Decision Making Capacity Assessment Professional Training Program

Class 1 – October 1, 2025

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Elder Education Institute

SOUND generations

Welcome!

- Two 15-minute breaks in morning and afternoon
- One hour lunch
- Additional time for questions and discussion between topics

Time	Topic
830a	Welcome, logistics, agenda, program overview
840a	Intro polls, changing landscape for assessment
900a	Guest speaker: Dr Adria Navarro, PhD LCSW
920a	How capacity issues come up Legal/clinical views of DM/capacity, history, models
940a	Break
955a	Types of capacity/decisions
1050a	Break
1105a	Types of capacity/decisions – continued
1150a	Discussion/questions
12-1p	Break for Lunch
100p	Discussion/questions, afternoon agenda
110p	Case studies in breakout rooms
130p	Groups report out, discussion/questions
150p	DMC assessment: history/scholarship
200p	Break
215p	DMC assessment: frameworks and approaches
310p	Break
325p	Doing the work of DMCA: process, referrals, models
355p	Discussion/questions
425p	Recap, resources, future classes, other events

Heads-up: CEU Questions

These will be multiple-choice and true/false questions.

1. The steps of the decision making process are…
2. "Everyone should be able to access to competent professional services" is an example of…
3. Capacity assessments can lead to…
4. "As a professional, you should know your own strengths and weaknesses" is an example of…
5. In the United States, specific professions are recognized at a national/federal level to assess capacity.

What this program is NOT

- Does NOT make you an "expert" at performing a capacity assessment
  - After completing this program, there are additional learning and mentorship opportunities for you to build your experience and enhance your learning.
- Does NOT make you a "certified capacity assessor"
  - There is currently no such certification in any U.S. jurisdictions.
  - Note, Canada does have "Designated Capacity Assessors" – each specific province's Ministry of Justice and/or Solicitor General determines who can qualify for this designation.

What this program IS – part of the roadmap

- Building your knowledge and understanding toward professional competence in this increasingly important service area of assessing decision making capacity.

CLINICAL CORE COMPETENCIES + **CAPACITY SPECIFIC KNOWLEDGE** + **PRACTICAL LEARNING PROCESS**

THE "ROADMAP" TO BECOMING ADEPT AT ASSESSING DECISION MAKING CAPACITY

CLINICAL CORE COMPETENCIES

- Active clinical licensure with defined scope of practice for comprehensive assessments of mental health, cognition, and functioning.
- Education/training and practical experience in cognitive testing tools and other instruments commonly used in assessing capacity.
- Experience with in-home comprehensive assessments of mental health and functioning, including home safety – crisis work helpful.
- Familiarity with supports including interpreters, amplifiers for hearing impairment, magnifiers for low vision, PPE, etc.
- Ability to document clearly in plain (non-jargon) language to explain the clinical visit, assessment process, observations, impressions, description of tests/results, findings, recommendations.

CAPACITY SPECIFIC KNOWLEDGE

- Understanding of decision making capacity and how it relates to legal and financial matters as well as functional needs.
- Knowledge of legal standards and criteria for various types of capacity, including to execute legal instruments (e.g. will, DPOA, Advance Directive, Trust, contracts), and what approaches and tools are used in assessing these.
- Knowledge about cognition and cognitive processes, and how they relate to the decision making process.
- Ability to assess decision-making capacity for specific decisions, through interviews with the person as well as information from collateral contacts.
- Ability to document in appropriate formats to meet the needs of the case.

PRACTICAL LEARNING PROCESS

- Shadow: Observe an experienced assessor throughout the visit(s) and assessment process of one or more cases.
- Be shadowed: Conduct assessment visit(s) and completion of case(s) under the supervision of an experienced assessor.
- Participate in consultation/supervision and/or a collaborative working group on a regular basis, with opportunities to:
  - Review cases,
  - Discuss methodology, approach, and problem-solving, and
  - Exchange feedback for continuous improvement.

Class	1 *(today)*	2 *(Oct 15)*	3 *(Oct 29)*	4 *(Nov 12)*
Capacity specific topics	• History of DM models • Legal/clinical views • Types of decisions/ capacities	• DM impact of cognition, dementia, mental health	• Cognitive tests, other tools for assessment • Interviewing for DM	• Case studies from class participants • Review, Q&A, discussion
Work process topics	• Process overview • Referrals and collaboration • Formats/models for assessment	• Consent/assent • Less restrictive alternatives • Supported DM models	• Documentation • Usage/impacts • Court forms • Testifying	• Finding others doing this work • Shadowing/ collaborating • Marketing your services
AND IN EACH CLASS	• Guest speakers from variety of roles/professions • Case studies, role plays, small group discussions • Attention to ethical/systemic/cultural issues • One hour lunch, morning and afternoon breaks.			

Introduction polls

1. What is your licensure/education?
2. What best describes your work environment?
3. How much do you feel like you know about the topic of decision-making capacity in general?
4. How much do you feel like you know about the process of assessing someone's ability to make decisions?

Doesn't Medicare cover DMC assessment?

- The Medicare Annual Wellness Visit is supposed to include (in 60 minutes) →
  - ❑IADL/BADL
  - ❑Decision making capacity
  - ❑Functional Assessment Staging Test
  - ❑Clinical Dementia Rating
  - ❑Medication review
  - ❑Safety for home/driving
  - ❑Advance care planning
- Medicare pays ~$270 for cognitive assessment of patients that present with cognitive impairment.

See https://www.cms.gov/medicare/payment/fee-schedules/physician/cognitive-assessment

Innovation in Aging, 2020, Vol. 4, No. S1

INCONSISTENT CAPACITY ASSESSMENT ACCESS FOR ADULT PROTECTIVE SERVICES: NATIONAL SURVEY RESULTS

Theresa Sivers-Teixeira, Kelly Sadamitsu, Gregory Stevens, Christina Penate, and Bonnie Olsen, *Keck School of Medicine of USC, Alhambra, California, United States*

- **73%** of counties reported primary care physicians complete requests for capacity declarations **less than half the time.**
  - **22.4%** refuse because they don't know how
  - **28.5%** refuse, concerned about being called into court
- **53%** of US counties have no access to assessments
- Key issue is lack of trained evaluators

Balancing needs

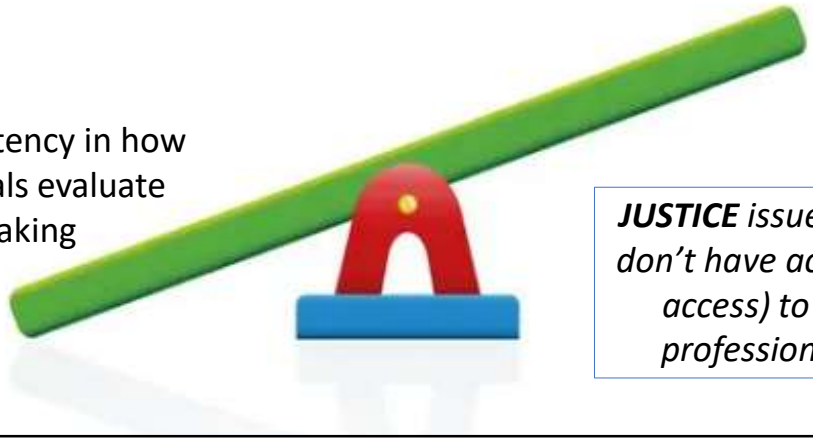
Providers say training in assessing capacity is "insufficient"

AND

Low consistency in how professionals evaluate decision-making capacity

(Seyfried, et al)

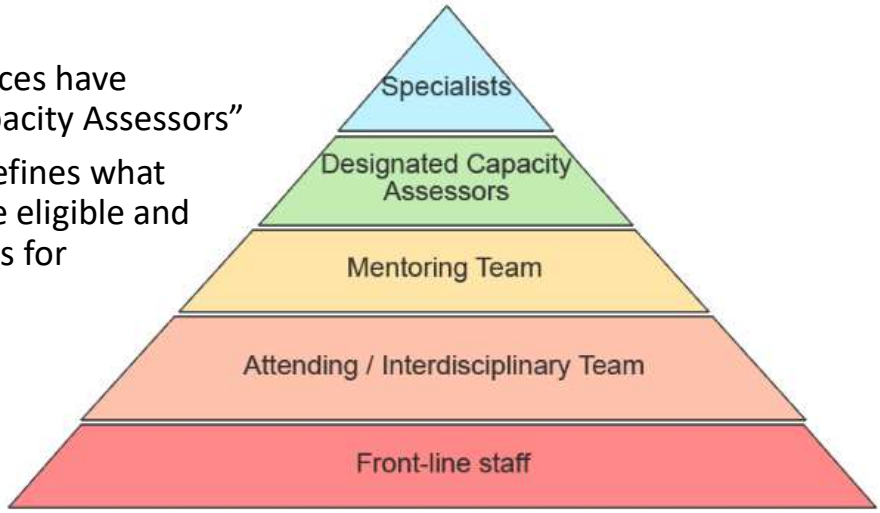
Increasing demand for capacity assessments as the older adult population continues to grow



***JUSTICE** issue when people don't have access (or equal access) to competent professional services.*

Canadian model

- Canadian provinces have "Designated Capacity Assessors"
- Each province defines what professionals are eligible and training / process for certification.



