Use and limitation of the MMSE in determining capacity

by Donna R. McMillan

Part of the evaluation in incapacity cases centers on the Mini Mental Status (or State) Exam, more commonly known as the MMSE. The test was originally developed as a simplified cognitive mental status exam for elderly patients who, particularly when cognitively impaired, cooperate for only short periods of time. Consisting of 11 questions, it requires only five to ten minutes of testing as opposed to other cognitive tests, which often take longer. A total of 30 points can be scored on the MMSE. One point is given for each correct answer; an incorrect answer scores zero points. The test is a snapshot of a person's mental state at a particular point in time, measuring orientation, short-term memory (retention and recall), and language, and requires verbal responses as well as following verbal and written commands. It measures cognitive status but not executive function, which includes organization (gathering and evaluating information) and regulation (assessing your surroundings and changing your behavior in response).

The MMSE was never meant to replace a complete clinical evaluation. An accurate assessment requires analysis of physical history, a full mental status examination, physical status, and pertinent laboratory data. While the MMSE may be a general indicator of cognitive function, some of its true value is as a baseline screening that can be used to analyze the score over time, determining improvement from treatment or worsening of a condition.

The MMSE also has a set of inherent assumptions in that it requires the person being tested to give verbal responses and to respond to verbal and written commands.

First, the person taking the test should be able to speak and should be fluent in the spoken language of the exam administrator. Consider how the score might be impacted if English is a second language or if the person taking the test is not fluent at all. The test can be administered in a variety of languages, but only if you have a test administrator who can speak the person's natural language.

The second assumption is that the person can see and is able to read and write in the language of the test. People with less than an eighth grade education have been more likely to test positive for dementia or mild cognitive impairment when there is none, and conversely, highly educated people tend to score higher on the test even when they have a cognitive impairment. A raw score of 24, one of the common but not universal cut-off scores between mild dementia and normal cognition, may very well mean normal cognition in someone with less than an eighth grade education, or mild to moderate dementia in a highly educated person.

The third assumption is that the person can hear. What might the impact be on the score for a person who has a sensory or language disorder, such as aphasia, but not a cognitive impairment? Is it noted on the test as a contributing factor? Not usually. Similarly, a hearing problem may be listed in another area on the form, but it is typically not noted as a factor to consider in the raw MMSE score.

Finally, cut-off scores, the scores at which the clinician determines mild, moderate, or severe cognitive impairment, vary. It may be by as little as a point or two, but when you are looking at no cognitive impairment to mild, moderate, or severe, the difference can be significant, especially when you start to factor in the assumptions listed above. Caution is warranted when evaluating a raw MMSE score. Fairness requires, at a minimum, that we consider the limitations of the test and whether any of the above assumptions are being factored into the score, which may be better, or worse, than it appears at face value.

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