Decision-Making Capacity Assessment Program

Class 2: April 2, 2025

for Sound Generations Elder Education Institute by

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Morning

Time	Topic
830a	Housekeeping, agenda
840a	Questions/thoughts from Class 1, discussion
900a	Guest Speaker: Dr Adria Navarro, PhD LCSW
920a	Polls
925a	Breakout rooms: brainstorm impacts on DMC
935a	Groups report back, discussion
950a	BREAK
1000a	Areas of cognition and executive functioning
1015a	Impact of dementia and other disorders
1050a	BREAK
1100a	Case study with Denise
1120a	Impact of other conditions/factors
1145a	Questions/discussion
12noon	BREAK FOR LUNCH

Afternoon

Time	Topic
100p	Questions/thoughts from morning, afternoon agenda
115p	Guest Speaker: Mark Stiefel
135p	Assessments: referrals and requests Collaboration with other parties
145p	Case study with Ashica
205p	BREAK
215p	Assessments: consent/assent, other factors
235p	Discussion of issues you've faced in your work
305p	BREAK
315p	Less restrictive alternatives
330p	Questions/discussion
400p	Recap, resources provided, CEU process, events

Heads up: CEU questions

These will be multiple choice or true/false questions:

1. An area NOT involved in decisional capacity is
2. Diminished financial capacity increases one's risk for financial exploitation. (T/F)
3. Dementia is defined as
4. Cognition and decision making can be impacted by
5. Supported decision making is

Questions/thoughts from last class?

Discussion

Guest speaker: Dr Adria Navarro, PhD LCSW

- Adria E. Navarro, PhD, LCSW is an established gerontological social worker who received the US-UK Fulbright Scholarship to conduct research and teaching at the University of York. Through policy and competency efforts, she hopes to enhance health professionals' assessment of decisional capacity through social care on behalf of older persons in California.
- Dr Navarro is co-founder and program manager of the USC-VHH Community Resource Center for Aging, situated within an academic health system. She provides consultation to an array of entities, as well as having taught the past decade as Associate Professor, MSW Program, Azusa Pacific University.
- Social workers are the largest provider of mental health care in the United States. They are employed within many institutions of care and are sanctioned in several states to evaluate capacity for the U.S. legal system. Dr. Navarro's career is dedicated to maintaining older persons' preferences in support of both their well-being and their safety.

Polls:

1. How much do you feel like you know about cognition and dementia?
   very little–some–moderate–quite a bit–expert

2. How much do you feel like you know about how cognitive impairment relates to the process of making decisions?
   very little–some–moderate–quite a bit–expert

Brainstorm in breakout rooms

What kinds of things impact cognition as it relates to decision making?

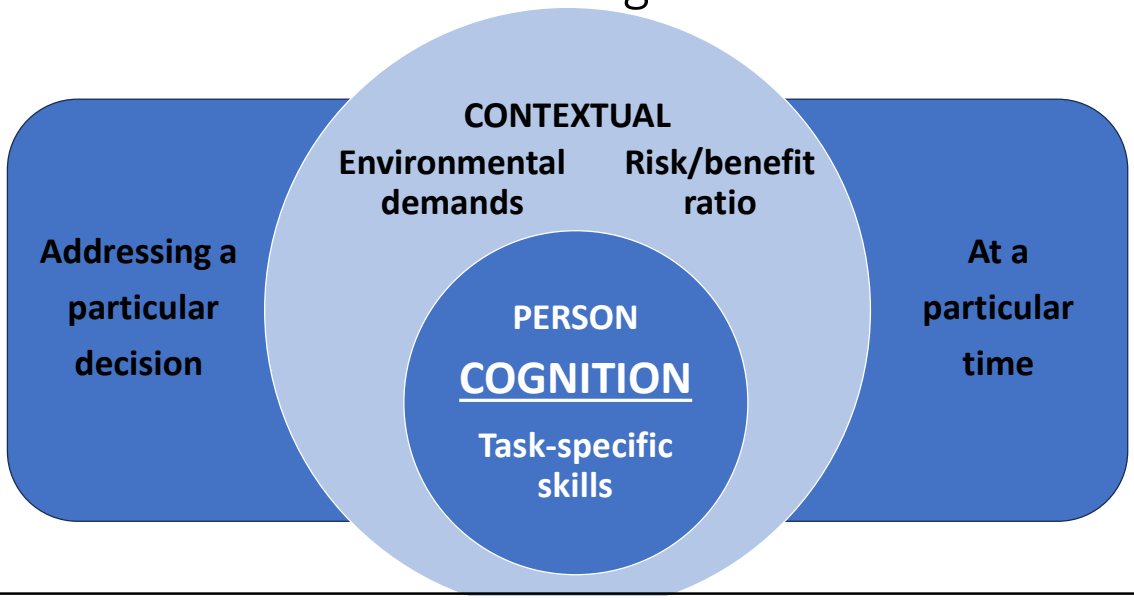
Room 1: Brain related
Room 2: Other medical related
Room 3: Other non-medical

Capacity vs cognition

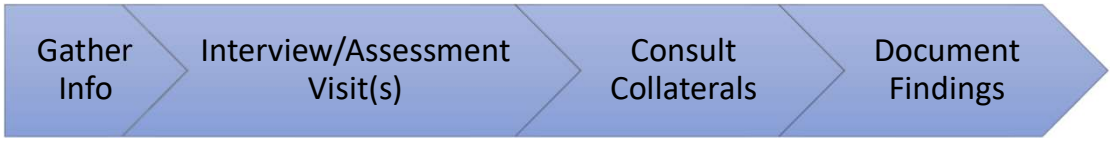
- Capacity refers to a continuum of decision-making abilities
- Is at the heart of being "at risk"
- Can be measured and is related to cognition
- …but is not the same as cognition
  (Marson & Ingram, 1996; Moye & Marson, 2007)

So how does cognition relate to capacity?