(image from various Canadian webpages)

Who decides in the US?

- Different states' statutes and guardianship processes have different requirements.
- Some states provide for a comprehensive, interdisciplinary team approach—such as an evaluation by a physician, psychologist, and social worker or mental health clinician.
- Some states don't specify anything!

Changing landscape of who decides

- Uniform Law (we'll discuss later) is in process of being adopted by states – already adopted by Washington, Maine.
- Calls for examination by "a physician, psychologist, or **other individual appointed by the court who is qualified** to evaluate the respondent's alleged impairment."

Wider opportunity for clinicians to do this work –
and we need to be trained and learn how to do it well.

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.

"Given the implications of a capacity assessment – loss of autonomy – the absence of guidelines and training is unethical."

Kelly Purser

Capacity assessment and the law: Problems and solutions. (2017) Springer, Switzerland.

How capacity comes up: What have you seen?

What kinds of issues / cases have you faced where decision-making capacity has been a question?

List in chat

Issues that can lead to a capacity assessment

- Medical procedures
- Advance care planning
- Contracts/legal agreements
- Romantic relationships
- Legal/estate planning process
- Needing help in the home
- Gifting assets to charity/others
- Concerns about pets
- Challenges managing finances
- Medication errors
- Dealing with mail and bills
- Disagreements with family
- Decline in functioning or health
- Moving into residential care
- Driving accidents
- Resistance to help
- Abuse, exploitation, neglect
- Self-neglect

"System" triggers

- Law enforcement or Adult Protective Services investigations:
  - Abuse, neglect
  - Exploitation, scams
  - Self-neglect
- Guardianship/conservatorship process
- Legal/status issues – decisions, documents, healthcare crisis

83.6% increase in elder abuse during pandemic

1 in 5 older adults report elder abuse

(Chang & Levy, 2021)

Some of the next big things?

- Death with Dignity / MAID – medical assistance in dying
- VSED – voluntarily stopping eating/drinking
- Secure memory care placement

Legal/clinical views: capacity vs competency

- Capacity: traditionally a medical/clinical term
- Competency: older legal/judicial term (competent to stand trial or participate in legal proceedings)

"Clinical capacity"

and

"Legal capacity"

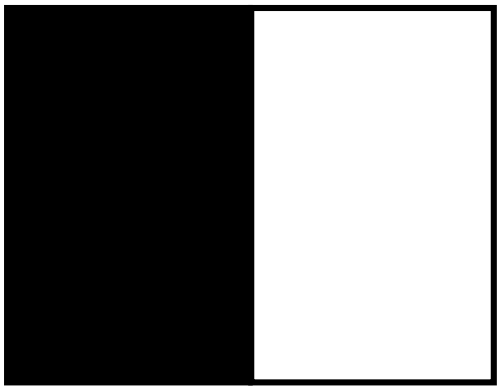
Legal definition of capacity

- Court determination of a person's ability regarding a specific task or decision, or whether diminished capacity limits their ability.
- The court may consider a clinical capacity assessment as evidence.
- Legal determination of incapacity may change the person's legal status and limit their rights.

Clinical definition of capacity

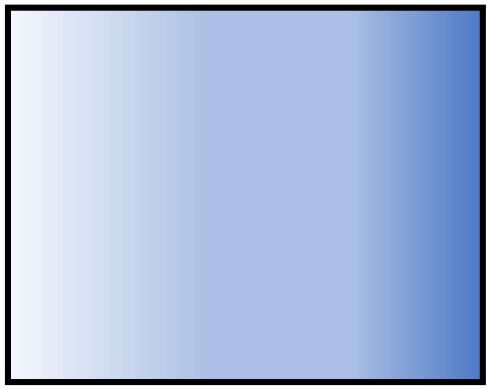
- A clinician's determination as to whether a person is capable of making a specific decision.
- This alone does not change their legal status, but may be considered in legal proceedings.

Legal view of capacity:



generally dichotomous,
"has capacity" or
"lacks capacity"

Clinical view of capacity:



a continuum,
based on the strengths and weaknesses of person's abilities

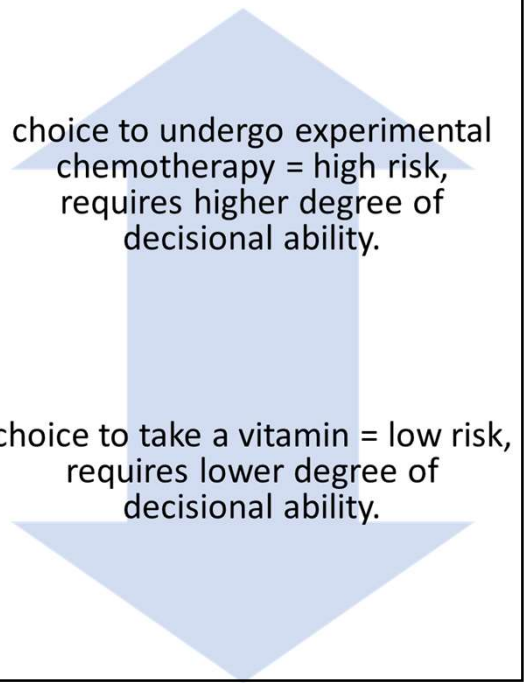
Clinical and legal together

- Clinicians and legal professionals look at capacity in ways that overlap and intersect.
- Clinicians may use different terminology than attorneys or judges, so clear communication is needed.

The ABA/APA handbooks have worksheets to track factors in assessing a client's capacity, which can be helpful to align clinical assessment to legal frameworks.

Context of decisions

- Bar is higher for decisional ability when:
  - Decision/situation is more complex,
  - Expected consequences are more serious, or
  - Risk of harm involved is higher.
- Difficult when a partially impaired person makes a moderately risky decision.



Legal history – background

- "Parens Patriae" doctrine – the crown/society obligation to take care of the vulnerable
  - BENEFICENCE – the obligation of crown/society to promote well being, to maintain or improve quality of life.
- Hippocratic oath: NON-MALEFICENCE "do no harm"
- Democratic ideal of AUTONOMY - the right of the individual to make decisions for oneself

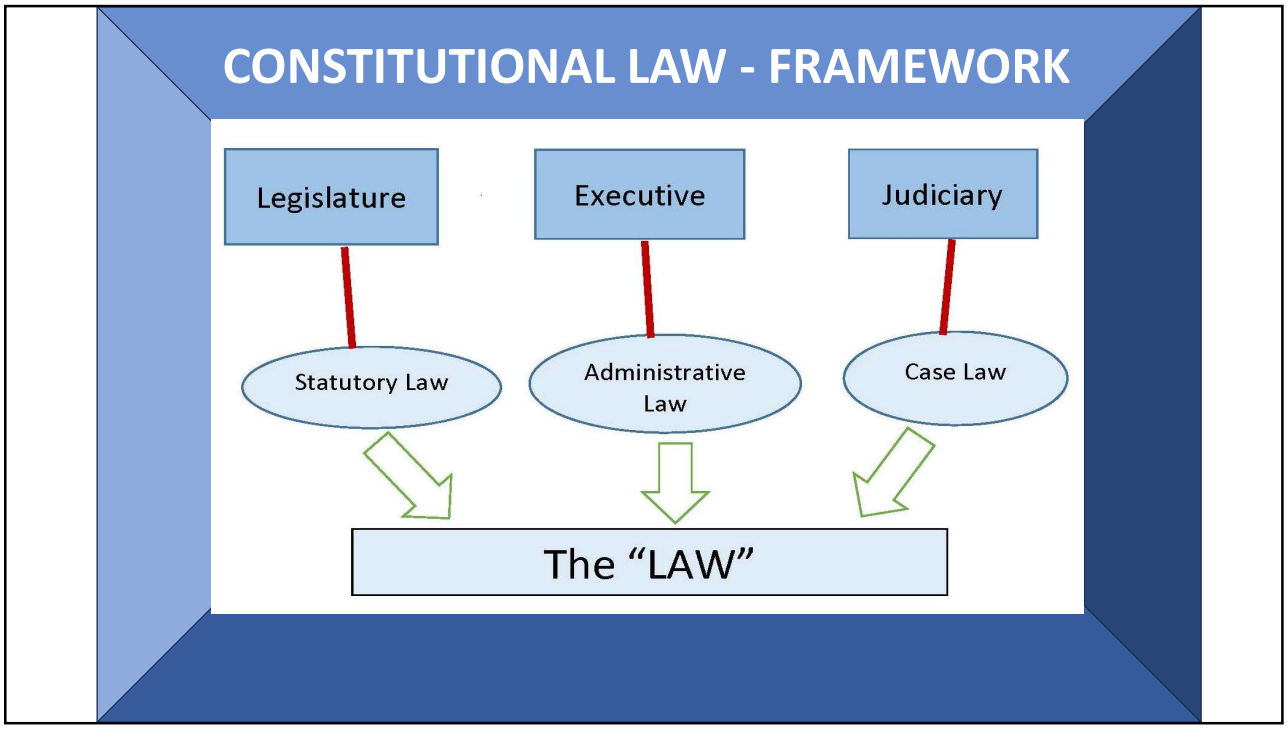
(from Appel, 2024)

