

Decision Making Capacity Assessment Professional Training Program

Class 2 – May 20, 2026



Aging Care Consultation Services
Karin Taifour, MA LMHC GMHS
206.999.5934
Karin@AgingCareConsult.com

Elder Education Institute



Agenda

Morning: capacity specific

- Cognition and memory
- Cognition related to the decision making process
- Impact on cognition of
 - Typical age-related changes
 - Neurocognitive issues
 - Mental health issues
 - Other issues and factors

Afternoon: work process

- Consent/assent
- Assessment approaches
- Less restrictive alternatives
- Supported decision making

Keep in mind: ageism and ableism

“Older adults are commonly considered incapable and dependent, which parallels ableist conceptualizations of people with disabilities, where **there is an emphasis on impairment, dependence, and inability, rather than a focus on the whole person...**

Aging decline and disability are ubiquitous and inevitable, but neither should be the cause for a therapist to think differently of a person’s potential to participate in meaningful life activities”

(Friedman & VanPuymbrouck, 2021)

“Aging is just another word for living.”
—Cindy Joseph, model, beauty CEO

**“Aging is
not lost youth
but a new stage
of opportunity
and strength.”**

—Betty Friedan, feminist icon

**“Age is something
that doesn’t matter
unless you are a
cheese.”** —Luis Buñuel, filmmaker

Recent findings on aging and improving

- Yale analysis: more than a decade of data from large, nationally representative study of Americans age 65+
- 45% had measurably improved cognitive and/or physical function over a period of up to 12 years from baseline.
 - Not only due to people with deficits recovering to a normal level of functioning, but also for those who started at normal levels of functioning.
- More positive age beliefs = more likely to improve in both cognitive/physical function.

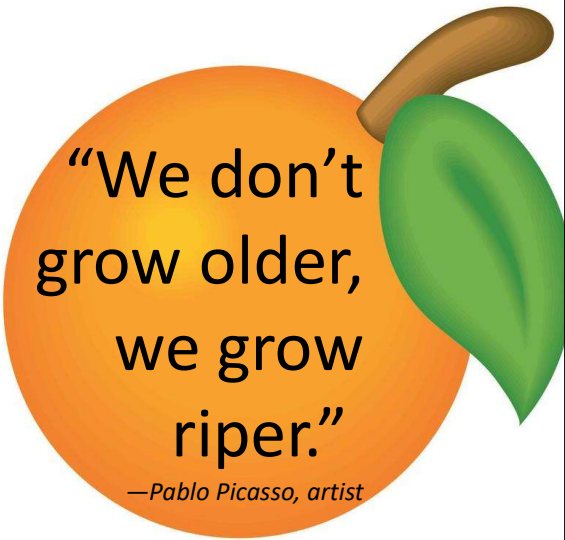
"This improvement pattern is picking up on a cognitive and physical reserve that is available to the general population of older persons."

Dr Becca Levy, Yale

*"Old age is like everything else.
To make a success of it,
you've got to start young."
—Theodore Roosevelt, US president*

*"The great thing about
getting older is that you
don't lose all the other
ages you've been."*

—Madeleine L'Engle, author



*"We don't
grow older,
we grow
riper."*

—Pablo Picasso, artist

Cognition and capacity

Areas of cognition and executive functioning
Cognition in tasks of decision making
Relationship between cognition, memory, capacity

Capacity vs cognition (Marson & Ingram; Moye & Marson)

• **Capacity** is related to ...but is not the same as **cognition**:

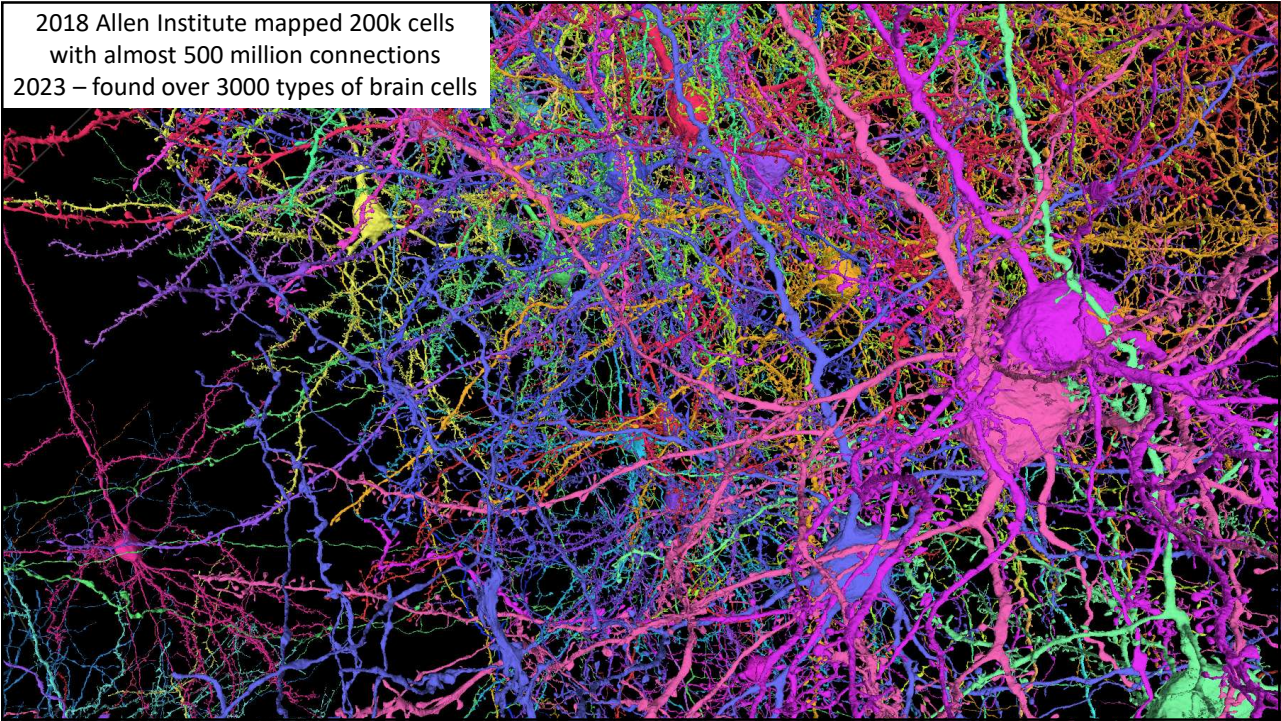
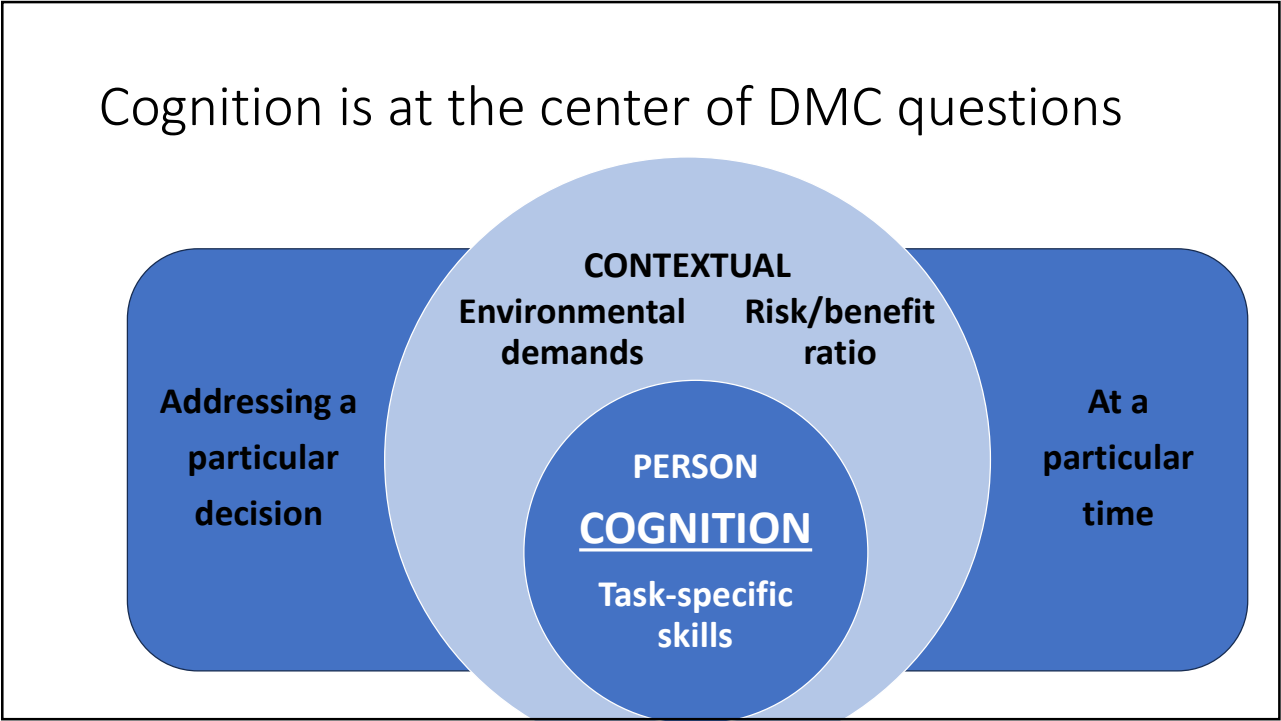


