlled diabetes.

III. Assessment of Cognitive Impairment and Cognitive Decline by LAP Professionals

Most LAP professionals and lawyers generally do not have the requisite training and expertise to formally assess and definitively diagnose cognitive impairment or cognitive decline. Formal assessment and evaluation of cognitive impairment and cognitive decline would be referred to neuropsychologists, geropsychologists, neuropsychiatrists, geriatric psychiatrists and neurologists. LAP professionals and lawyers, however, need a checklist of the 'red flags' that serve to alert us of the possibility that a colleague's cognitive functioning has dropped below the level that is required to practice law effectively.

In 2005, the American Bar Association Commission on Law and Aging and the American Psychological Association published *Assessment of Older Adults With Diminished Capacity: A Handbook for Lawyers.* We have adapted the *Capacity Worksheet for Lawyers* contained in this publication to serve as a worksheet and guide to LAP professionals called on to assess or assist a lawyer exhibiting signs of cognitive impairment or cognitive decline.

Cognitive Impairment Worksheet for Lawyer Assistance Programs

Attorney Name: _____ Date of Interview: _____
Place of Interview: _____

Observational Signs & Symptoms:

Behavioral Functioning at Work	Observations
Practice management • Deteriorating performance at work • Making mistakes on files / cases • Difficulties functioning without the help of a legal assistant /other lawyers • Committing obvious ethical violations • Failing to remain current re changes in law; over-relying on experience • Exhibiting confusion re timelines, deadlines, conflicts, trust accounting	
Appearance / dress • Inappropriately dressed • Poor grooming/hygiene	
Interpersonal disinhibition • Making sexually inappropriate statements that are historically uncharacteristic for the lawyer • Engaging in uncharacteristically sexually inappropriate behavior • Disinhibition in other nonsexual behaviors	
Self awareness • Denial of any problem • Exhibits/expresses highly defensive beliefs • Feels others out "to get" him/her, organized against him/her	
Significant changes in characteristic routine at work	

Cognitive Functioning	**Observations**
Short-term memory problems (reduced ability to manipulate information in ST memory) • Forgets conversations, events, details of cases • Repeats questions and requests for information frequently	
Executive functioning (slower and less accurate in shifting from one thought or action to another) • Trouble staying on task / topic • Trouble following through and getting things done in a reasonable time	
Lack of mental flexibility • Difficulty adjusting to changes • Difficulty understanding alternative or competing legal analysis, positions	
Language related problems • Comprehension problems • Problems with verbal expression o Difficulty finding the correct word to use o Circumstantiality (providing a lot of unnecessary details; taking a long time to get to the point) o Tangentiality (getting distracted and never getting back to the point)	
Disorientation • Confused about date / time sensitive tasks • Missing deadlines for filing legal documents	
Attention / concentration (problems with dividing attention, filtering our noise and shifting attention) • Lapses in attention • Overly distractable	

Emotional functioning	**Observations**
• Emotional distress: • Emotional lability (rapidly changing swings in mood and emotional affect):	

Other Observations/Notes of Functional Behavior

Mitigating/Qualifying Factors Affecting Observations
Stress, Grief, Depression, Recent Events affecting stability of client:
Medical Factors / medical conditions: o Sensory functioning (hearing / vision loss) o Family history of dementia o Substance abuse / dependence o Hypertension o Stroke history o Thyroid disease o Chemotherapy o Sleep apnea o Prescription medications o High cholesterol o _____ o _____ o _____

PRELIMINARY CONCLUSIONS ABOUT COGNITIVE FUNCTIONING

☐ **Intact** – No or very minimal evidence of diminished cognitive functioning:
☐ **Mild problems** - Some evidence of diminished cognitive functioning:
☐ **More than mild problems** - Substantial evidence of diminished cognitive functioning:
☐ **Severe problems** – Lawyer lacks cognitive capacity to practice law:

Adapted from the Capacity Worksheet for Lawyers, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, by the ABA Commission on Law and Aging and the American Psychological Association (2005).

IV. Intervening with the Lawyer Exhibiting Cognitive Impairment/Decline

A. Approaching the Impaired / Declining Lawyer

1. Partner with one or more individuals that the lawyer trusts, and that has/have firsthand observations of the lawyer's behavior that is raising concerns about the lawyer's continued competence to practice law.
2. Consider utilizing the Cognitive Impairment Worksheet to gather and organize concerns regarding the impaired/declining lawyer.
3. Have a non-confrontational meeting with lawyer and the concerned individual/s; actively avoid confrontation.
4. Starters / icebreakers
    - *I am concerned about you because…*
    - *We have worked together a long time. So I hope you won't think I'm interfering when I tell you I am worried about you…*
    - *I've noticed you haven't been yourself lately, and am concerned about how you are doing…..*
5. Get the lawyer to talk; listen, do not lecture.
6. While listening, add responsive and reflective comments.
7. Express concern with gentleness and respect.
8. Share firsthand observations of the lawyer's objective behavior that is raising questions or causing concerns.
9. Review the lawyer's good qualities, achievements and positive memories.
10. Approach as a respectful and concerned colleague, not an authority figure.
11. Act with kindness, dignity and privacy, not in crisis mode.
12. If the lawyer is not persuaded that his/her level of professional functioning has declined or is impaired, suggest assessment by a specific professional (in most instances, a neuropsychologist) and have contact information ready.
13. Offer assistance and make recommendations for a plan that provides oversight (such as a buddy system or part-time practice with co-counsel).
14. Remember that this is a process, not a onetime event.

B. Do's and Don'ts

1. Do
    - Be direct, specific, and identify the problem
    - Speak from personal observations and experience; state you feelings
    - Report what you actually see
    - Be respectful and treat the lawyer with dignity
    - Act in a non-judgmental, non-labeling, non-accusatory manner
    - Offer to call the lawyer's doctor with observations
    - Refer for evaluation, have resources at hand
    - Suggest alternative; inactive status, disability leave
    - Suggest the potential consequences for inaction: malpractice or disciplinary complaints

2. Don’ts
    - Ignore and do nothing
    - Include family, unless requested
    - Insist or threaten if lawyer directs you to back off; attempt to discuss again at a later date.

Adapted from the Texas Lawyer Assistance Program’s *The Senior Lawyer In Decline: Transitions With Dignity – ABC’s of helping the senior lawyer in need*