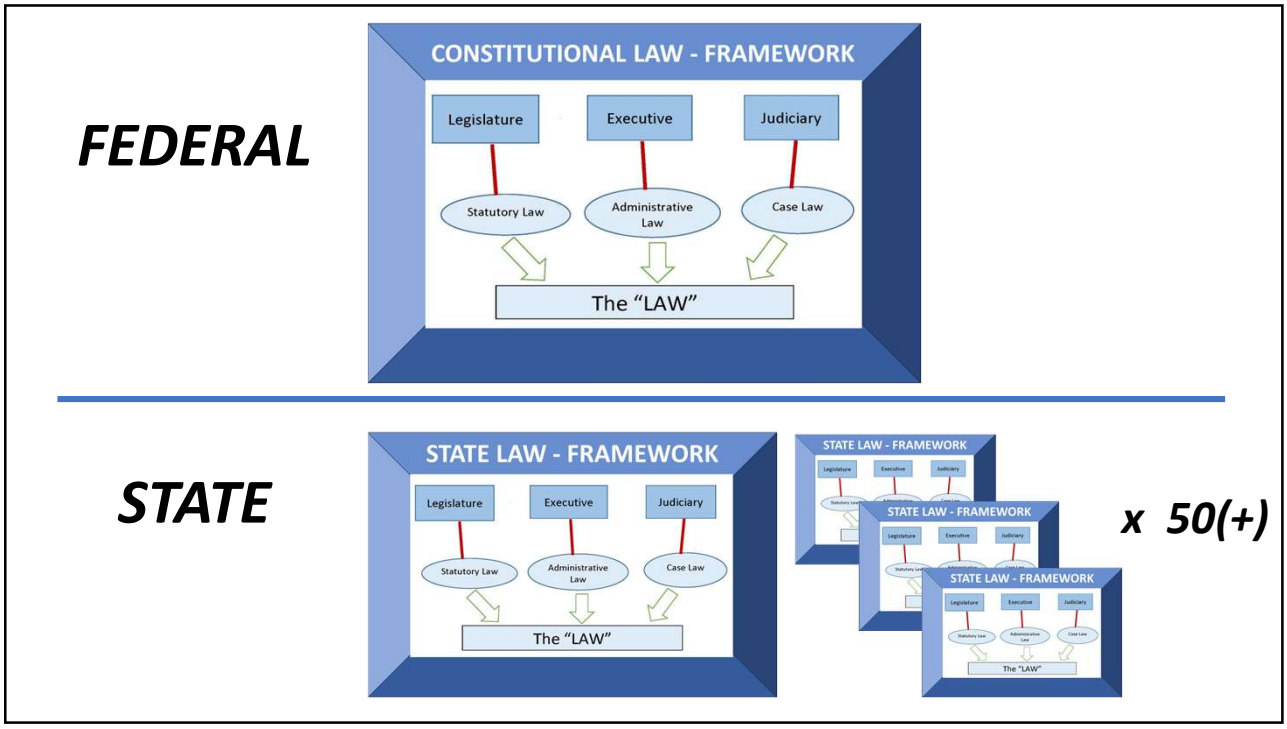
Legal structure basics (U.S.)

(ABA/APA)

American law is broadly divided into four areas:

- ***Constitutional law*** sets the basic framework for governmental powers, civil rights, and civil liberties.
- ***Statutes*** are enacted by elected legislatures, and set out provisions that may be quite broad in scope or fairly detailed.
- ***Administrative rules, regulations, and policies*** interpret and flesh out the statutes.
- ***Case law*** is the body of principles and rules arising from specific disputes heard in the courts. Judges apply constitutional, statutory, and administrative law to individual conflicts, as well as the principles derived from previous cases, to resolve cases and controversies.





Earlier focus on liability/immunity, consent

Generally found in common law, statutes, courts – vs legislation.

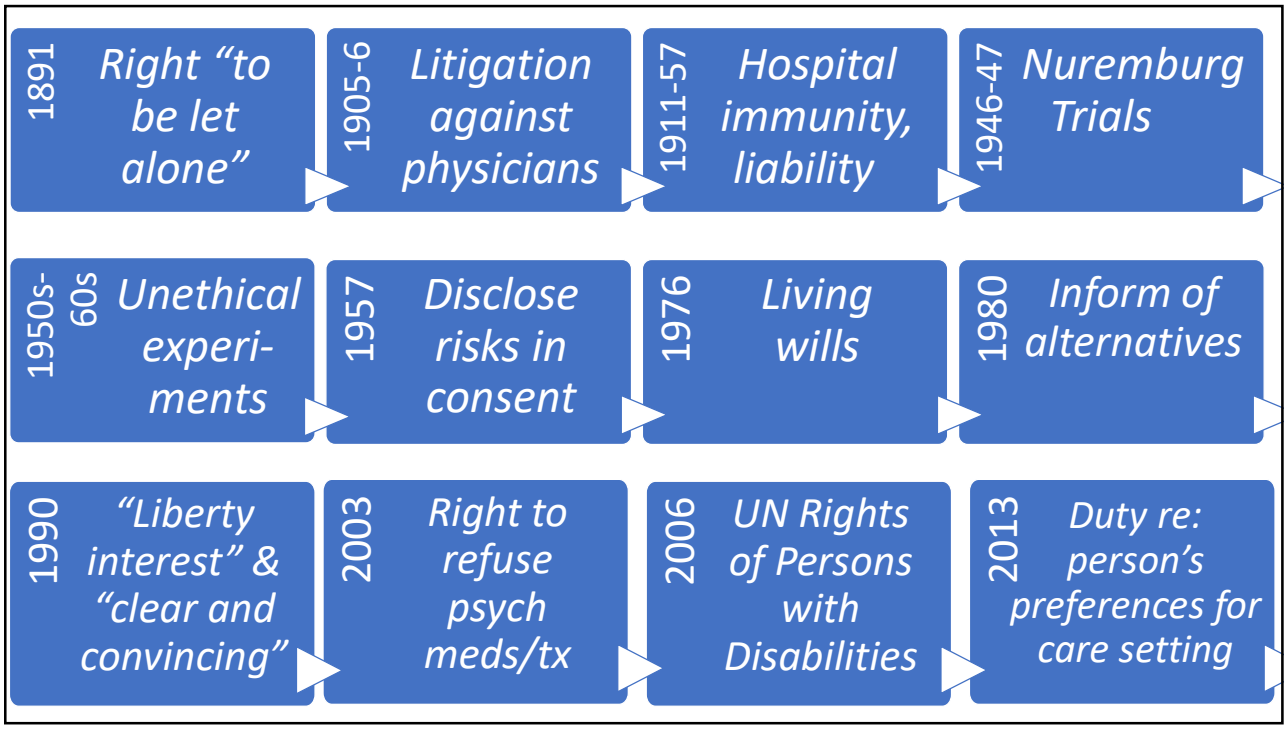
- 1820s-30s: cases on wills and contracts with physician witnesses
- 1891: US Supreme Court Botsford case – right "to be let alone"
- 1905-1906: cases regarding litigation against physicians in Minnesota and Illinois
- 1911 Oklahoma, 1914 New York, 1957 New York: cases on hospital immunity and liability
- 1946-47: Nuremburg trials
- 1950s: ethical concerns of Tuskegee, Willowbrook, Army experiments
- 1957: Salgo case in California led to specific standards for disclosing risks in consent process

(from Appel, 2024)

Later focus on human rights, civil rights

(Appel, 2024)

- 1976: Quinlan case led to California Natural Death Act for living wills
- 1980: Maryland Osheroff case – expectation to inform patients of reasonable alternative treatment options
- 1984: California Durable Power of Attorney for Health Care
- 1990: US Supreme Court decision on Cruzan case spoke to "liberty interest" but states could have "clear and convincing evidence standard" – after that, US Congress passed Patient Self Determination Act
- 1992: first psychiatric advance directive statute in Minnesota – to authorize (not refuse) treatment
- 1993: Uniform Law proposed regarding health care decisions
- 2003: Vermont Hargrave case upheld right of agent to refuse psych treatment on patient's behalf, even if that meant permanent hospitalization
- 2006: UN Convention on Rights of Persons with Disabilities
- 2013: Raven case decision by WA Supreme Court clarified duty of guardian to take incapacitated person's preferences into account in making residential placement decisions.



U.S. laws: guardianship, capacity related

States each have their own laws on guardianship and capacity.

- The Uniform Law Commission, a national organization, provides model or "uniform" laws for adoption by state legislatures.
- 2007: Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act (UAGPPJA) focused on jurisdiction in adult guardianship cases.
- This law was adopted by states nationwide except for Florida, Michigan, and Texas.

U.S. laws: Uniform act, continued

- 2017 Uniform Guardianship, Conservatorship and Other Protective Arrangements Act **(UGCOPAA)** is much broader and deals with substantive issues relating to guardianship and conservatorship of adults and minors.
- Adopted by Maine (2018), Washington (2019), Kansas (2025).
- Pending legislation currently in Alaska, Idaho, Utah.
- Prior versions adopted in Alabama (1997), DC (1997), Hawaii (1997), U.S. Virgin Islands (1997), Minnesota (2003), and Massachusetts (2009).