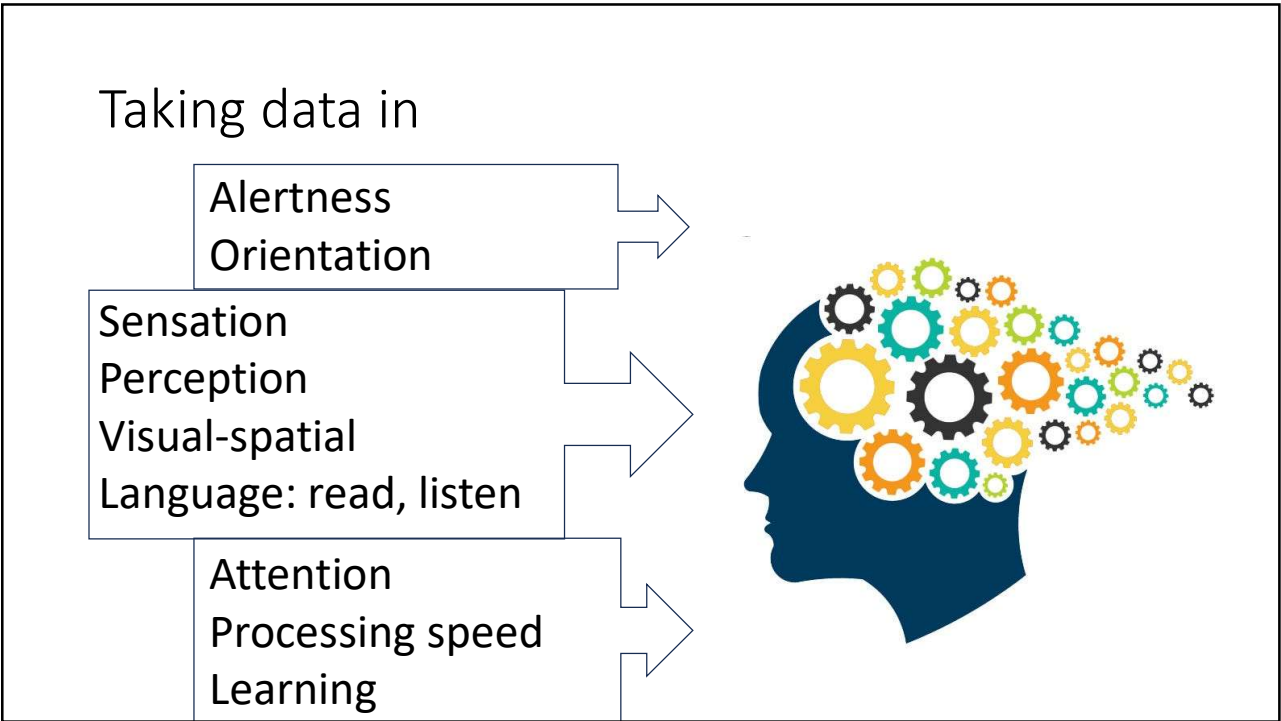
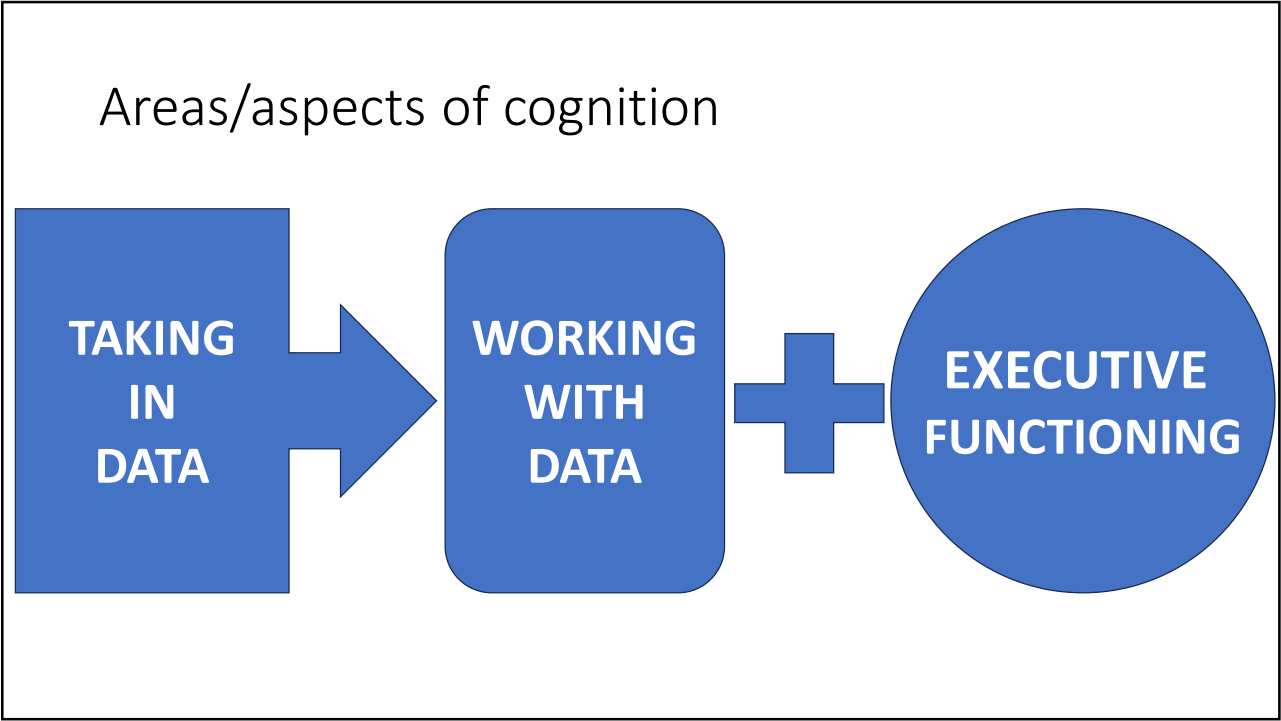
a continuum of
decision making
abilities



mental processes of
learning, understanding,
acquiring, and using
knowledge

So how does cognition relate to capacity?





Working with data



- Short-term working memory
- Long-term retrieval
- Comprehension/knowledge
- Calculation
- Motor control
- Social cognition
- Creativity, imagination
- Judgment
- Insight
- Reasoning – fluid, logical, abstract
- Planning
- Problem solving

Types of memory

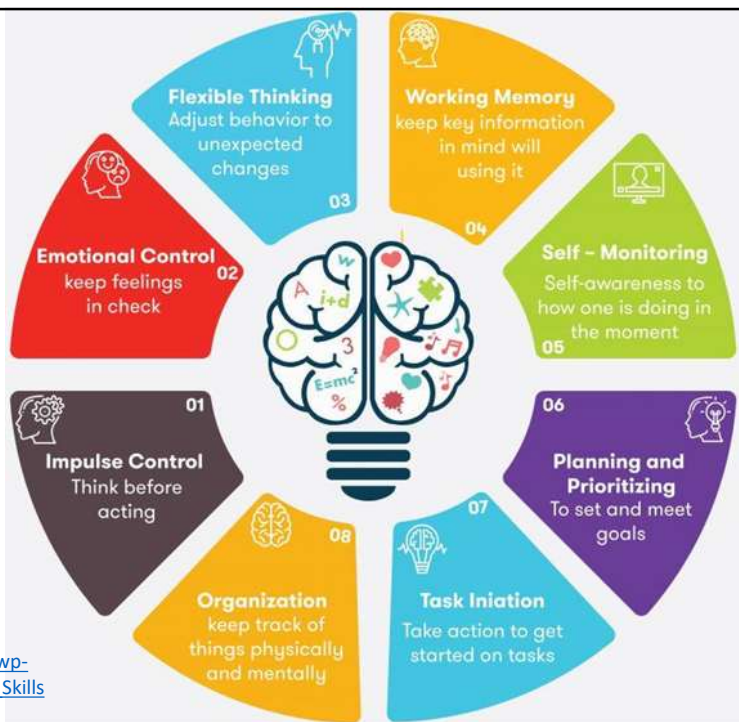
- **Short-term:** taking in small pieces of info, using it for a brief period.
- **Long-term:** stored memory that is retrieved when needed – divided into procedural and declarative, then into episodic and semantic.