Person In Environment – cognition at center



Assessment process: cognition key part



- What's the problem?
- What is to be assessed?
- What legal standard(s)?
- Health status.
- Relevant history.

- Probing questions around DM steps of their understanding, appreciation, reasoning, and choices.
- Cognitive tests, decision aids.

- Get info from family, CG, others.
- Review records or other history.

- Clearly record observations.
- Discuss analysis of interview and other data.
- Clearly state findings and recommendations.

Areas/aspects of cognition

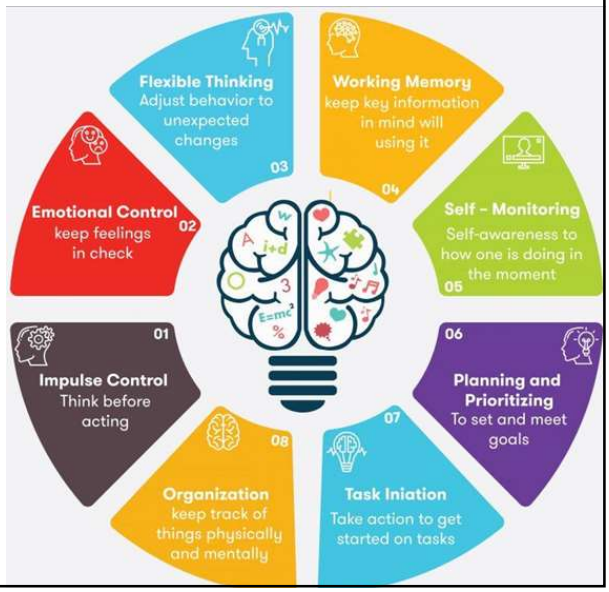
TAKING DATA IN:	WORKING WITH DATA:	
• Sensation • Perception • Alertness • Orientation • Attention • Processing speed • Language: read, listen • Visual-spatial • Learning	• Short-term working memory • Long-term retrieval • Comprehension/ knowledge • Calculation • Reasoning: fluid, logical, abstract • Creativity, imagination	• Judgment • Insight • Motor control • Social cognition • Planning • Problem solving

Areas/aspects of cognition

EXECUTIVE FUNCTIONING:

- Flexible Thinking
- Working Memory
- Self-Monitoring
- Planning & Prioritizing
- Task Initiation
- Organization
- Impulse control
- Emotional Control

Source: https://sciences.ucf.edu/psychology/psychsociety/wp-content/uploads/sites/26/2022/03/Executive_Functioning_Skills_and_Strategies.pdf



APS view of executive functioning

APS training cites Schillerstrom's (2013) definition of Executive Function:

- The ability to plan, sequence, monitor, and inhibit complex goal-directed behavior.
- Involves judgment, insight, and problem solving, and
- Poor executive function is expressed behaviorally as lack of interest or disinhibition

(Schillerstrom, et al., 2013 – cited in APS TARC Capacity Screening in Adult Protective Services: Guidance and Resources).

Related: cognitive load, decision fatigue

- Idea of cognitive load – example of driving your car, easier with less going on, harder in heavy traffic or bad weather
- Decision fatigue (Berg/AMA 2025)
  - Psychiatrist Dr Lisa McLean: "It's no surprise that after a long day of making decisions you may feel tired and exhausted, and you just don't want to have to make any more decisions."
  - "The morning is when we make the most accurate and thoughtful decisions, and we tend to be more cautious and meticulous."
  - "We hit a plateau in the afternoon and by evening our decisions may be more impulsive."

Related: metamemory

- Knowledge and awareness of your own memory, including the contents and processes of your memory.
- Also includes the strategies you use to help you remember something.

Metamemory deficit in older adults is a potential indicator of impaired decision making.

Related: cognitive reserve

- Concept originated in the late 1980s:
  - Researchers studying autopsied brains – looked like advanced Alzheimer's, but people had no symptoms when alive.
  - Thinking was they didn't have symptoms when alive because they had a large enough "cognitive reserve" to offset damage and continue to function as usual. *(Harvard Health)*
- Since then, research has shown that people with greater cognitive reserve are better able to stave off symptoms of degenerative brain changes.
- Cognitive reserve can also help you function better for longer if you're exposed to unexpected life events, such as stress, surgery, or toxins in the environment. *(Kremen 2022)*

Cognitive reserve, continued

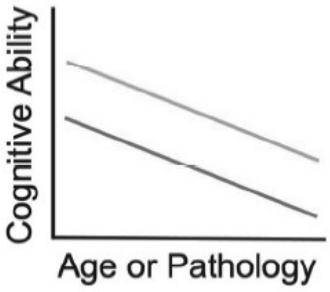
- Idea that if you take care of your brain over time by getting educated and staying active, you build its capacity to cope with changes as you age. This gives the brain more options and pathways to process information, which maintains your thinking skills.
- Associated with improved global cognition, executive functions, and attention.
- Protects against brain damage and dementia, slows the cognitive aging process, and reduces the risk of psychiatric disorders.

"In the face of disruption caused by ageing or disease, some people's brains cope better than others."
- Dr Yaakov Stern of Columbia University *(from AgeUK 2022)*

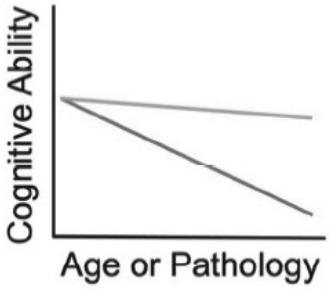
Cognitive reserve and related concepts *(Kremen 2022)*

Reserve	Cognitive reserve	Total or overall cognitive resources
	Brain reserve	Total neural resources or neurobiological capital
Maintenance	Cognitive maintenance / maintaining cognitive reserve	Minimizing cognitive decline over time Relative absence of deterioration over time in brain structure/function
Resilience	Cognitive resilience	Ability to maintain cognitive performance in face of adverse brain-related change
	Brain resilience	Brain structure/function better maintained given factors that risk/cause adverse brain change
	Resistance	Avoiding cognitive decline or brain pathology despite adverse factors

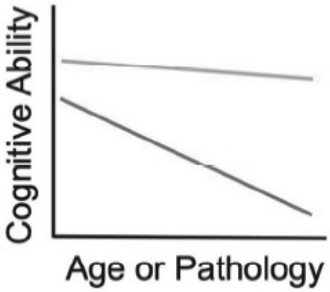
How these concepts play out (Kremen 2022)



Grey group has higher baseline cognitive reserve. Groups have same degree of resilience.