UGCOPPA definitions

- **Cognitive incapacity:** "unable to receive and evaluate information or make or communicate decisions."
- **Functional incapacity:** "lacks ability to meet essential requirement for physical health, safety, or self-care even with appropriate technological assistance."
- **Guardianship required when** it is "necessary to provide continuing care and supervision."
- **Specific conditions** for a declaration of incapacity include: "mental illness, mental deficiency, physical illness or disability, physical or mental infirmities accompanying advanced age, alcoholism, drug addiction, or other cause."

Various types of capacity

Legally defined in federal/state law:

- execute/sign power of attorney document
- consent to medical care
- consent to release health care information
- execute/sign a health care advance directive
- testamentary capacity – to make a will
- contractual capacity – execute/sign contracts
- donative capacity – to make a gift
- financial capacity (guardian/conservatorship)
- consent to sexual relations

Others

- capacity for independent living
- capacity to drive
- capacity to return to work
- capacity to serve as agent/proxy for others under POA/directive

About power of attorney documents

- Document specifying "powers" or areas of authority granted to another:
  - Finance
  - Health care
  - May be combined in one document

- "POA" – typically only in effect while person has capacity.
- "DPOA" – Durable, remains in effect if/after person loses capacity.
  - Note – in Oregon, POA documents are all durable unless they specifically stated otherwise.

About power of attorney documents

- "Principal" – person signing the document, giving the authority to
- "Agent" or "attorney in fact" – the person named in the document to have authority under the powers specified in the document.
- "Execute" – signing actual document under process required.

Note, any POA is only in effect as long as the signer/principal is alive. When you die, the Power of Attorney dies with you.

Capacity to execute POA

- Traditionally similar to contractual capacity.
- Most states have this in probate statutes.
- Some courts have said standard is similar to executing a will.
- California: "A natural person having the capacity to contract may execute a power of attorney."

Guidance from Australia on financial POA

Australia's Office of the Public Advocate (2003) suggested standards for a person to sign a financial DPOA:

1. know the nature and extent of estate and finances;

2. understand that POA gives the agent complete authority in estate and finances in the same way person has now;

3. know that POA document can direct agent to act in particular way and that POA can be revoked (while person has capacity);

4. understand DPOA authority is activated without any formal procedure when he or she loses capacity;

5. appreciate very high level of trust in agent who is not monitored in any way. Any failings are usually only dealt with after the fact in court.

(referenced in ABA/APA Psychologists Handbook)

Capacity for types of medical decision making

- Consent for treatment
- Refusal of treatment
- Consent for information release (HIPAA)

Across states, core element is the ability to <u>understand</u>

- the nature and purpose of the proposed treatment or procedure,
- its potential benefits and risks, and
- the benefits and risks of the alternative approaches.

Thresholds may differ for consent vs refusal

Capacity to execute health care POA

- Differs from capacity for medical decisions.
- Not well defined in most states – many have statutes on HC advance directives and POAs, but capacity not addressed.
- Utah: important distinction, person may lack capacity to make HC decision but retain capacity to appoint HC agent.

- Need to understand:
  - What it means to give authority to another for healthcare decisions,
  - through a legal instrument,
  - because of future (or present) inability to make treatment decisions;
- And to make a choice, which requires:
  - the ability to determine who would be an appropriate agent, and
  - the ability to express a consistent choice of an appropriate agent.

HC agent vs Proxy

It depends on the document and relevant statutory definitions.

- HC-POA documents name an "agent" to act on your behalf.
- Living wills or advance directives sometimes include a section to name a "proxy" or "surrogate" that can make decisions much like a HC-POA agent.
- Some hospitals give patients opportunity to name a proxy.
- You may also hear "medical surrogate" or "medical proxy" which have essentially same meaning.

About HC advance directives

- Advance directives (aka "living wills") developed in response to medical technology's advancing sophistication and capabilities.
- These are legal documents that provide instructions for medical care and only go into effect if you cannot communicate your own wishes.
- These are "legally recognized but not legally binding." *(House, 2023)*
  - There may be circumstances where your wishes can't be followed exactly.
  - E.g., a complex medical situation where it's unclear what you'd want.
  - Advance directives are difficult to use outside the hospital environment.

Source https://www.guardianship.org

POLST vs advance directive

ASPECT	POLST	ADVANCE DIRECTIVE
Purpose	Converts patient wishes into medical orders for current treatment	Outlines general preferences for future medical care
Target Audience	Patients with serious illness or frailty, typically nearing end of life	All adults, especially those planning for future healthcare decisions
Content	Specific medical orders (e.g., CPR, intubation, antibiotics, artificial nutrition)	General treatment preferences and designation of a healthcare proxy
Who Completes It	Healthcare professional in consultation with the patient or their representative	Individual (often without immediate healthcare professional involvement)
Signatures Required	Both patient (or representative) and healthcare provider	Individual's signature (and often witnesses or notary, depending on state laws)
Legal Status	Binding medical order	Legal document
Scope	Applies to current medical situations and specific treatments	Broad scope for future medical care preferences
Use Case	Ensures specific wishes are followed in real-time medical scenarios	Provides a framework for decision-making if the patient becomes incapacitated

Capacity to execute (HC) advance directive

- Most states have advance directive statutes and case law, but…
- Few of these laws define the mental capabilities and knowledge required. *(ABA/APA Handbook for Lawyers)*

Limitations to HC agent

- Many states' laws and/or local hospital policies limit the authority of healthcare proxies and even guardians to consent to extraordinary treatment, e.g.
  - Withdraw life-sustaining therapies (ventilation, artificial feeding and hydration)
  - Psychiatric / mental health – inpatient mental health treatment, administration of psychotropic medications or electroconvulsive therapy
  - Consent to abortion, sterilization, amputation
- These typically require review by court or oversight body.

Evolving advance directives: examples in WA

- Mental Health Advance Directive (Washington Law Help / Northwest Justice Project, revised 2024, includes optional DPOA)
  - WA law: if over 13 and can make informed decisions about MH care
- Living with Dementia Mental Health Advance Directive (End of Life Washington 2020)
- Advance Directive for Voluntary Stopping of Eating and Drinking (Washington Law Help / Northwest Justice Project, 2025)

Testamentary capacity – signing a will

Defined under probate laws in most states.
Common points:

- Understand the nature and extent of his or her property (what they own, their estate);
- Understand the natural objects of his or her bounty (who would inherit their estate without any will in place);
- Understand the disposition that he or she is making of that property; and
- Be able to relate these elements to one another and say how they want their estate to be handled.

"Where there's a will, there's a lawsuit."
- Ann Landers

Signing a will

Capacity at time of signing is most important

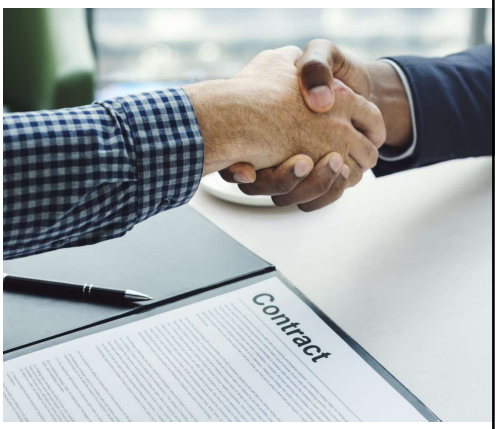
- Can lack capacity before or after – if person has a "lucid moment" they're ok to sign.
- If person has capacity but is affected by an "insane delusion" at the time of signing, then they can't sign.

Donative capacity – to make a gift

- Similar to testamentary capacity…
- Except it affects the donor's financial circumstances now and in the future, rather than after death.
- Some states use a higher standard for donative capacity than for testamentary:
  - Donor has to know the gift to be irrevocable and that it would result in a reduction in the donor's assets or estate, so potentially greater consequences

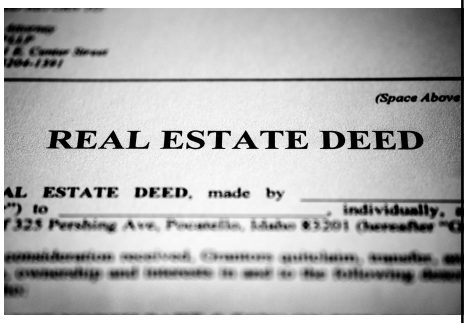
Contractual capacity

- Whether the person possesses sufficient mind to understand, the nature, extent, character, and effect of the act or transaction.
- Focus is the particular contract, not business in general.
- If transaction is complicated, a higher level of understanding may be needed, vs a simpler arrangement.



Capacity to convey real property

- Also termed capacity to execute a deed
- Similar to donative and contractual capacities
- Grantor typically must be able to understand the nature and effect of the act at the time of the conveyance



About financial capacity

- Legal view: represents the financial skills sufficient for handling one's estate and financial affairs, and includes elements of contractual, donative, and testamentary capacities.
- "Medico-legal construct" – the ability to independently manage one's financial affairs in a manner consistent with personal self-interest and values, including:
  - Performance skills (count money, balance checkbook, pay bills),
  - Judgment skills for financial self-interest, and
  - Values that guide personal choices.