Procedural: info used to perform or complete tasks that are done often, like paying a bill.	Declarative: facts and events such as a family member’s birthday.
Episodic: contextual info from a specific experience, e.g. how they celebrated their last birthday.	Semantic: more general knowledge or factual based; learned subjects such as math.

Executive function

- A higher-level set of cognitive process that coordinate lower-level cognitive functions.
- Last to develop, first to decline: “Arrives late and leaves early”
- Filtering and prioritizing: What do I need to focus on to make this decision?

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



Executive functioning and cognitive processes

- Impulse control
- Emotional control
- Flexible thinking
- Working memory
- Self-monitoring
- Planning/prioritizing
- Task initiation
- Organization
- Abstract reasoning
- Inhibiting inappropriate responses
- Monitoring/managing time
- Recognizing a problem
- Foreseeing outcomes
- Evaluating the results
- Adapting to change

Many happen subconsciously

APS view of executive functioning

APS training cites Schillerstrom's 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).

Cognition – and DMC – can vary

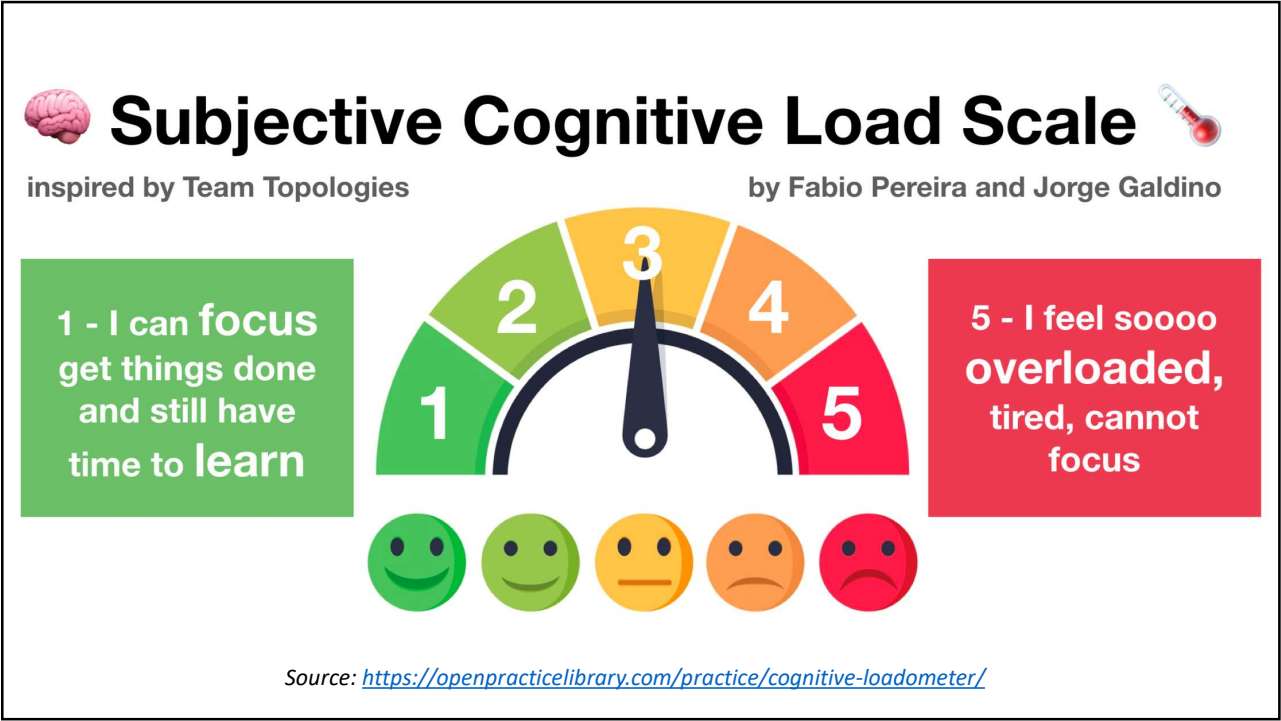
- As a result of physical or mental stress.
- According to the complexity of the decision.
- From day to day.
- From morning to evening.

Related concepts to cognition and DM

- Cognitive load
- Decision fatigue
- Metamemory
- Cognitive reserve

Cognitive load

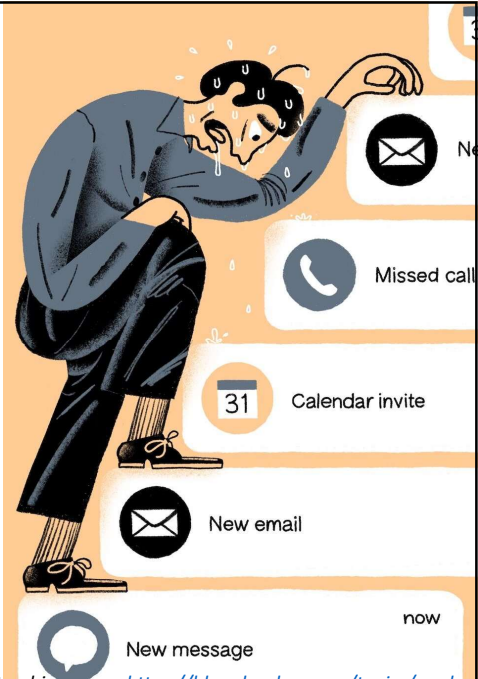




Decision fatigue

“After a long day of making decisions... you just don’t want to have to make any more decisions.”

- Dr Lisa MacLean
(Berg/AMA 2025)



(Graphic source: <https://blog.dropbox.com/topics/work-culture/workplace-tools-making-decision-fatigue-worse>)



Metamemory: thinking about how you think



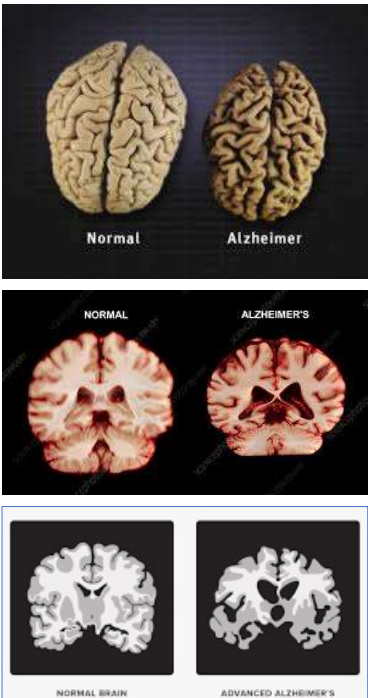
Metamemory deficit in older adults is a potential indicator of impaired decision making.