Groups have equal baseline cognitive reserve. Grey group has higher degree of resilience.



Grey group has higher baseline reserve and higher resilience.

Brain changes with age

- Certain parts of the brain shrink, including those important to learning and other complex mental activities.
- In certain brain regions, communication between neurons may be less effective.
- Blood flow in the brain may decrease.
- Inflammation, which occurs when the body responds to an injury or disease, may increase.
- High blood pressure in middle age, along with other cerebrovascular risk factors, such as diabetes and smoking, increase the risk of developing dementia.

Physical health and the aging brain:

Healthy lifestyle behaviors:

- physical activity,
- not smoking,
- not drinking heavily,
- following the Mediterranean-style diet, and
- engaging in mentally stimulating activities.

- People who have 4-5 behaviors = 60% lower risk of Alzheimer's vs those with 0-1.
- 2-3 behaviors = 37% lower risk.
- Higher levels of physical activity = slower rates of cognitive decline.

(NIA/NIH)

Impact of aging on cognition

Some things get better with age:

- Vocabularies
- Knowledge/meaning
- Learning and experiences

Some things get worse:

- Blood flow in the brain
- Inflammation
- Neuron connections

Cognitive processes impacted by aging

- Processing speed
- Reaction time
- Word finding
- Reasoning
- Name recall
- Multitasking
- Focus / attention

- Less efficient at creating new memories so
  - Remembering yesterday is harder than longer term, and
  - It takes more time / effort to learn a new task.

  (AgeUK)

Everyone's different – influence of genes, lifestyle, and environmental factors

Executive function impacted by aging

- Slows down starting **in your 30s**
- Declines significantly beginning at age 60
- Working memory
- Speeded information processing
- Attentional control

Emotions and DM

- Compared with younger adults, older adults use more emotional information when carrying out cognitive tasks.
- Older adults may be biased by stereotypes about memory in aging or beliefs about their own memory. (Hertzog 2019, Ryan 2021)
- This can cause lower confidence and use of different strategies, such as a greater reliance on (potentially misleading) external cues. (Perman 2014)
- For younger adults, major focus of decision-making is “gain” – but focus changes to “prevent loss” in later life. (Samanez-Larkin 2015)

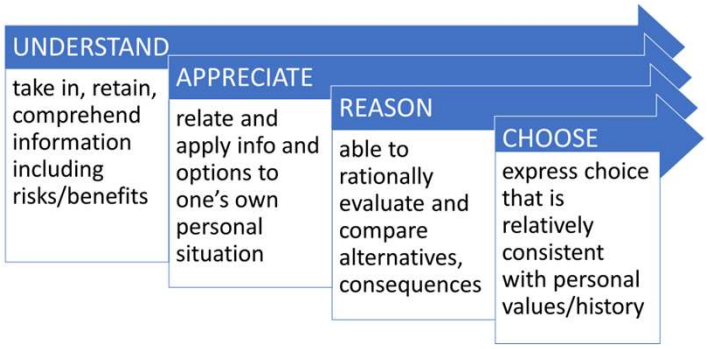
Decision making avoidance

(Nolte & Lockenhoff, 2025)

- Older adults more likely to avoid making decisions than younger adults.
  - "avoid" = delay, evade, reject, or delegate to another decision maker, favoring passive decision making in a context when active DM would be possible. E.g. fail to act.
  - They "respond to higher perceived demands with decreased willingness to engage in cognitively taxing tasks" and generally report less motivation for more effortful DM processes.
- Cognitive and affective factors include choice difficulty, subjected cognitive effort involved in comparing options, emotional toll of making a decision, anticipated/feelings of regret.
- Lower levels of numeracy have been linked to more passive DM.

Specific to the decision making process

- What areas of cognition and executive functioning are involved at each step?



Cognition and understanding

UNDERSTAND

COGNITIVE TASK	IMPACTED BY (in additional to MCI/dementia)
Sensation	PTSD, psychosis, sensory impairment
Perception	Anxiety, PTSD, psychosis, sensory impairment
Alertness	Depression, psychosis
Orientation	Psychosis, loneliness
Attention	General aging, depression
Processing speed	General aging, depression, psychosis, sensory impairment
Language: read/listen, receptive	Depression, education
Short-term working memory	General aging, depression, anxiety, PTSD, psychosis, loneliness

Cognition and appreciating

APPRECIATE

COGNITIVE TASK	IMPACTED BY (in addition to MCI/dementia)
Long-term retrieval	Depression, anxiety, psychosis, loneliness, education
Learning	General aging (speed/effort), anxiety, education
Comprehension/knowledge	Education, life experience
Calculation	Education
Reasoning: fluid, logical, abstract	General aging, depression, anxiety, psychosis, loneliness
Creativity, imagination	Depression, anxiety
Self- Monitoring	Depression, anxiety, psychosis

Cognition and reasoning

REASON

COGNITIVE TASK	IMPACTED BY (in addition to MCI/dementia)
Visual-spatial	Psychosis, sensory/motor impairment
Reasoning: fluid, logical, abstract	General aging, depression, anxiety, psychosis, loneliness
Problem solving	Depression, anxiety, psychosis
Flexible Thinking adjust to change	Depression, anxiety, PTSD, psychosis Psychosis, especially schizophrenia
Plan, prioritize, sequencing	Depression, anxiety, psychosis
Impulse control, inhibition	Depression, anxiety, PTSD, psychosis
Emotional control	General aging, depression, anxiety, PTSD
Insight	Depression, anxiety, psychosis