Financial capacity

- "Highly cognitively mediated"
- Financial knowledge and skills
  - Vary widely for cognitively normal people
  - Are associated with education and socioeconomic factors.

Conservatorship vs financial capacity

UGCOPPA language: (state statutes vary)

- Court may appoint a conservator if "the individual is unable to manage property and business affairs because of an impairment in the ability to receive and evaluate information or make decisions, even with the use of appropriate technological assistance" and
- The individual has property that will be wasted or dissipated unless management is provided or money is needed for the support, care, education, health, and welfare of the individual or of individuals who are entitled to the individual's support and that protection is necessary or desirable to obtain or provide money.

(from ABA/APA Handbooks)

Capacity to consent to sexual relations

- Not universally defined, different language in various states.
- Most widely accepted criteria (consistent with those applied to consent to treatment): knowledge, understanding, voluntariness
- Need to consider factors of "possible coercion, unfair persuasion, or inappropriate inducements."

(ABA/APA Handbook for Psychologists)

One sexual consent framework: Lichtenberg

- Client's awareness of the relationship – is the person aware who is initiating the sexual contact? Does the person believe that the other person is a spouse and thus acquiesces it is she/he cognizant of the other's identity & intent? Can the person state what level of sexual intimacy would be comfortable?
- Client's ability to avoid exploitation – is the behavior consistent with formerly held beliefs and values? Does the person have the capacity to say no to uninvited sexual contact?
- Client's awareness of potential risks- does the person realize that the relationship could be time limited? Can the person describe how he/she will react when the relationship ends?

Lichtenberg,P.A et al, Gerentologist, 30, 117-120

Others

- Others have specific definitions of capacity based on statutes and court decisions in different jurisdictions:

to marry

to engage in mediation

to testify, litigate, sue and be sued

to vote

Others – not legally defined in statutes

- Independent Living (closest is guardianship language around independent functioning)
- Driving
- Return to work

These involve functional performance tasks and abilities that can be assessed by PT, OT, or other specialists.

Generally 4 factors involved:

- The presence of a disabling condition;
- A functional element— e.g. inability to meet essential needs to live independently;
- A problem with cognition; and
- A necessity component – less restrictive alternatives have failed.

Others – not legally defined in statutes

Ability to serve as agent/POA for others

- Most statues that mention it at all, say agent must be **"fit"** to carry out role.

- Abilities at or above those needed to manage the tasks for one's self.
- Act in person's best interests on top of the tasks of the role.

Case studies in breakout rooms

- One person read the case study aloud
- One person take notes on discussion
- What is the key question or type of decision/capacity in this case?
- What other types of decisions/capacity may be involved?
- If you have remaining time, please introduce yourselves and share what kind of work you do.

Scholarship on assessing capacity

- 1977: American Journal of Psychiatry paper by psychiatrist Loren Roth, attorney Alan Meisel, and sociologist Charles Lidz: "Tests of Competency to Consent to Treatment" – proposed 5 tests:
  - Evidencing a choice, "reasonable" outcome of choice, based on "rational" reasons, ability to understand, and actual understanding.
- 1980s-90s: psychiatrist Paul Appelbaum and psychologist Thomas Grisso developed model of decision-making capacity – not based on diagnostic labels or test scores, but on decisional abilities.
  - 1997 MacCAT-T tools
  - 1998 book "Assessing Competency to Consent to Treatment: A Guide for Physicians and Other Health Professionals"

Appelbaum & Grisso's elements endure:

UNDERSTAND
take in, retain, comprehend information including risks/benefits

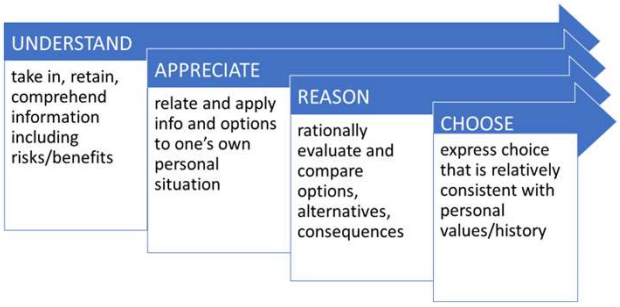
APPRECIATE
relate and apply info and options to one's own personal situation

REASON
rationally evaluate and compare options, alternatives, consequences

CHOOSE
express choice that is relatively consistent with personal values/history

Additional issue with most types of DMC

DECISION MAKING CAPACITY



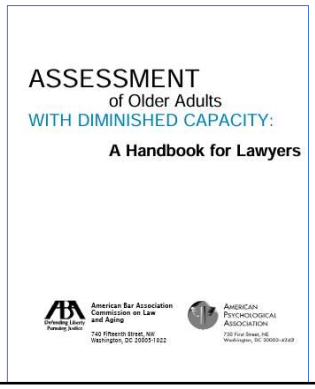
FUNCTIONAL ABILITY

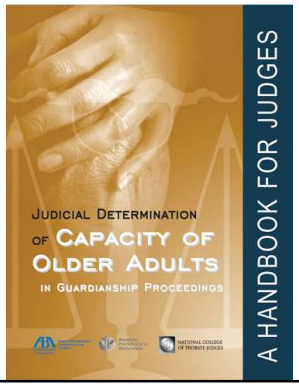
Ability to execute their communicated choice – carry out their stated decision.

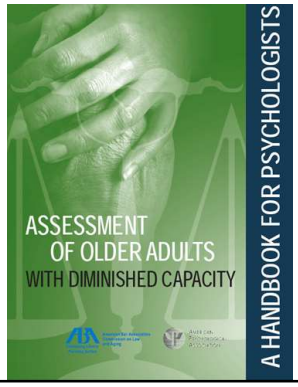
- Performance of the tasks involved.
- Ability to engage supports if/when needed to do so.
- Ability to adjust to change.

Scholarship on assessing capacity

- American Bar Association Commission on Law and Aging, along with the American Psychological Association, published handbooks for lawyers (2005), judges (2006) and psychologists (2008)

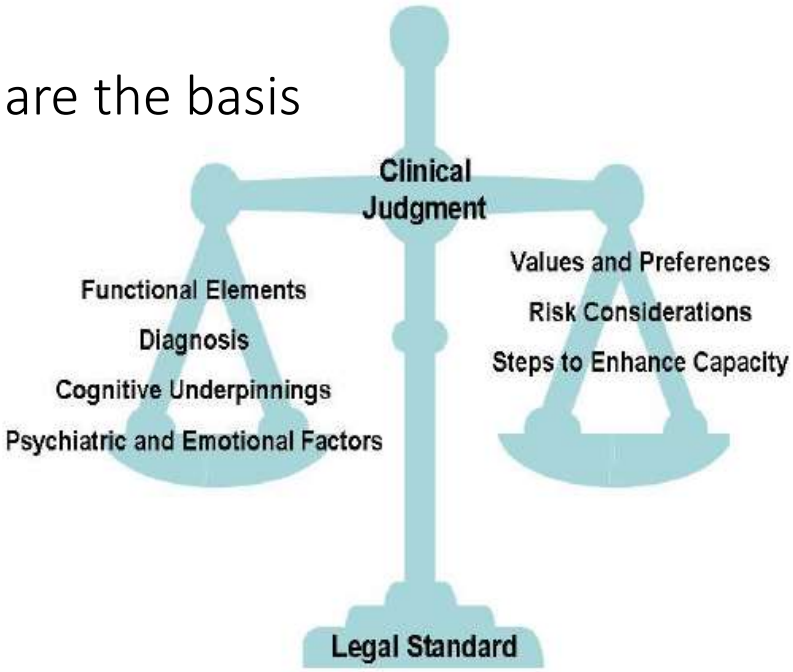






Legal standards are the basis

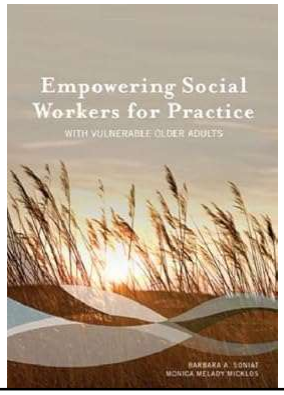
- Many types of capacity are defined by law with particular standards ***which vary state to state***
- These legal standards should be the basis of your analysis in assessing capacity.