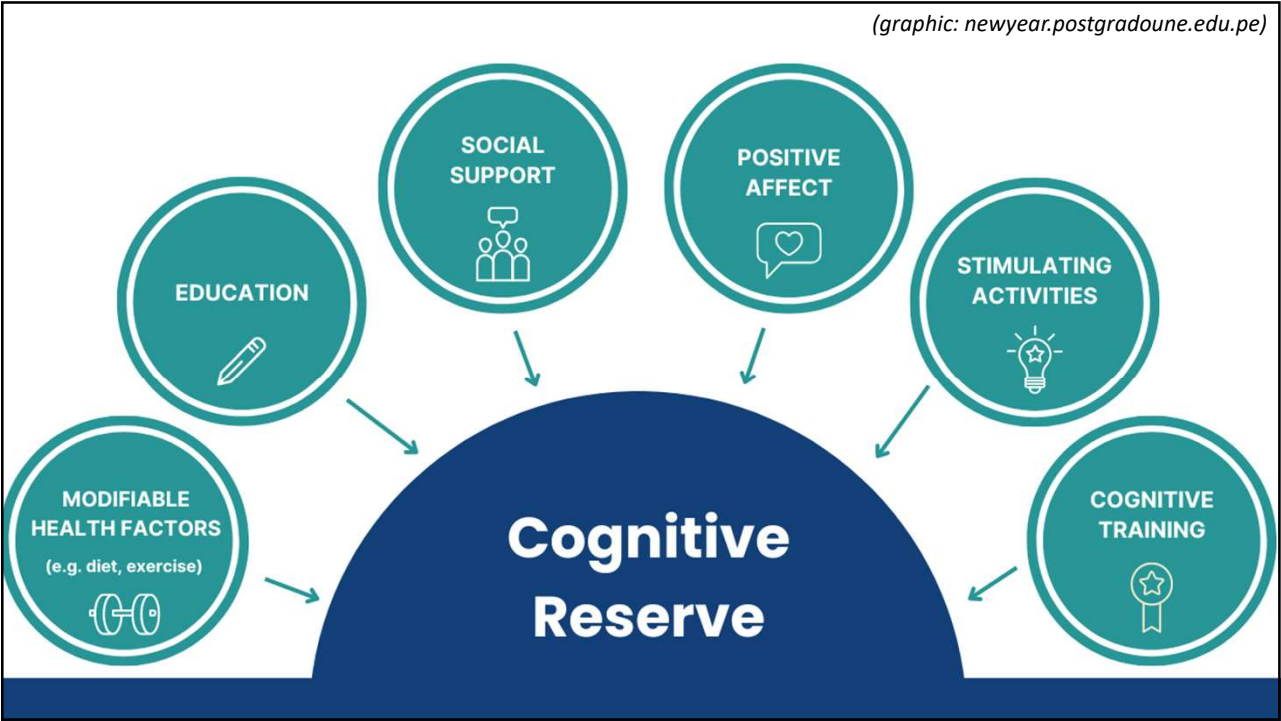
(graphic source: <https://www.lecturio.com/inst/pulse/metacognition-do-you-really-know-what-you-think-you-know/>)

Cognitive reserve

- Concept originated in the late 1980s.
- Researchers studying autopsied brains that looked like advanced Alzheimer’s, but from people who had no symptoms when alive.
- Theory: 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)





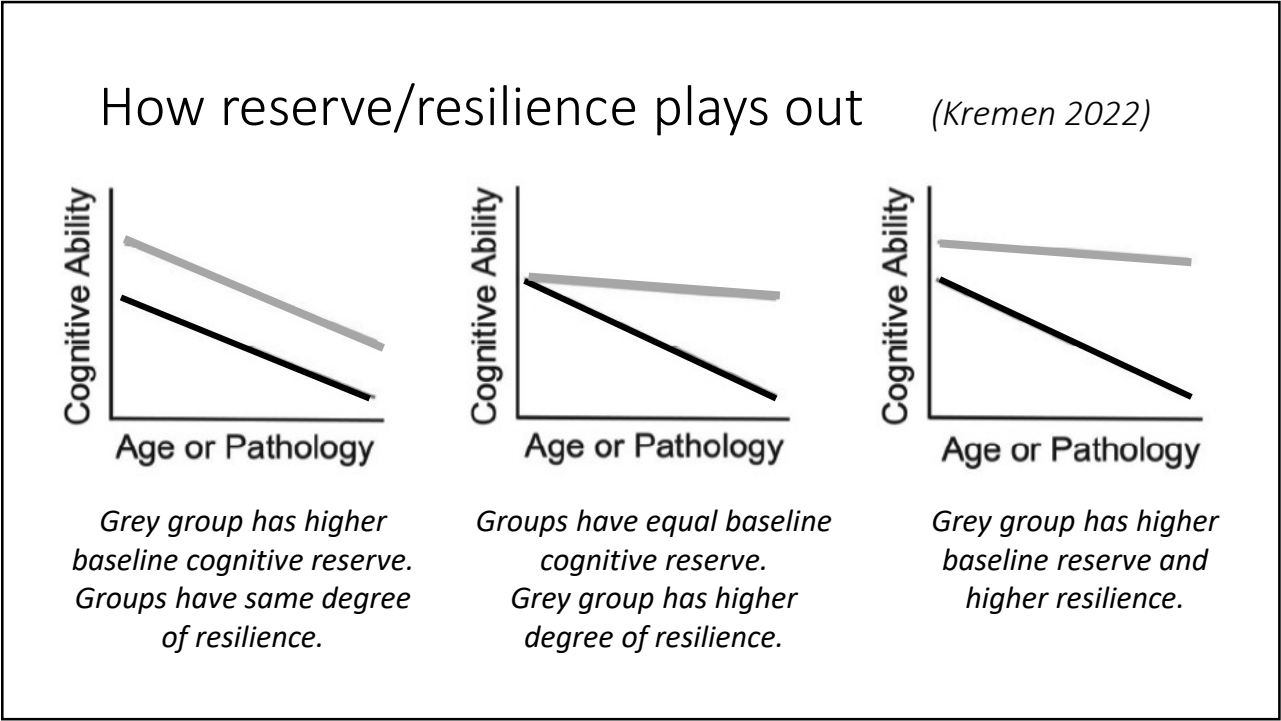
Cognitive reserve, continued

- 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 – more pathways to process information, which maintains thinking skills.
- Improved global cognition, executive functions, and attention.
- Protects against brain damage and dementia.
- Slows cognitive aging process.
- Reduces 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



Emotions and decision making

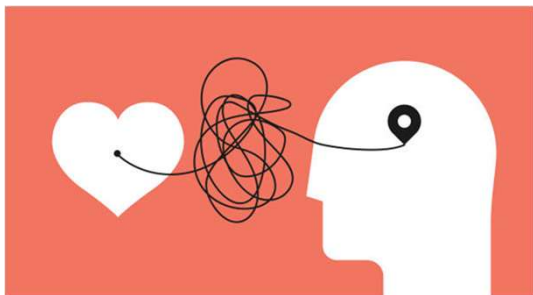
- Compared with younger adults, older adults use more emotional information when carrying out cognitive tasks.
- For younger adults, major focus of decision-making is “gain”
- Later in life, focus changes to “prevent loss”

(Samanez-Larkin 2015)

The diagram features a central illustration of a human brain, colored in shades of purple and grey. Surrounding the brain is a circular arrangement of ten different emoji icons connected by a dashed line. The icons represent a variety of emotions: happiness (smiling face), surprise (face with wide-open mouth), sadness (frowning face), anger (furious face), and others.

(graphic source: <https://www.linkedin.com/pulse/when-emotions-prevent-you-from-making-right-decisions-enza-artino/>)

Emotions and decision making



(graphic source: <https://phchristian53.medium.com/deciding-with-your-head-vs-your-heart-9a832f1689b>)

- Older adults may be biased by stereotypes about memory in aging or beliefs about their own memory. (*Hertzog, Ryan*)
- This can cause lower confidence and use of different strategies, such as a greater reliance on (potentially misleading) external cues. (*Perman*)

Decision making avoidance

(*Nolte & Lockenhoff*)

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”
- Generally report less motivation for more effortful DM processes.