Cognition and choosing

CHOOSE

COGNITIVE TASK	IMPACTED BY (in addition to MCI/dementia)
Expressive language, writing	Sensory/motor/communication disability
Task Initiation	Depression, anxiety, psychosis
Organization	Depression, anxiety
Impulse control, inhibition	Depression, anxiety, PTSD, psychosis
Emotional control	General aging, depression, anxiety, PTSD
Insight	Depression, anxiety, psychosis
Motor control	Sensory/motor impairment
Social cognition	Psychosis

Look at a specific decision: doing a will (1)

Capacity specific step	Cognitive tasks
Understanding the act of making a Will and its effects	• Semantic knowledge with regards to terms such as death, property, and inheritance
Understanding the nature and extent of their property relevant to the disposition	• Long-term semantic and autobiographical memory related to assets • Short-term episodic and working memory are necessary for more recently acquired assets and property, or if there have been changes to the estate • Ability to form working estimates of assets, and comprehension of the approximate value attached to one's estate

Look at a specific decision: doing a will (2)

Capacity specific step	Cognitive tasks
Evaluating claims of any who might expect to benefit; appreciating the nature of any significant conflict	• Historical and short-term episodic personal memory are required to recall nature of relationships with testator • Executive functions including planning and reasoning are required for distributing one's estate
Communicating clear, consistent rationale for the plan, especially if any significant departure from prior Wills/expressed wishes	• Higher order executive functions such as judgement, reasoning, planning, and the ability to connect one's beliefs and values to the disposition of assets • Language or ability to communicate choice and rationale

Impact on cognition

- Delirium, Mild Cognitive Impairment (MCI) and dementia
- Mental health disorders:
  - Mood – depression, bipolar
  - Anxiety and worry
  - PTSD and stress
  - Psychotic – schizophrenia
- Other factors impacting cognition

Great quote

"Just like dementia does not equal lack of capacity, people can lack capacity without dementia."

Laura Mosqueda

Diagnostic complications

Sharon K. Inouye, professor at Harvard Medical School:

- Cognitive impairment of any kind can affect each stage of diagnostic process.
- Patients with cognitive impairment may underreport or misreport their initial symptoms.
- These result in delay in seeking care or an accurate diagnosis.
- Very high rate of adverse drug reactions in older adults with cognitive impairment.
- Multimorbidity is often not fully considered.
- Together, all of this adds up to very high rates of diagnostic errors and worse clinical outcomes.
- Delirium: up to 50% of hospitalized older adults – unrecognized approximately two-thirds of the time.

(NASEM 2022)

Cognitive changes: dementia and MCI

Dementia

- Progressive decline in cognition and/or behavior caused by brain disease
- Decline in **two or more** areas: memory, reasoning, language, visual perceptual processes, executive functions, social interpersonal behaviors, or personality.
- Interferes with customary activities and social relationships

Mild cognitive impairment (MCI)

- Memory problems or decline in **one** area.

About one-third of people living with MCI due to Alzheimer's disease develop dementia within five years.

Lifetime risk of dementia – new research

- After age 55 years: **42%**
- But 45-60% for women, Black adults and APOE ε4 carriers *(Fang 2025)*
- Number of people living with dementia will likely increase from 55 million in 2019 to 139 million by 2050

  (Nicholls 2024)

"The relative growth in new dementia cases was especially pronounced for Black adults."

Dementia/neurodegenerative and cognition

- Research in Alzheimer's, ALS, and Frontal Temporal Dementia found cognitive performance can predict impaired decisional capacity.
- Decisional capacity is intrinsically related to executive function in these neurodegenerative disorders.
- Executive dysfunction is strongly correlated with disease severity and may predict a lack of decisional capacity, especially for informed consent. *(Portley 2023)*

Good proxy, as neuropsych batteries are long and burdensome especially for cognitive impaired patients and they are vulnerable to non-cognitive factors such as mobility/motor impairment.

Impact of psychotic symptoms in dementia

- Psychotic symptoms in major neurocog disorders: 41% *(Tampi 2019)*
- Around 20% of Parkinsons disease patients experience psychosis or hallucinations. Risk of developing hallucinations in PD patients is likely influenced by PD duration and stage as well as cognitive status. (Gkintoni 2024)

Impact of psychotic symptoms in dementia

- Recent studies suggest a link between psychotic symptoms in dementia and worse executive control and visuoperceptual deficits.
- Alzheimer's patients with psychosis symptoms have worse deficits in working memory and executive functioning and overall have a more severe cognitive decline.
- Presence of delusions and hallucinations, both independently and in combination, is associated with poorer clinical outcomes in Alzheimer's disease. Both together was linked to worse outcomes than the presence of either symptom alone.

Impact of COVID regarding dementia

- Covid pandemic 'had lasting impact' on cognitive function and working memory of people aged 50+ regardless of infection status. (UK NHS)
- People with dementia were more likely to catch COVID.
- COVID causes severe neurological complications in people with dementia – it accelerates disease progression in all types of dementia.
- After having COVID-19, elders have significantly increased risk for new diagnosis of Alzheimer's disease within first year, especially in people age 85+ and in women. (Ding 2023)

Impact on self-awareness / insight

- Some people may have shock and denial around a diagnosis that may impact their insight.
- Anosognosia is not denial, but an inability to recognize disease or deficits

Anosognosia

- *60% of people with MCI*
- *80% of people with Alzheimer's*

Subjective cognitive complaints

- Where the person complains of cognitive impairment difficulties but they perform well enough on cognitive testing tools. It's possible they are aware of subtle changes not picked up in testing. (Jessen et al 2014)
- One study showed subjective complaints predated MCI dx by 9 years. (Kryscio et al 2014)
- However, ambiguous findings due to influence of mood disorders as well as anosognosia/lack of awareness in people who actually have cognitive impairments.