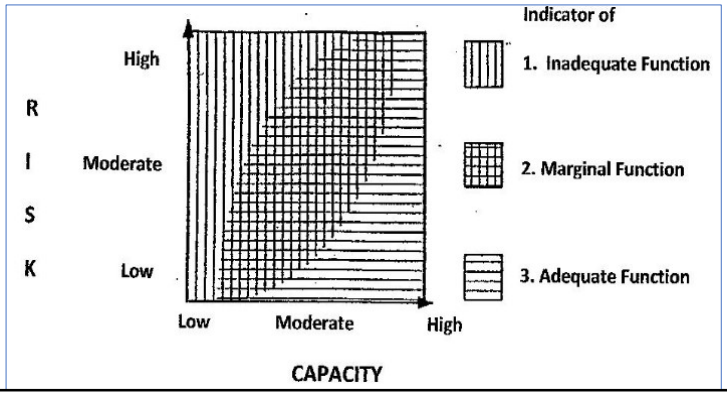


From the ABA/APA Handbook for Psychologists

Books on assessing capacity

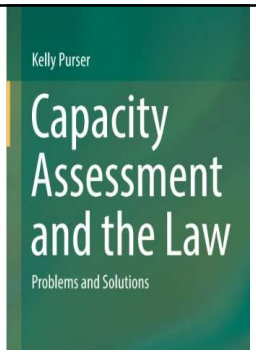
- 2010: Barbara Soniat & Monica Melady Micklos book, *Empowering social workers for practice with vulnerable older adults* – included capacity-risk model for assessment:

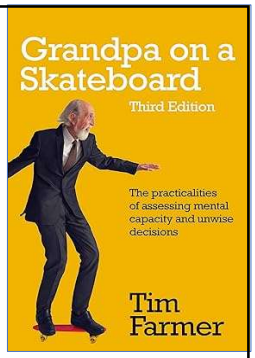


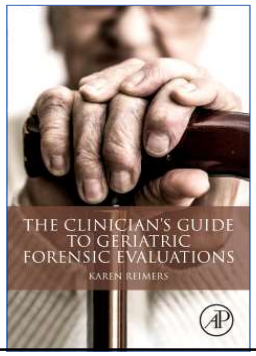


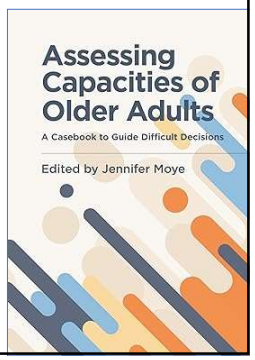
More books

- 2017: Kelly Purser, *Capacity assessment and the law: problems and solutions.* (Australia)
- 2017: Tim Farmer, *Grandpa on a skateboard: the practicalities of assessing mental capacity and unwise decisions.* (UK)
- 2019: Karen Reimers, *The clinician's guide to geriatric forensic evaluations.*
- 2020: Jennifer Moye edited book, *Assessing capacities of older adults: a casebook to guide difficult decisions.*



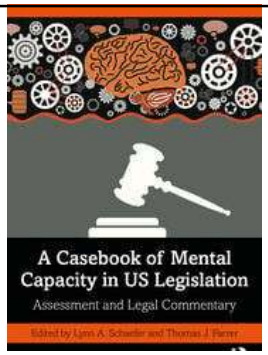


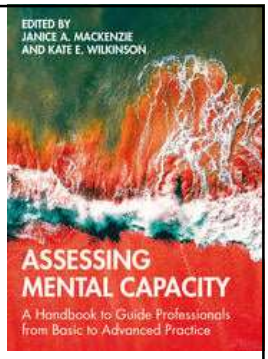


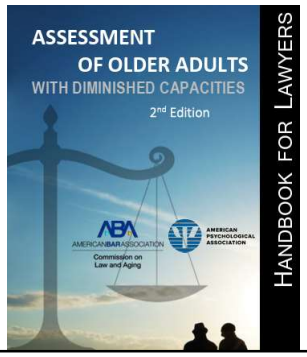


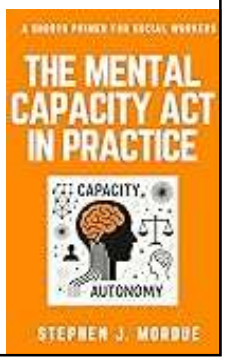
More books

- 2020: Janice Mackenzie & Kate Wilkenson, *Assessing mental capacity: a handbook to guide professionals from basic to advanced practice.* (UK)
- 2021: ABA/APA updated edition of handbook for lawyers.
- 2022: Lynn Shaefer & Thomas Farrer, *A casebook of mental capacity in US legislation: assessment and legal commentary.*
- 2025: Stephen Mordue, *The Mental Capacity Act in practice: a shorts primer for social workers.* (UK)





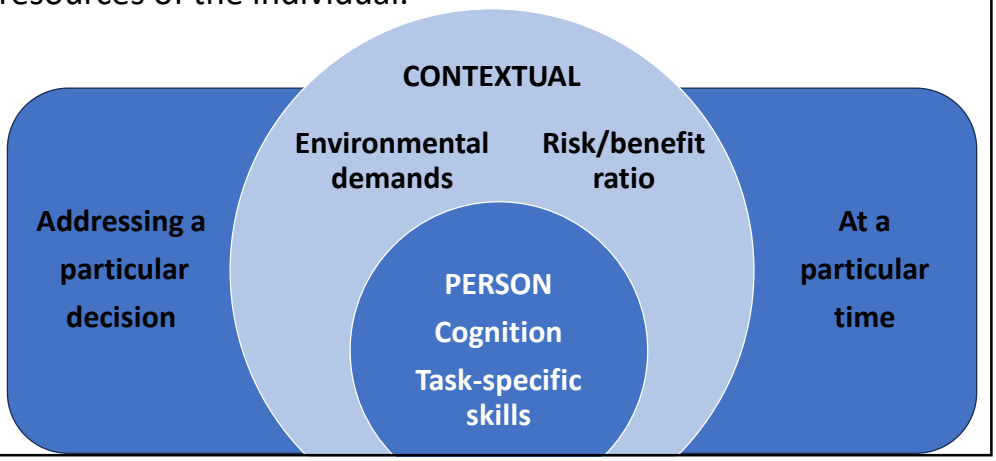




DMC assessment: approaches, models, and formats for assessment

Person in environment

- All capabilities are a function of the demands of the environment versus the resources of the individual.



Remember what capacity is NOT

- It's not a diagnosis – no diagnosis equals lack of capacity.
- It's not IQ – IQ largely measures acquired knowledge.
- It's not brain change – scans can provide correlative evidence.

Common principles: US, UK, Australia, Canada

These countries' mental capacity laws all have key principles in common:

- Adults have the right to make their own decisions, and to be assumed to have capacity unless shown otherwise. Capacity should be viewed as decision-specific.
- Adults should be offered all reasonable support and assistance in making and acting on decisions before others step in to make decisions for them.
- Adults have the right to make decisions that others disagree with or feel are unwise, the right to have a different tolerance for risks, and the right to fail after making a decision.
- Others involved in decision making must prioritize the person's best interest and preferences, and infringe as minimally possible upon their basic rights and freedoms.

Common principles: US, UK, Australia, Canada

The right to make your own decisions	The right to make decisions that others disagree with or feel are unwise	Reasonable support and assistance in making and acting on decisions
Assumed to have capacity unless shown otherwise	The right to have a different tolerance for risks	Help should infringe the least amount on rights, freedoms.
Capacity should be viewed as decision-specific.	The right to fail after making a decision.	Keep best interest and preferences at the forefront

Dignity of risk

"Most actions carry some degree of risk. Walking down the street can be a risk; we might get hit by a car or fall and skin our knees yet we can't give up walking. **Sometimes people are so afraid of what can go wrong that they don't live a full life.** In many cases it requires negotiation and creativity as well as a common understanding of the goals."

"Overprotection may appear on the surface to be kind, but it can… smother people emotionally, squeeze the life out of their hopes and expectations… Many of our best achievements came the hard way: We took risks, fell flat, suffered, picked ourselves up, and tried again."

Robert Perske's *Dignity of Risk* (1972)

From McCalmon D, Sprow J, Miller S (2015). Guide to assessing risk: for community-based residential providers. Washington Department of Social and Health Services, online at https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/DDA%20Guide%20to%20Assessing%20Risk%20revised%20SM%20June%202105.pdf

Types of risk

- Risk to self – self neglect
- Risk from others – abuse, exploitation, undue influence
- Risk to others – inability to provide care to another, driving, physical safety, environmental hazards

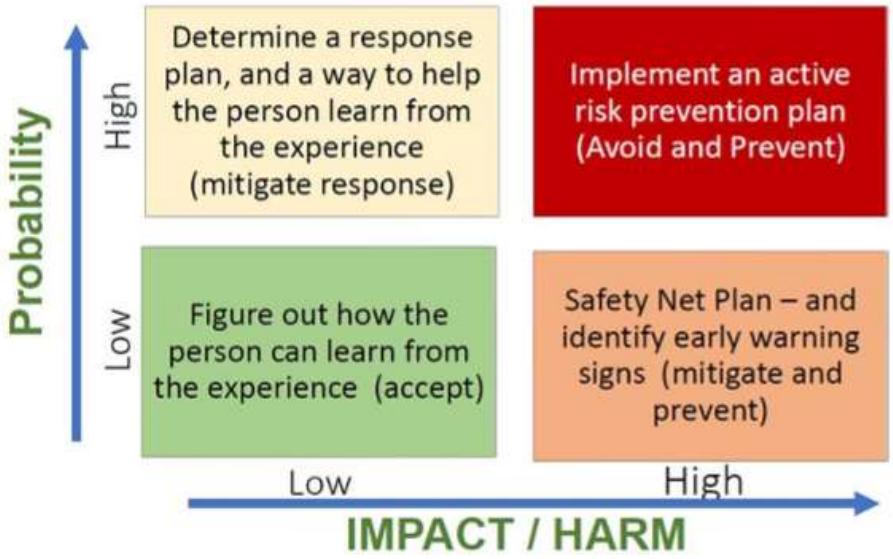
Also need to weigh:

- Severity of risk – extent of potential harm
- Probability of risk – degree of certainty that harm will occur

Evaluating risk is key to assessing capacity

- What are the risk factors in a particular situation?
- Is there such a thing as acceptable or safe risk?
- How long have the risk factors been present?
- What is different about the situation now in comparison with the recent past?
- What are the potential consequences associated with each risk factor?
- How significant are the potential consequences for the client? For others?
- What is the likelihood that the consequences will occur if the individual continues to refuse or accept help?