Decision making avoidance

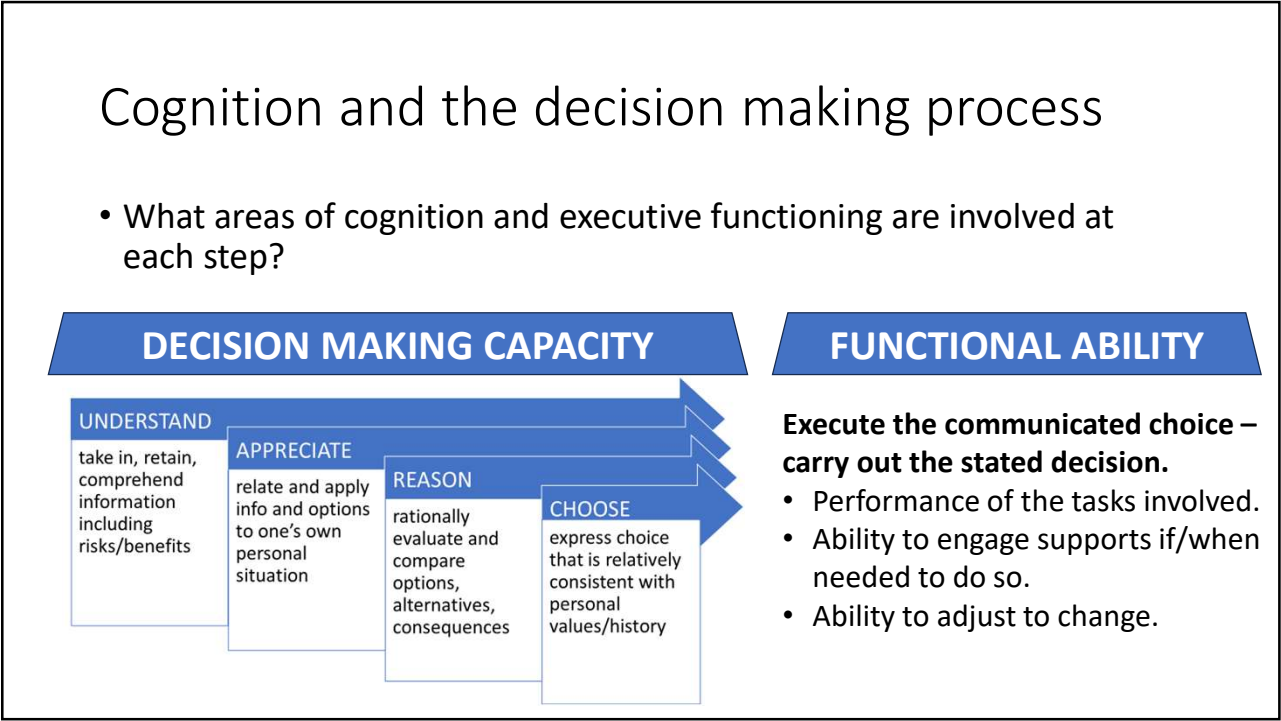
(Nolte & Lockenhoff)



- Cognitive factors: choice difficulty, cognitive effort involved in comparing options.
- Affective factors: emotional toll of making a decision, anticipated/feelings of regret.

Lower levels of numeracy have been linked to more passive decision making patterns.

Relationship between cognition and DMC



Cognition and understanding

UNDERSTAND

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

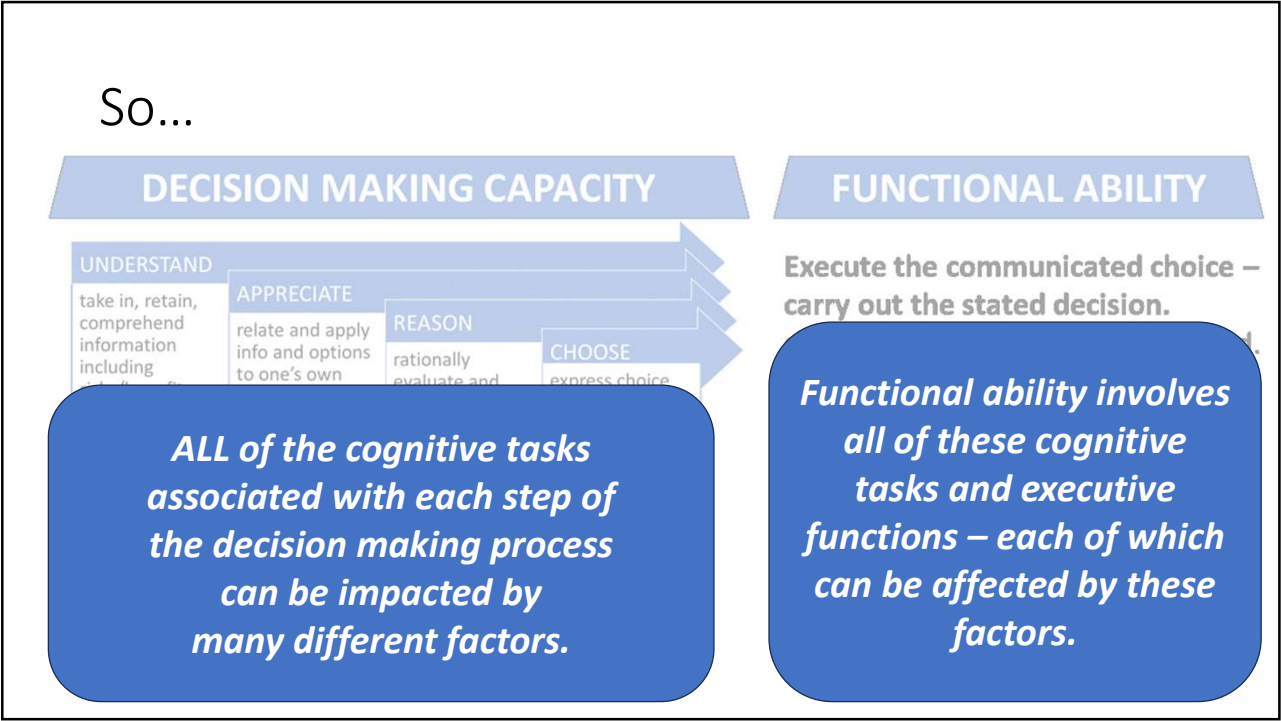
Cognition and appreciating

APPRECIATE

COGNITIVE TASK	IMPACTED BY (in addition to MCI/dementia)
Memory, 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	Depression, anxiety, psychosis, loneliness General aging
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	Depression, anxiety, psychosis General aging, loneliness	
Problem solving	Depression, anxiety, psychosis	
Flexible Thinking Adjusting 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

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.



Look at a specific decision: doing a will



Capacity specific step	Cognitive tasks
Understanding of • <i>the nature and</i> • <i>extent of their property</i> • <i>relevant to the disposition</i>	• Long-term semantic and autobiographical memory related to assets. • Short-term episodic and working memory for more recently acquired assets and property, or changes to the estate. • Ability to form working estimates of assets. • Comprehension of approximate value attached to one’s estate.

Look at a specific decision: doing a will



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.

Look at a specific decision: doing a will



Capacity specific step	Cognitive tasks
• Communicating clear, consistent rationale for plan • Especially if any significant departure from prior Wills or expressed wishes	• Higher order executive functions such as judgement, reasoning, planning. • Ability to connect one’s beliefs and values to the disposition of assets. • Language or ability to communicate choice and rationale.

Things that impact cognition and the decision making process

Typical Age-Related Changes		
Neurocognitive Issues	Mental Health Issues	Other Issues and Factors

Typical age-related brain changes

- ↓ grey and white matter
- ↓ neurons
- ↓ neural connections
- ↓ brain volume
- ↓ ability to make new neural connections
- ↘ chemical reactions
- ↘ neurotransmitter production
- ↘ production of myelin

Gray matter structure
Superior frontal cortex
Middle frontal cortex
Superior parietal cortex

Structural connectivity
Superior white matter tracts
Anterior white matter tracts

Functional connectivity
Within-network connections

■ Susceptible to age-related degeneration

(Source: Zamroziewicz 2017)

BUT...

Remember “typical” changes may not affect everyone the same, or at all.

Fun fact:
Verbal fluency correlates with longevity in old and very old age. (Ghisletta)

> 106-year-old UK woman reveals the key to a long life is 'chocolate and partying'

THE PROJECT

Impact of aging on cognition

Some things get better with age:

- Vocabularies
- Knowledge/wisdom
- Meaning
- Learning and experiences

Some things get worse:

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

(these are generalizations)

Cognitive processes impacted by aging

- 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

- Working memory
 - Processing speed
 - Attentional control
- Slow down **starting in your 30s**
 - Decline significantly beginning at age 60

See handout: Conditions Associated with Executive Dysfunction

Executive function impacted by aging

- Executive functions depend on certain brain areas:
 - frontal lobes
 - prefrontal cortical regions
 - prefrontal-parietal networks
 - hippocampus
- As these areas experience typical age-related changes, executive functions are impacted.

Areas involved early in most dementias.