Cognitive training? (per NIA/NIH)

- A large randomized, controlled trial called the Advanced Cognitive Training for Independent and Vital Elderly (ACTIVE) trial tested the effects of cognitive training over 10 years. The study found that participants who had training in reasoning and speed of processing experienced less decline than those in the memory and control groups.
- Beware of claims that playing certain computer and online games can improve your memory and thinking. There currently is not enough evidence available to suggest that commercially available computer-based brain-training applications have the same impact on cognitive abilities as the ACTIVE study training.

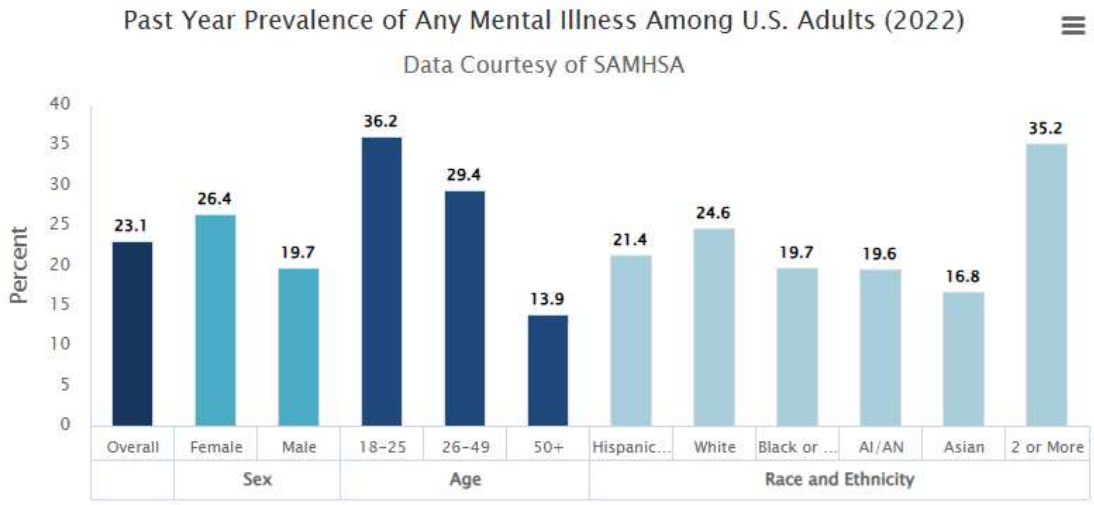
Impact on cognition: mental health disorders

- Mood – depression, bipolar
- Anxiety and worry
- PTSD and stress
- Hoarding
- Psychosis – schizophrenia
- Delusions

Stats on aging and mental health (WHO)

- By 2030, one in six people in the world will be aged 60 years or over.
- Loneliness and social isolation are key risk factors for mental health conditions in later life.
- One in six older adults experience abuse, often by their own carers. This has serious consequences and can lead to depression and anxiety.
- Approximately 14% of adults aged 60 and over live with a mental disorder.
- Mental disorders among older adults account for 10.6% of the total years lived with disability for this age group.
- Globally, around a quarter of deaths from suicide (27.2%) are among people aged 60 or over.

Mental illness rates in US: 23.1% in 2022



Prevalence in older adults (SAMHSA/WHO)

- Depression (major depressive episode, 2021) 14%
- Anxiety (any anxiety disorder, 2003) 9%
- PTSD 1.0%
- Bipolar 0.7%
- OCD 0.5%
- Psychotic and other disorders 0.1 to 1.7%
- Delusional disorder 0.03 to 0.1%
- Substance use disorder 9.1%

Less than half of older adults with mental health and/or substance use problems receive treatment

Risk factors for mental health issues

- Physical and social environment challenges
- Cumulative impacts of earlier life experiences
- Specific stressors related to ageing, ageism
- Exposure to adversity
- Decline in functional ability
- Bereavement
- Drop in income or reduced sense of purpose with retirement
- Social isolation and loneliness 25%

Depression in context of dementia

- People with Alzheimer's disease and other dementias commonly experience depression: 37 to 41% (Leung et al., 2021)
- And they may be less likely to report it than someone without dementia.
- Suicide attempts may also increase in people recently diagnosed with dementia.
- Antidepressant medication has limited efficacy in treating depression that occurs in dementia (Costello et al., 2023)

Depression prevalence

- Depression in general older population 12-14%
- Depression prevalence in people with MCI living in the community is 25% (Ismail et al., 2017)

Depression and dementia intertwined

- Depressive symptoms appeared to be associated with poorer memory at baseline and contributed to faster memory loss over time.
- And in reverse, poorer memory seemed to be associated with greater depressive symptoms at baseline and greater change in depressive symptoms over time.

(Yin 2024)

Depression: prelude to dementia?

- Depressive symptoms may represent non-cognitive prodromal features of a dementia (Leoutsakos et al., 2019).
  - This concept, known as mild behavioral impairment (MBI), is characterized by changes in behavior or personality starting after the age of 50 and persisting, at least intermittently, for six months.
- The risk of dementia is more than doubled for both men and women with diagnosed depression (Elser et al., 2023)
- Numerous studies have demonstrated that depression, particularly when persistent over time, is a well-established risk factor for cognitive decline and dementia (Helvik et al., 2019).

Impact of depression on cognition

- Adults over the age of 55 are less likely to experience MDD than younger adults but are more likely to experience sub-threshold depressive symptoms, which can still impact cognition (Biella et al., 2019).
- Late-life depression (LLD): cognitive impairment appears earlier in depressed individuals. (Niu 2024)
- Early onset, first episode before age 60
  - Lower global cognition at baseline as compared to others.
- Late-onset, first depressive episode after age 60
  - More rapid decline in verbal skills and delayed recall (Ly 2021)
  - Significantly greater decline in executive function (Loyal 2025)

Depression and aging: double jeopardy

- Age and depression may interact to produce a “double jeopardy” for cognitive impairment, and executive functioning. (Niu 2024)
- Research showed significant interaction between age and depression for executive functioning, specifically for middle-aged Hispanic and Black adults, but not non-Hispanic White adults.
- Historically minoritized people may be particularly sensitive.