(Soniat & Melady-Mickos, 2010)



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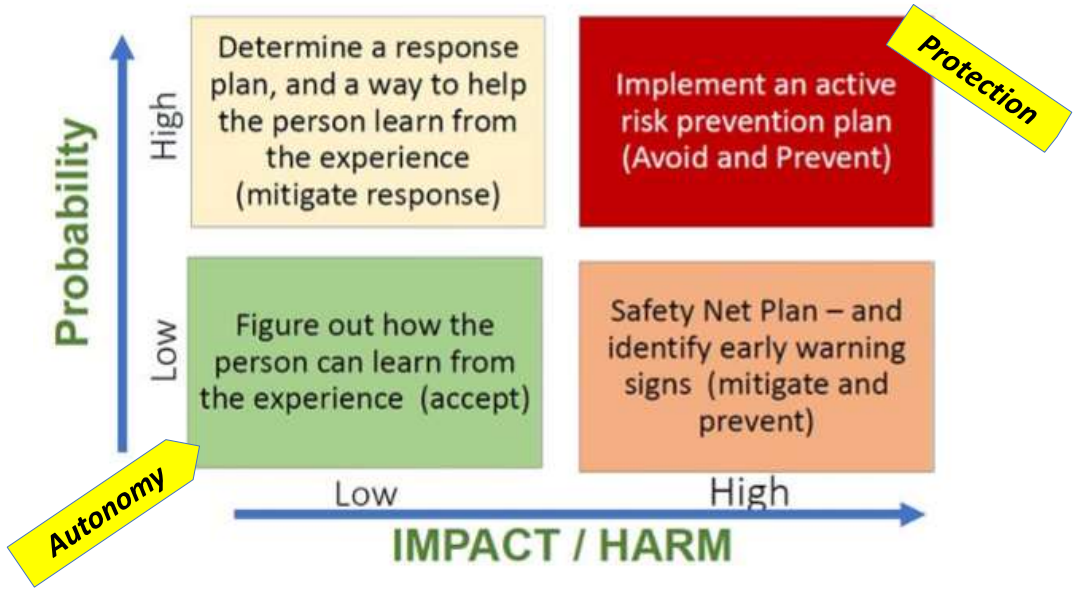

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"Honoring the wishes of a person with capacity demonstrates respect for the individual.

Honoring the wishes of a person without capacity is a form of abandonment."

Linda Farber-Post

(quoted in Naik 2008)

Risk vs reason

- People may consciously choose an option knowing and accepting potential risks.
- People make decisions for different reasons, including reasoning based on personal values, preferences, and beliefs.
- The outcome should be viewed as less important to assess than the individual's meaningful line of reasoning.

*What may be the limitations of capacity assessments having a large focus on **reasoning related to logic and rationale when making decisions** versus the **influence of personal values and preferences when making decisions?***

Insight is often seen as key

- Accurately understand and recognize their own strengths and impairments and the impact on their life, which influences how they make decisions regarding self-care strategies and supports.

GOOD INSIGHT	POOR INSIGHT
Accurately assess their situation Identify problems and deficits Recognize the need for assistance	May not recognize impairments Can't see severity of impairments Deny need for assistance
Clearer decision making	Hinders decision making
Better engagement with appropriate supports	May resist appropriate supports Less ability to engage with supports

Insight and capacity

- Cairns and others (2005) suggested there is conceptual overlap between insight and mental capacity, and argued that 'insight' was the strongest predictor of incapacity.
  - "...[T]his construct, although no less complex than capacity, is more intuitive to mental health professionals...."
- Neil Allen (2014) referred to the strong, though not absolute, relationship between capacity and insight: it is possible to have insight and lack capacity, and vice versa.

Insight debate

- Høyer (cited by Allen): "[T]hose agreeing with their treating psychiatrist have insight, those who disagree have not."
- Allen: "Is this really what insight boils down to? Agreeing with your doctor because s/he knows best?... The term, insight, does not appear in any mental health or capacity legislation… And we talk about it all the time in mental health."

Models/formats: ABA/APA guidance

- Helpful to look at all three handbooks to see how approaches align
- These are focused primarily on guardianship, but provide approach to different capacity questions

ABA/APA handbook for psychologists

A Framework for Capacity Assessment

1. Legal Standard
2. Functional Elements
3. Diagnosis
4. Cognitive Underpinnings
5. Psychiatric or Emotional Factors
6. Values
7. Risk Considerations
8. Steps to Enhance Capacity
9. Clinical Judgment of Capacity

This handbook has a Capacity Worksheet, and Chapter VI covers specific capacities and provides case studies that show different approaches to report writing.

- Medical
- Sexual
- Financial
- Testamentary
- Driving
- Independent living

ABA/APA handbook for lawyers

What attorneys look for in a clinical capacity assessment:

- Demographic information
- Legal background and referral
- History of present illness
- Psychosocial history
- Informed consent
- Behavioral observations
- Tests administered
- Validity statement [re testing]
- Summary of testing results
- Impression
- Recommendations

Model tools in ABA/APA handbook for judges

- Model clinical evaluation report with supplemental info on cognition and functioning, with instructions in an appendix.
- Also has model court investigator report with supplemental capacity checklist.
- You can also see the forms and guidelines for judges to evaluate the court visitor or clinician's information, questions to ask witnesses, etc.

Clinical eval areas:

- Physical and mental conditions
- Cognitive and emotional functioning
- Everyday functioning (ADLs/IADLs)
- Values and preferences
- Risk of harm
- Treatment and housing
- Supplemental info goes into details for above areas

Assessing medical decision making capacity

Look at this capacity area as an example of how to approach other types of capacity

Physicians under-diagnose incapacity

- An analysis of 8 studies showed physicians identified only 42% of patients with incapacity vs formal evaluation of medical DMC. *(Barstow, 2018)*
  - Unable or unwilling?
  - Reluctant to confront the issue?
- Gan (2023) found assessment of capacity usually done by doctors – generalists including junior staff, who often lack relevant skills and training.

  "Our study supports the need for multidisciplinary staff training in the practical aspects of mental capacity assessment in older/complex patients and for research into the most effective training methods and tools to aid assessment."

Research on medical DMC in older inpatients

- One in six required mental capacity assessment. Of these, 30% had repeated assessments.
- Most common: capacity for decisions on discharge destination and care needs.
- Rate of incapacity was highest for decisions relating to discharge against medical advice.
- Delirium = most common brain condition linked to need for capacity assessment.

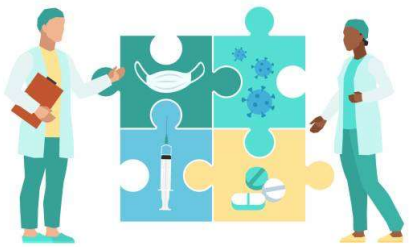
(Gan et al, 2023)

Prevalence of incapacity	
In healthy older adults	8%
OA hospital inpatients	26%
OA inpatients with Alzheimer's disease	54%
OA inpatients with delirium	82%
OA at end of life facing medical decision	71%

(Compiled from Barstow, Gan, Dixon)

Risk factors for impaired medical DMC *(from Barstow)*

- Acknowledged fear of or discomfort with institutional health care setting
- Age < 18 years
- Age > 85 years
- Chronic neurologic condition
- Chronic psychiatric condition
- Low education level
- Significant cultural or language barrier



Medical DMC assessment: specific tools

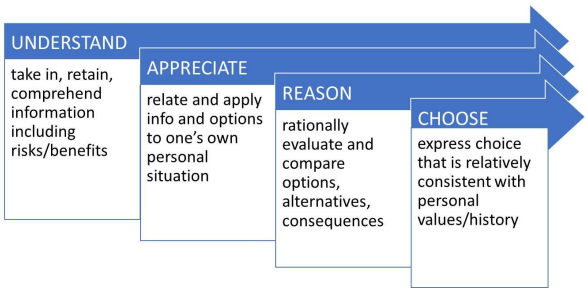
There are several tools/forms available today:

- MacArthur Competence Assessment Tool for Treatment
  - Developed by Applebaum & Grisso in 1990s
  - 1998 book "Assessing Competency to Consent to Treatment: A Guide for Physicians and Other Health Professionals"
- Aid to Capacity Evaluation (Canadian bioethicist Etchells)
- Assessment of the Capacity to Consent to Treatment (Moye for VA)

Various formats, similar approach

Questions to assess medical DMC

Look at steps of DM process



Look at person's approach:

Burden-based: how it will negatively impact them or others

Goals-based: how it might impact what they want

Values-based: e.g. Jehovah's Witnesses don't accept transfusions

Understand

Questions to determine the patient's ability to understand treatment and care options

What is your understanding of your condition?