Impact on cognition and DM from



- Reversible causes of cognitive impairment
- Delirium
- Dementia and Mild Cognitive Impairment
- Subjective cognitive complaints

Neurocog diagnostic complications



Sharon K. Inouye, Harvard Med professor:

- Cognitive impairment of any kind can affect each stage of diagnostic process.
- People with cognitive impairment may underreport or misreport initial symptoms.
- Results in delay in seeking care or delay in getting an accurate diagnosis.
- Very high rates 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.

(NASEM)

Reversible cognitive impairment causes

- Drugs/substances
- Medication side effects
- Dehydration
- Mood/anxiety
- Electrolyte imbalances
- Emotional disorders
- Metabolic or endocrine disorders
- Nutritional deficiencies
- Trauma
- Tumor
- Infections
- Acute illness
- Arteriosclerosis complications
- Seizures
- Strokes
- Sensory deprivation

Some “dementias” can reverse or improve

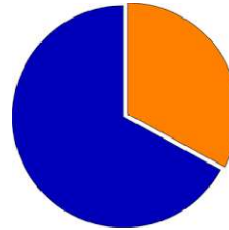
Dementia-like symptoms can be caused by:

- Depression, thyroid problems, kidney/liver disease, or deficiencies of vitamin B12 or vitamin D
- Alcohol/substances
- Side effects of medications or drug combinations
- Vasculitis, an inflammation of brain blood vessels
- Subdural hematoma, common after a fall
- Tumors
- Chronic meningitis
- And...

Delirium: more frequent than we think



About HALF
of hospitalized
older adults



About TWO-THIRDS
of cases go
unrecognized

Delirium

Presentation:

- Acute confused state
- Disturbance in alertness, consciousness, perception and thinking
- Sudden onset

Can be caused by:

- Infection
- Dehydration
- Chemical imbalance
- Head trauma
- Anesthesia
- And more – see handout

Normal Pressure Hydrocephalus (NPH)

- Excessive spinal fluid in brain due to tumor, head injury, hemorrhage, meningitis, or infection (unknown 50% of time).
- Most common in age 60+
- Prevalence 0.2% in age 70-79, 6% in age 80+
- No gender difference, limited racial/ethnic data.
- No cure/treatment except from surgery: shunt inserted into brain to drain fluid = fast recovery.
 - ***IF caught before dementia sxs set in – otherwise dementia may remain.***

Great article: <https://www.yalemedicine.org/news/normal-pressure-hydrocephalus-patient>

NPH symptoms:
“wobbly, wacky, wet”

Inability to walk normally

Dementia: changes in motivation, short-term memory, concentration and personality

Loss of bladder control

Dementia and MCI

Dementia

- Progressive decline in cognition and/or behavior caused by disease affecting the brain.
- 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.

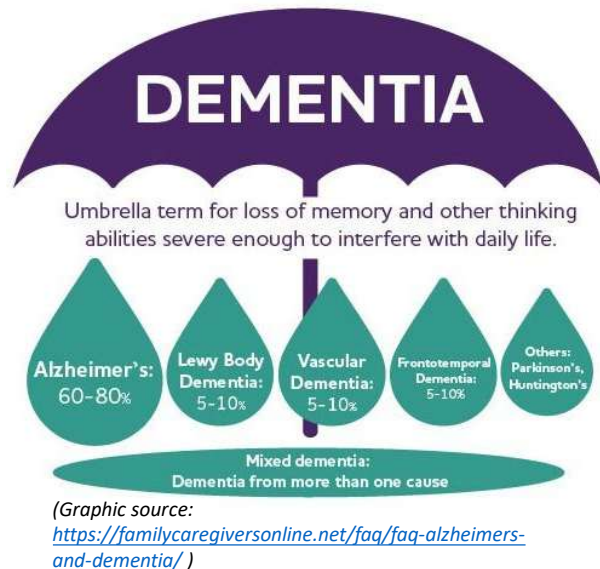
Mild cognitive impairment (MCI)

- 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.

Dementia: syndrome, not single disease

- Includes many different conditions affecting memory, problem-solving, thinking abilities.
- Everyone loses some neurons as they age, but dementia = far greater loss/change.
- Old terms "senility" or "senile dementia" reflect incorrect belief that serious mental decline is a normal part of aging.



Dementia research is always advancing

LATE, or Limbic-predominant Age-related TDP-43 Encephalopathy

- Identified in 2019 – article in journal *Brain* in March 2022.
- Can be confused for Alzheimer's disease – also causes memory loss.
- But symptoms tend to progress slower than Alzheimer's.
- Completely different underlying pathology/cause.
- It only shows up in adults over 80 years old.
- **May occur in as many as 25% of adults over age 80.**

"Science evolves and changes how we see disease and cognitive aging."
– Jason Karlawish

Dementia and COVID

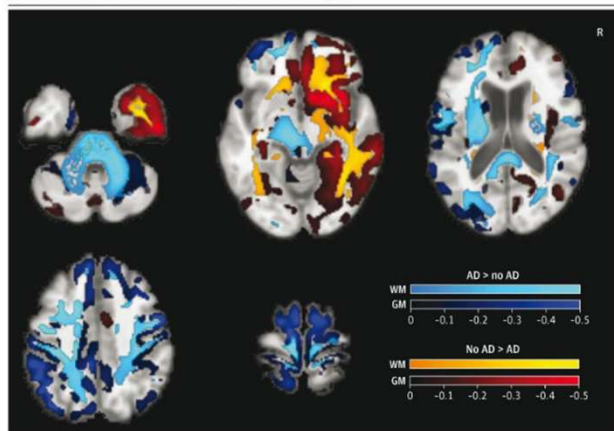
(UK NHS, Ding)

- Covid pandemic “had lasting impact” on cognitive function and working memory of people aged 50+ regardless of infection status.
- After having COVID: significantly higher risk for new Alzheimer’s dx within first year, especially in people age 85+ and in women.
- People with dementia were more likely to catch COVID.
- And in people with existing dementia, COVID causes severe neurological complications, and accelerates disease progression in all dementia types.

Mixed dementia – very common

- When people have two or more causes/types of dementia.
- Most common in 85+yo.
- In people diagnosed with Alzheimer’s dementia:
 - Alz Disease Research Centers studies: more than 50%
 - Community based studies: “considerably higher”

Figure 4. Alzheimer Disease (AD) Copathology in Frontotemporal Lobar Degeneration (FTLD)-Related Syndromes and Increased Rates of Posterior Cortical Atrophy



(Graphic source: VaneVrede et al (2025),
<https://jamanetwork.com/journals/jamaneurology/fullarticle/2830013>)

Mixed dementia – issues

- **Symptoms vary** depending on the combination of brain changes and may not align neatly with diagnostic criteria.
- **Underdiagnosed:** most diagnoses based on main disease/symptoms, mixed dementia more often identified during autopsy.
- **Still important to consider**, as it influences treatment strategies and care approaches.

Aphasia – common in various dementias

- Two types – can have either/both:
 - **Expressive** (Broca's aphasia) affects speech production
 - **Receptive** (Wernicke's aphasia) impacts language comprehension
- **Non-language** problems with aphasia:
 - Weakness or paralysis on right side
 - Apraxia – loss of voluntary movements
 - Dysarthria – weakness in oral muscles

Aphasia

- Affects two million Americans – more common than Parkinson's
- After stroke/TBI: can take weeks, months, or years to improve.
- Speech therapy can help

Dementia and executive functioning *(Portley)*

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

EF is good proxy, as neuropsych batteries are long and burdensome especially in people with cognitive and mobility/motor impairments.

***“Just like dementia
does not equal lack of capacity,
people can lack capacity
without dementia.”***

Dr Laura Mosqueda

“If you meet one person with dementia...

...**you’ve met one person with dementia.”**

- Every person is unique and every case of dementia is unique.
- Nearly all dementias are progressive, meaning the brain changes and symptoms worsen with time. But **how**, and **how quickly**, it progresses and what abilities are affected all varies by individual.
- And, people with dementia have good days and bad days like everyone else, so every day can be different.

Dementia and anosognosia

- 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 symptoms. It is a lack of self-awareness and insight as to their deficits.

Anosognosia

*Up to **60%** of people
with MCI*

***80%** of people
with Alzheimer’s*

(Source: Alz Assn)

Dementia and anosodiaphoria

(Lindau/Bjork)

- Neurological condition – lack of emotional response or concern towards one's own recognized medical illness or disability.
- Often following brain injury or stroke, and often associated with right hemisphere of the brain.
- Despite being aware of deficit, person is unable to fully appreciate the significance or implications.