Depression impact on cognition

- Depressive symptoms significantly affect fluid intelligence and information processing. (Forbes 2024)
- Depression is associated with moderate deficits within the domains of executive function, attention and memory. (Rock 2014)
- Impaired verbal fluency is common in late life depression. (Szymkowicz 2023)
- Deficits in executive function are also common in geriatric depression occurring in nearly 40% of elderly depressed patients (Alexopoulos 2000).
- Deficits in selective attention, working memory, and long-term memory persist in remission from a major depressive episode. (Forbes 2024)

Bipolar disorders

- Progression of cognitive decline is not a general rule with bipolar disorders.
- However, people with bipolar disorders who experience a greater number of manic or hypomanic episodes may have more neurocognitive impairment.

Depression and anxiety

- Depression and anxiety can be antecedents but not consequences of impaired affective control. (Chau 2025)
  - Supports resource allocation model that argues cognitive processes engaged by emotional disorder's symptoms, e.g. maladaptive thinking styles, deplete available cognitive resources for goal-directed tasks.
- Anxiety superimposed on late life depression (LLD) results in greater changes to prefrontal and medial temporal brain regions compared to depression alone. (Persaud 2024)

Anxiety

(Gulpers 2022)

- Lifetime prevalence rates of anxiety disorders in older adults: 15%.
- 18.5% for subsyndromal anxiety complaints.
- Higher anxiety levels in older adults are associated with worse cognitive functioning and increased risk for dementia.
- High scores on the GAD-7 (worse anxiety) associated with worse scores on executive functioning and processing speed, and with higher odds of cognitive impairment.

Anxiety impact on cognition

- Agoraphobia: worse scores on all cognitive domains including executive functioning, higher odds of cognitive impairment
- Panic disorder was significantly associated with worse scores on memory tasks
- Men with any anxiety symptoms were more likely to have substantial worsening in Trails B completion time vs men with no baseline anxiety. (Kassem 2017)
- Sub-clinical "worry" – reduced performance in several areas, including executive functioning and episodic memory (de Vito et al., 2019), and with decline in learning and memory at 2-year follow-up (Pietrzak et al., 2012).

PTSD and stress-related disorders

- Stress impacts cognitive flexibility and processing speed. (Fang 2024)
- Cognitive flexibility is often dysfunctional in patients with stress-related disorders, including depression and PTSD, where biased attention to perceived threats, ruminative focus on negative outcomes and perseverative behaviors are often a main symptom of the disorder (Clancy et al., 2016; Disner et al., 2011).
- Reduced cognitive flexibility shortly after a stressful or traumatic event is predictive of PSTD symptom severity a full year later (Ben-Zion et al., 2018).
- Stress exposure led to more disadvantageous and risky decisions than nonstress conditions (Starcke and Brand 2016).

Hoarding

- Estimated prevalence rates of clinically significant hoarding symptoms from 2.0% to 5.3%. (Makin)
- Especially in elderly patients with severe hoarding disorder, the combination of self-control deficits and refusing to seek help can lead to acute illness and extreme self-neglect, suggesting a potential influence on dispositional capacity. (Kim)

Hoarding and cognitive functions

- People with hoarding disorder commonly have traits of indecisiveness, difficulty with categorization, disorganization, slowness in completing tasks, and often report difficulties with memory, concentration and attention.
- Higher incidence of cognitive impairment on measures of visual memory, visual detection, and visual categorization.
- Relative strengths on measures of verbal and visual abstract reasoning.
- (Mackin)

Psychotic disorders

- As individuals with schizophrenia grow old, illness burden is compounded by multiple medical comorbidities, loss of familial and other social supports, and an elevated risk of institutionalization (Cohen 2018, 2020).
- Cognitive deficits are strongly associated with day-to-day function of individuals with schizophrenia – persists into at least the eighth decade of life (Kalache 2015, Lowenstein 2012, Rajji 2008).
- A projected 25% of individuals with schizophrenia will be older than age 55 by 2025.

Psychotic disorders and DM

(Dong X, et al, 2024)

- Individuals with schizophrenia spectrum disorders (SSD) exhibit less adaption to changing information about risk, which may reflect risk imperception.
- Disorganization may be related to overall decision-making deficits, where more severe disorganized symptoms cause further deviation from optimal decisions in a complex, dynamic risk-taking task.
- Linked to relative difficulty in integrating information and adjusting decisions accordingly (Sterzer et al., 2019).

Psychotic dx/sx plus dementia

- Individuals with schizophrenia began to experience a decline in cognitive abilities 14 years before the onset of psychosis, at a rate significantly faster than those with other psychotic disorders.
- Dementia has been shown to worsen psychotic symptoms like hallucinations and delusions.
- Co-occurrence of cognitive impairments, such as dementia, hallucinations, delusions, and psychosis, can significantly impact neuropsychology. Combining these factors can worsen cognitive impairments, change disease progression, and affect therapy responses (Gkintoni 2024)

Psychotic disorders

- Domains of cognitive impairment in schizophrenia: attention, memory, executive function, social cognition, and perceptual–motor function. (Fang 2024)
- Cognitive remediation for people with schizophrenia resulted in a pattern of improvement in executive function, although it did not have a significant impact on global cognition or MOCA test score. (Golas et al 2025)

Neuromodulation for improving cognition in schizophrenia (Hung 2024)

Repetitive transcranial magnetic stimulation (rTMS)	Working memory Language function Executive function Social cognition
Transcranial direct current stimulation (tDCS)	Working memory Attention Social cognition
Transcranial alternating current stimulation (tACS)	Working memory Processing speed
Electroconvulsive therapy (ECT)	General (not specified)