What are the options for your situation?

What is your understanding of the benefits of treatment, and what are the odds that the treatment will work for you?

What are the risks of treatment, and what are the odds that you may have a side effect or bad outcome?

What is your understanding of what will happen if nothing is done?

Questions on this and following slides from Barstow (2018) who adapted from Tunzi (2001)

Appreciate

Questions to determine the patient's ability to appreciate how that information applies to his or her own situation

Tell me what you really believe about your medical condition.

Why do you think your doctor has recommended (specific treatment/test) for you?

Do you think (specific treatment/test) is best for you? Why or why not?

What do you think will actually happen to you if you accept this treatment? If you don't accept it?

Reason

Questions to determine the patient's ability to reason with that information in a manner supported by the facts and the patient's own values

What factors/issues are most important to you in deciding about your treatment? What are you thinking about as you consider your decision?

How are you balancing the pluses and minuses of the treatments?

Do you trust your doctor? Why or why not?

What do you think will happen to you now?

Choose

Questions to determine the patient's ability to communicate and express a choice clearly

You have been given a lot of information about your condition. Have you decided what medical option is best for you right now?

We have discussed several choices. What do you want to do?

Example: medical decision making

An 88-year-old woman who lives alone presents to the emergency department after a fall. After concerning labs, she is admitted to the hospital. Her outpatient records show that she has not refilled her heart failure medications in 6+ months.

On day 3 of hospitalization, she states that she is feeling better and wants to go home. Physical examination reveals global muscle weakness and inability to get out of bed without assistance.

The inpatient team recommends transfer to a rehabilitation facility, but the patient refuses.

Example: medical decision making

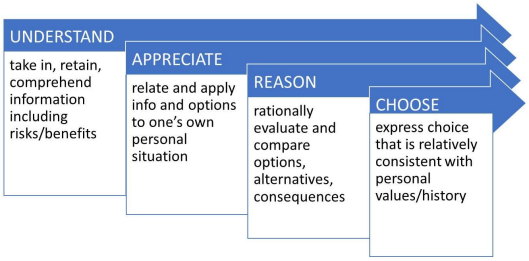
A 56-year-old man with schizophrenia is brought to the emergency department by his brother. He has a large, nonhealing ulcer on his left lower leg that is obviously infected.

His brother reports that the patient has diabetes mellitus and stopped taking his medications six months ago. On examination, the patient demonstrates disorganized thinking and describes auditory hallucinations.

He refuses treatment and says the government is trying to kill him.

Similar process to look at other decisions

- Look at context of **type of decision** and **statutory/legal definitions.**
- Look at **steps of DM process** and **person's approach to DM:**



Burden-based: how might it impact them and others;

Goals-based: how it might impact what they want and their short- and long-term interests;

Values-based: intersection with family, social/cultural roles, spirituality, etc.

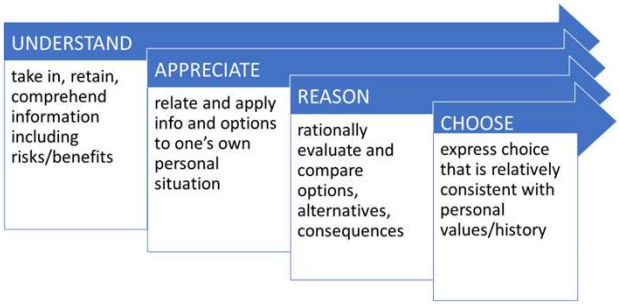
Capacity is not only specific, it's also dynamic

- Capacity for any decision may fluctuate.
- May be affected by one or more factors, including:

- Medical condition, illness or recovery
- Medications and their side effects
- Mental health symptoms
- Pain
- Fatigue
- Stress
- Environment
- Times of day

How might those factors impact….

DECISION MAKING CAPACITY



FUNCTIONAL ABILITY

Ability to execute their communicated choice – carry out their stated decision.

- Performance of the tasks involved.
- Ability to engage supports if/when needed to do so.
- Ability to adjust to change.

Keys to doing this work

- Scope of practice, competence
- Ethical, legal, judicial issues
- Having a good approach from the start

Is assessing DMC within your scope?

A lot of this work is within most clinicians' scope of practice:

- Assess the client's entire situation:
  - Interview and assess client,
  - Gather collateral information,
  - Review history if available/applicable;
- Screen/test for deficits that may affect cognition or functioning,
- Coordinate info with other involved parties, and
- Document findings.

Ethics: Ethical ABC's

(adapted from Moberg & Kniele, 2006)

- **A**ttain professional competence.
  - Know your **scope of practice** as well as your **scope of competence**.
  - Have the adequate knowledge/training for the task.
  - Be aware of what you don't know.
- **B**alance the need to respect an individual's freedom of choice and self-determination with the need to promote their safety.
- **C**hoose, use, and interpret assessment methods appropriately.

Ethics: evaluating your own clients?

- You may be asked to conduct a capacity assessment of your patient/client explicitly because you "know" this person well.
- Even with the patient's/client's consent, that dual role presents a number of potential ethical concerns:
  - Impact of bias, therapy confidentiality,
  - Obligation to court or other party vs client, and
  - Risk to the therapeutic relationship.

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.
- **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.

Legal and judicial issues

- Is your licensure/credential adequate for what's needed?
- Do you understand the legal standards involved?
- Do you know what to assess in order to answer the question(s) being asked?
- Are you the right person for the job?

Approaches to doing assessment visits

"Capacity assessments are ultimately human judgments occurring in a social context."

(Moye, Marson)

"A true assessment seeks the big picture, with all its variability, intermittency, and nuance – each person is a challenging and complex constellation of abilities and limitations in a cultural, social, biological, and environmental context."

(Charles Sabatino, speaking at 2022 EJI Symposium)

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."*

What should (hopefully) happen before DMCA

- Medical assessment to ensure issues are identified, addressed – particularly any affecting cognition.
- Problem solving:
  - Involve person, family, providers of care/services, other involved parties.
  - Consider formal resources.
  - Mobilize informal resources.
  - Less restrictive alternatives, supported decision making, etc.

Issue(s) may be resolved without needing a formal capacity assessment

Why proceed to capacity assessment?

- No adequate solutions from problem-solving.
- Risk to person / others too high.
- Other, less intrusive methods, have failed.
- Problem persists or becomes worse.
- Appointment of legal decision maker may solve the problem.

But, even a determination of incapacity may not address the initial triggers or concerns identified.

About doing the work of DMC assessment

- Process overview
- Referral specifics
- Formats/models for assessment

"Capacity work isn't about perfection – it's about presence, clarity, and care."
Stephen Mordue

Process of assessment

Gather Info	Visit(s) for Interview/ Assessment	Consult Collaterals	Document Findings
• Problem? • What to assess, legal standard(s)? • What report is needed? • Health status. • Limited info/ background.	• Consent/Assent. • Thorough assessment with probing questions on DM steps, values, historical choices, etc. • Use appropriate cognitive tests, decision aids, supports, etc.	• Get info from family, care providers, etc. • Review records or other history. • Validate what was reported by person/others.	• Clearly record observations. • Discuss interview • Explain analysis of various data. • Clearly state findings and recommendations.

Referral or request

- Referral is the "pre-assessment" phase. Need to determine what is being assessed, how 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.

What's the problem?

- There is nearly always a **problem** that leads to a capacity assessment.
- In rarer cases it is the desire to **prevent** problems – like doing an assessment before the person signs their will or legal documents to avoid challenges later.

What to assess? Legal context?

- What specifically are you being asked to assess?
- Look to who is requesting the evaluation to provide you with the **statutory definitions of the specific capacity** in question.

Generally, we are being asked for

*"A clinical assessment and opinion as to whether a person has the requisite ability to perform **a task** or to make **a decision** that is being questioned by another."*

(Moye, 2020)

Legal context – standards?

- Ask what is the **legal standard** for the evidence:
- You won't make the legal argument that a lawyer would, but it will help you see what to pay attention to during the visit.

Beyond a reasonable doubt	Most criminal cases – highest and most demanding standard
By clear and convincing evidence	Most commonly used in guardianship cases, fraud, punitive damages
By a preponderance of the evidence	Most civil law cases, "more likely than not"

What report is needed?

- Begin with the end in mind: know from the start what is needed and expected for your documentation and any formal report structure.
- Court forms? Or formatting requirements for documentation that will be submitted to court?
- Any specifics that need to be included?
- Ask for redacted examples for reference.

If not given specifics:

Use a report format that works for your needs (your practice, agency, or clinic).

_____

Make a template to help make sure you cover everything you need to at the visit.

Our next classes

October 15	Cognition and mental health in capacity
October 29	Cognitive testing and other assessment tools
November 12	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 Next on 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 Next on Oct 21 Register at https://us02web.zoom.us/meeting/register/tZYuduChrzMtHdwZFNfXLh8vnk_CDPb6Nq6J#/registration