Anosognosia and anosodiaphoria each seem to increase with progression of dementia from MCI, as a result of right hemispheric alterations.

Dementia and depression

- People with Alzheimer's disease and other dementias commonly experience depression: 37 to 41% (*Leung*)
- 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*)

Dementia and psychotic symptoms

- 41% of people with major neurocog disorders experience hallucinations or psychotic symptoms. *(Tampi)*
- 20% of Parkinsons disease patients experience psychosis or hallucinations.
 - Risk likely influenced by PD duration and stage as well as cognitive status. *(Gkintoni)*

Dementia and psychotic symptoms

For people with any dementia:

- Psychotic symptoms linked to worse executive control and visuoperceptual deficits. *(Hopkins)*

For people with Alzheimer's:

- Psychosis sx linked to worse deficits in working memory and executive functioning, and to overall more severe cognitive decline.
- Presence of delusions or hallucinations associated with poorer clinical outcomes.
- Both together was worse than either alone. *(Murray)*

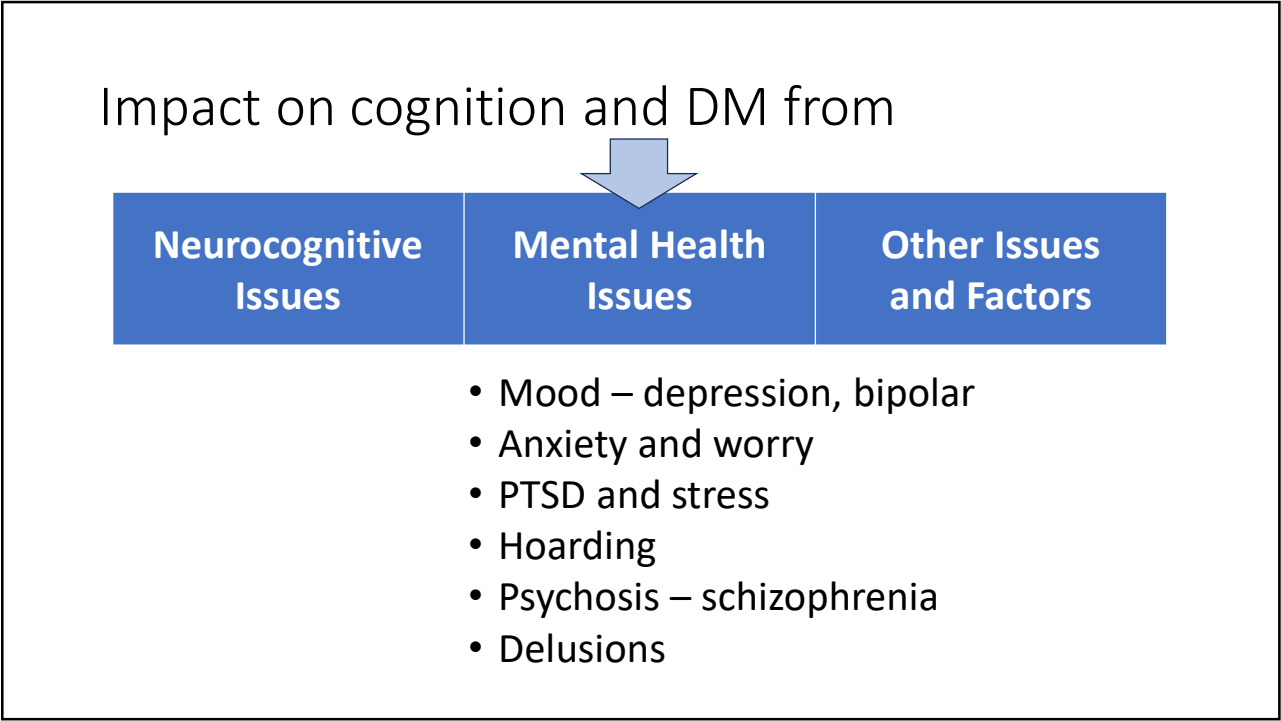
Subjective cognitive complaints

- 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)*
- One study showed subjective complaints predated MCI dx by 9 years. *(Kryscio)*

Mood disorders may play a role, as well as anosognosia or lack of awareness, in people who actually have cognitive changes.

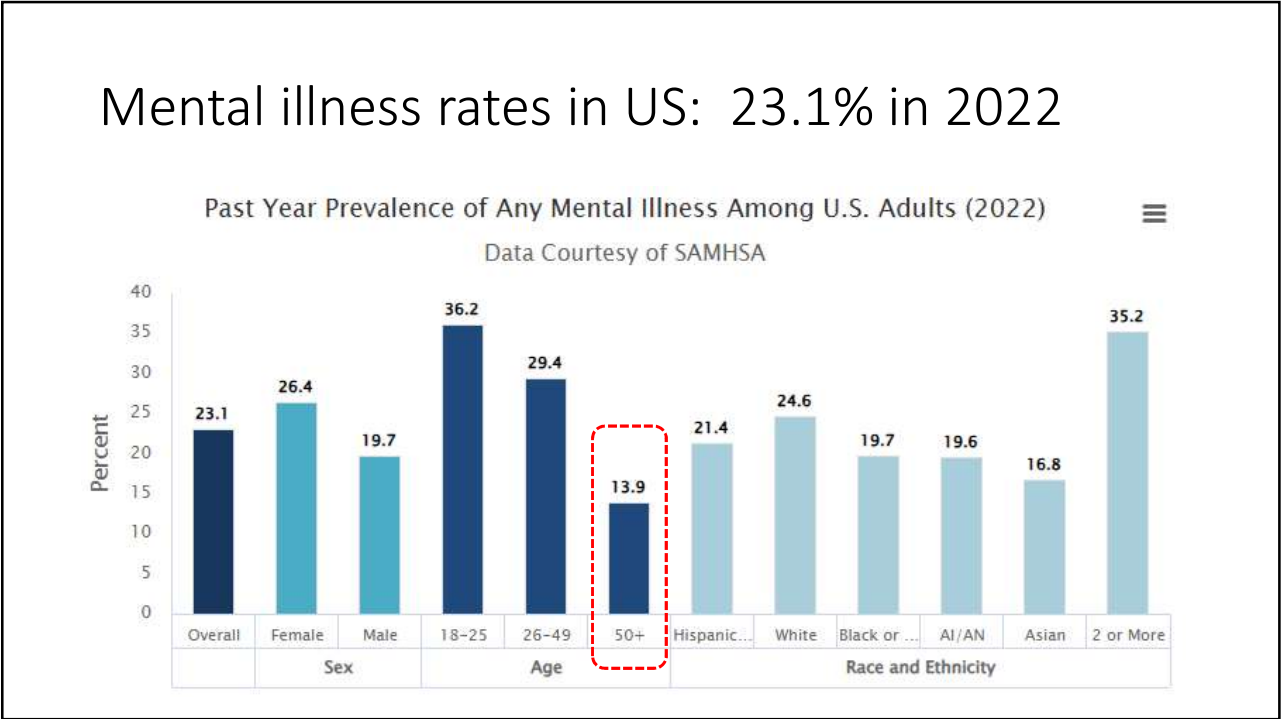
Subjective cognitive complaints

- Reported by 25% of people age 90+ in one study. *(Soleimani)*
- Reported by 28.1% in people age 85+ in an international study. *(Rohr)*
- Correlated with worse global cognition, executive function, and verbal episodic memory – but this may be influenced by racial/cultural background. *(Soleimani)*



Aging and mental health stats *(WHO)*

- By 2030, one in six people in the world will be aged 60 years or over.
- 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.
- 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.