Delusional disorder

- Mean age of onset 40 years
- Women up to 3x more than men
- Women more erotomanic type, men more paranoid type
- Older adults, particularly women, are at a higher risk for developing delusional disorder, possibly due to age-related changes in brain function and increased vulnerability to stressors.
- May be the result of dopamine circuit disruptions causing misrepresentations of salient and non-salient information, deficits in error processing, cognitive biases. (Rootes-Murdy)

Case study: Denise / “Mr T”

Impact of other conditions and factors

- Physical / mobility
- Environmental
- Literacy / language
- Social / cultural / spiritual

Physical/mobility factors

- Mobility limitations and decline significantly correlate with cognitive decline in older adults (Cao)
- Physical and psychological determinants were significantly linked to cognitive impairment, including lower muscle strength, reduced functional mobility and of cardiorespiratory fitness (Martins)
- Environment, autonomy, and engagement in daily activities influence cognitive impairment (Martins)

Environmental factors

- Indoor temperature range between 68°F and 75°F minimized cognitive issues.
- Deviations of 7°F or more in either direction doubled the likelihood of reported attention problems.
- "This research highlights the need for public health interventions and housing policies that prioritize climate resilience for older adults. As global temperatures rise, ensuring access to temperature-controlled environments will be crucial for protecting their cognitive well-being."
  - Amir Baniassadi, PhD, lead author of the study at the Marcus Institute for Aging Research

Literacy / language factors

- Non-native English speakers: age / formal learning of English, or access to qualified interpreters
- Communication impairments: needed supports/accommodations
- Reading comprehension
- Education level
- Financial literacy
- Health literacy

Social/cultural/spiritual factors

- Study found spiritual well-being more positively related to cognitive flexibility in older adults than younger (Halder)
- Religion and cognition by race: (Sauerteig-Rolston)
  - For Hispanic older adults, frequent attendance at religious services was associated with a slower rate of cognitive decline
  - For non-Hispanic white adults, religious salience was associated with lower initial levels of cognitive function.
  - No association between religious involvement and cognitive function among non-Hispanic Black respondents.

Loneliness factors

- Distressing feeling that social needs are not met by the quantity and particularly the quality of one's social relationships - different from but may coincide with social isolation, a depressive episode, or both. (Camacho 2024)
- Loneliness by itself, aside from other factors, raises dementia risk comparable to having a single APOE4 gene. (Oken 2024)
- For every one-point increase in loneliness, the risk of developing dementia increased by 40%. (Camacho 2024)

Loneliness and cognitive impairment

- Bidirectional association between loneliness and memory function – each makes the other worse. (Yin 2019)
- Loneliness may lead to lower cognitive functioning, particularly among people willing to disclose or recognize their feelings of loneliness – but atypical results among Latinos. (Camacho 2024)
- Loneliness is associated with cognitive decline and volumetric reduction in the frontal white matter. (Lee 2024)

Guest speaker: Mark Stiefel

- Mark Stiefel is an expert in financial and organizational management with a master's degree in Industrial Engineering from Stanford University. His success in family office services comes from extensive experiences managing projects, contracts, properties and performing complex financial analysis in the maritime and aerospace sectors. His focus is assisting Family Offices, busy people and seniors through his practice **Seattle Life Management (https://www.seattlelm.com/)**.
- Mark makes a significant difference in his clients' lives and provides the satisfaction of knowing their financial affairs and home management tasks are professionally fulfilled. He is detail oriented and genuinely cares about each client and is dedicated to achieving positive outcomes.
- In his free time, Mark volunteers for local nonprofits, specifically in the area of advising on sound financial management. He is currently the treasurer of a local nonprofit and he serves as the non-lawyer member of the Washington Bar Association, Client Protection Board.

Back to our assessment process

Gather Info	Interview/Assessment Visit(s)	Consult Collaterals	Document Findings
• What's the problem? • What is to be assessed? • What legal standard(s)? • Health status. • Relevant history.	• Probing questions around DM steps of their understanding, appreciation, reasoning, and choices. • Cognitive tests, decision aids.	• Get info from family, CG, others. • Review records or other history.	• Clearly record observations. • Discuss analysis of interview and other data. • Clearly state findings and recommendations .

Referral or request

- Referral is the "pre-assessment" phase. Need to determine what is being assessed and how the assessment should be planned.
- Setting and/or "sponsor" – can impact informed consent process.
- Any chance of court/legal involvement is important to know.
- Language/sensory support needs, cultural background also crucial.

from ABA/APA Handbook for Psychologists

Getting Oriented to the Case

What:	What types of decisional or functional processes are in question? What data are needed? Am I an appropriately qualified evaluator?
Who:	Who is the client? What is the older adult's background? Who is requesting the evaluation? Who are the interested parties? Who sees the report? Is the court or litigants involved?
When:	How urgent is the request? Is there a court date? What is the time frame of interest? Is the individual medically stable?
Where:	In what context / setting does the evaluation take place?
Why:	Why now? What is the history of the case? Will a capacity evaluation resolve the problem?

Referral or request – specific to attorneys

- Consultation: A lawyer's conversation with a clinician to discuss concerns about the client's presentation. Usually client is not identified and consultation does not require client consent.
- Referral: A formal referral to a clinician for evaluation, which may or may not result in a written report. Requires client consent.

Collaboration

- Input/information:
  - Referral or request for assessment: context, factors, history
  - Medical records: clinic notes, history of diagnoses and medications, neuropsych test reports
  - Other documents: facility assessment/plan of care services
  - *How much to get before the visit vs after?*
- Working with other involved parties
  - *Need for release of information (ROI)?*
  - Medical: may be allowed under coordination of care w/o ROI

Case study with Ashica

Karlawish on assessing capacity *(from EJI 2022 Symposium)*

- Capacity for what? *"Never end a sentence with the word 'capacity.' "*
- Have a plan: open-ended questions, multiple choice
- Begin with assumption that person understands the key facts
- **It's not just cognitive testing:** *"Assessing cognition is distinct and separate from assessing decisional abilities – but they are related."*
- *"Severity of cognitive impairment increases the odds of impaired ability but cannot substitute for an assessment of ability."*

Informed consent vs assent: EJI Panel

Dan Marson	• Important to get "assent" and establish alliance. • In more adversarial situations, informed consent is more important.
Laura Mosqueda	• Assume capacity unless proven otherwise. • "We might have someone sign a consent in order to do testing that proves they don't have the capacity to sign the consent."
Eric Drogin	• You don't know if they're capable of consent until you explore it. "Unwillingness to participate is not tantamount to disability in and of itself." • Without it, can make some observations, but need to be cautious, reflective on what can/can't be observed.

Karlawish: look at ability vs impairment

	Able to perform activity of daily living (ADL), e.g., pay bills?		
		YES	NO
Able to decide how to manage IADL impairment	YES	living independently	dependent and ok
	NO	living independently	dependent and not OK

…but concerning?

(from EJI 2022 Symposium)

Influences on the assessment process.

- **Ethical** – implicit biases, ageism, "to whom is your duty" e.g. confidentiality, legal privilege.
- **Logistical** – client centered process/setting, payment question.
- **Systemic** – supports (and their positive/negative aspects), legal proceedings, processes related to client services/care.
- **Social/cultural** – respect for the client's personal identity and role in both formal and informal contexts; culture of origin.

Issues of equity/justice/access

- **Equity** – address needs of older adults who experience inequities based on income, age, race, gender, sexual orientation, ability, language, and other identities.
  - Older Americans Act asks service providers to prioritize those with the greatest economic and social needs, e,g, those experiencing cultural, social, or geographical isolation, including isolation due to racial or ethnic status and those facing housing instability or interpersonal safety concerns.
- **Justice** – advocacy for client's rights to be protected and decisions respected as fully as possible, with right to needed care/services.
- **Access** – inclusive, minimize barriers, center the older adult

Problem: DMC assessments are not widely available – we're working to change that!

Discussion of issues you've faced in your work

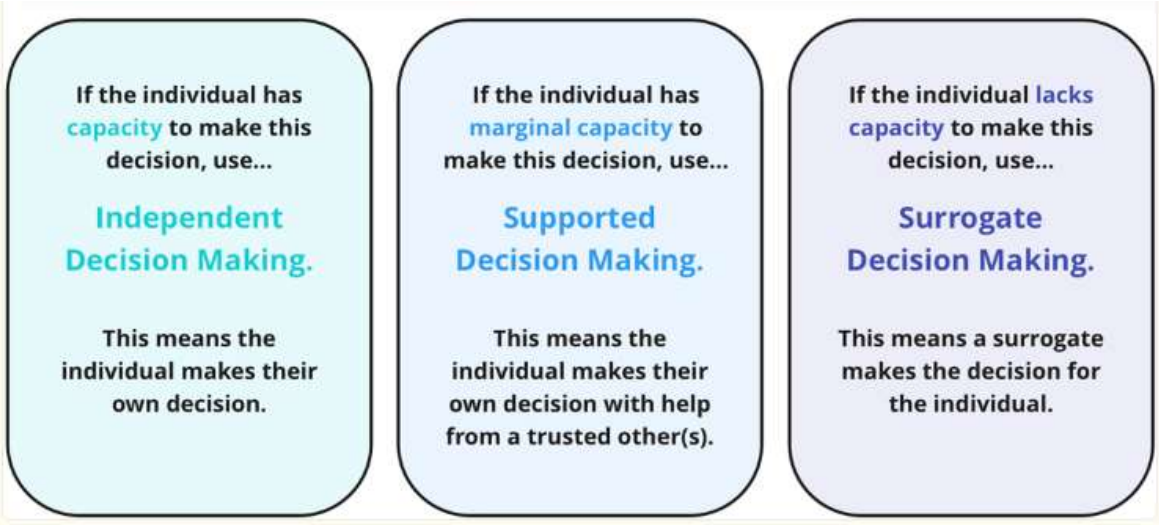
Less restrictive alternatives

- Education
  - Information provided to the patient can be simplified with alternate forms of communication, e.g., visual aids. (Tymchuk 1988)
  - Educational intervention improved decisional capacity in severely depressed patients. (2003 Lapid)
  - Education can assist psychiatric patients in achieving capacity to consent. (Palmer 2002)
- DPOA, representative payee, fiduciary
- Protective arrangements – can be tailored to the situation
- Supported decision making – various models

Supported decision making *(Largent 2023)*

- An approach to decision making in which a person with marginal capacity identifies a trusted person or network of persons to aid them in making their own decisions.
- Recognized by law in a growing number of states
- Even where not formally recognized, it can be practiced informally, helping patients, care partners, and clinicians strike an appropriate balance between respecting autonomy and recognizing vulnerability.

Supported decision making *(Largent 2023)*



Our next classes

May 7	Cognitive testing and other assessment tools
June 4	Case studies and discussion, next steps

Coming up – mark your calendars

Capacity Consultation Group	Older Adult Mental Health Consult Group
Hosted by Dr Adria Navarro of USC 12noon to 1pm on zoom on the 4th Thursdays March 27, April 24, May 22, June 26, July 24, Aug 28, Sept 25, and Oct 23 (Nov/Dec TBD) (to sign up, email Adria.Navarro@med.usc.edu)	Sponsored by GRAT/ACCS 12noon to 1:30pm on zoom on selected Tuesdays Feb 18, Apr 15, Jun 17, Aug 19, and Oct 21 Register at https://us02web.zoom.us/meeting/register/tZYuduChrzMtHdwZFNfXLh8vnk_CDPb6Nq6J#/registration

There's more…

June 15:	**World Elder Abuse Awareness Day** https://www.napsa-now.org/world-elder-abuse-awareness-day/
Sept 8-10:	**National Adult Protective Services Assn conference (in Bellevue)** https://www.napsa-now.org/annual-conference/
Sept 11:	**NAPSA Financial Exploitation Summit (in Bellevue)** https://www.napsa-now.org/calendar/financial-exploitation-summit-2/