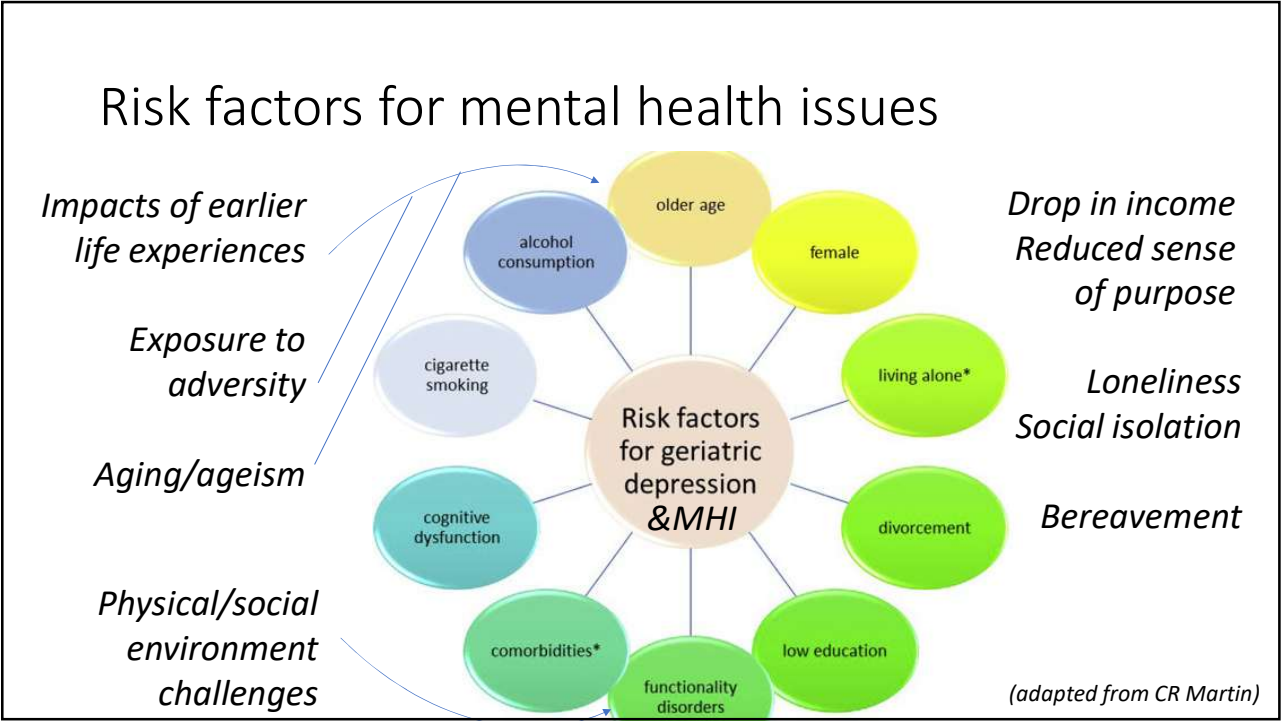


Prevalence in older adults (SAMHSA/WHO)

- 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%

MOST UNTREATED

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



Depression prevalence

- Depression in general older population 12-14%. *(NIMH)*
- Depression prevalence in people with MCI living in the community is almost double that, at 25%. *(Ismail)*
- Adults 55+ less likely to experience MDD than younger adults, but more likely to experience sub-threshold depressive symptoms. *(Biella)*



Often undiagnosed or under-diagnosed in older adults

Depression, dementia intertwined *(Yin; Helvik)*

- 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.
- Numerous studies have demonstrated that depression, particularly when persistent over time, is a well-established risk factor for cognitive decline and dementia.

Depression impact on cognition *(Niu)*

- Late-life depression (LLD): cognitive impairment appears earlier in depressed individuals.

EARLY ONSET first episode < 60yo	LATE-ONSET first episode > 60yo
Lower global cognition at baseline (Ly)	More rapid decline in verbal skills and delayed recall (Ly) Significantly greater decline in executive function (Loyal)

Depression impact on cognition

- As depression is often undiagnosed or under-diagnosed in older adults, it is more likely to affect cognition over time.
- Depressive symptoms affect cognition and DMC:
 - Sleep disturbance
 - Loss of energy and/or loss of interest in usual activities
 - Sense of hopelessness, worthlessness or suicidal ideation

Cognitive – and capacity – issues caused by depression can fluctuate and may be reversible with appropriate treatment

Depression impact on cognition



- Fluid intelligence and information processing significantly affected. (*Forbes*)
- Moderate deficits in executive function, attention and memory. (*Rock*)
- Impaired verbal fluency is common. (*Szymkowicz*)
- Deficits in executive function occur in nearly 40%. (*Alexopoulos*)
- Deficits in selective attention, working memory, and long-term memory persist even in remission from a major depressive episode. (*Forbes*)

Depression and Hopelessness

- Hopelessness is a more severe level of depression – important to monitor, as it is repeatedly found to be associated with poor health outcomes. *(Do)*
- Baseline hopelessness showed a trend for faster decline in episodic memory. *(Soleimani)*
- Severity of hopelessness associated with worse executive function. *(Soleimani)*



Bipolar disorders impact on cognition *(Forbes)*

- Cognitive impairments similar to those in depression are common, but 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 *(Chau; Persaud)*

- Depression and anxiety can contribute to impaired affective and executive control.
 - Supports resource allocation model, e.g. maladaptive thinking styles deplete available 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.



Anxiety

(Gulpers)



- Lifetime prevalence rates of anxiety disorders in older adults: 15%.
- 18.5% for subsyndromal anxiety complaints.

In older adults, higher anxiety levels are associated with worse cognitive functioning and increased risk for dementia.

Anxiety impact on cognition *(de Vito, Pietrzak)*

Higher scores on the GAD-7 (worse anxiety) associated with:

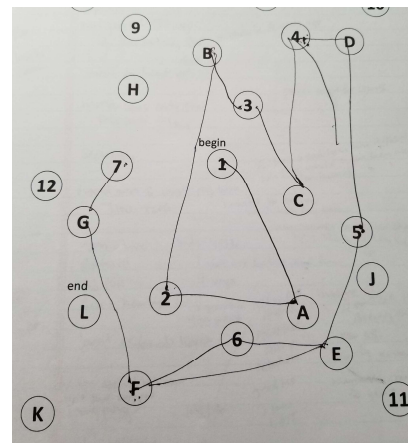
- Worse executive functioning
- Slower processing speed
- Higher odds of cognitive impairment.

Sub-clinical “worry” reduced performance in several areas:

- Executive functioning
- Episodic memory
- Learning and memory

Specific anxiety impacts on cognition

- **Agoraphobia:** worse scores on all cognitive domains including executive functioning, higher odds of cognitive impairment.
- **Panic disorder:** significantly associated with worse memory.
- **Men with any anxiety symptoms:** more likely to have substantial worsening in Trails B completion time vs men with no baseline anxiety. *(Kassem)*



PTSD and stress-related disorders

- Stress impacts cognitive flexibility and processing speed. (*Fang*)
- Cognitive flexibility is often dysfunctional in PTSD. (*Clancy; Disner*)
- Reduced cognitive flexibility shortly after stressful/traumatic event is predictive of PTSD symptom severity a full year later. (*Ben-Zion*)
- Stress exposure led to more disadvantageous and risky decisions than nonstress conditions. (*Starcke & Brand*)



Hoarding

- Estimated prevalence of clinically significant symptoms: 2.0 to 5.3%. (*Makin*)
- Especially in elders: combination of self-control deficits and refusing to seek help can lead to acute illness and extreme self-neglect, suggesting a potential influence on capacity. (*Kim*)



Source: Steri-Clean Inc, Hoarders.com

Hoarding and cognitive functions *(Makin)*

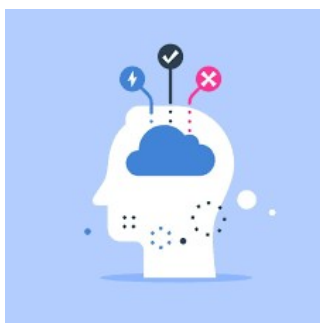
- People with hoarding disorder:
 - commonly have traits of indecisiveness, difficulty with categorization, disorganization, slowness in completing tasks, and
 - often report difficulties with memory, concentration/attention.
- Higher incidence of cognitive impairment on measures of visual memory, visual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

Psychotic disorders

- 25% of people with schizophrenia age 55+ *(Golas)*
- Aging with these disorders: illness burden compounded by multiple medical comorbidities, loss of supports, and higher risk of institutionalization. *(Cohen).*
- Cognitive deficits are common, including attention, working memory, verbal learning and memory, and executive functions. *(Kalache; Lowenstein; Rajji)*



Psychotic disorders and decision making



- Individuals with schizophrenia spectrum disorders (SSD) exhibit less adaption to changing information about risk, which may reflect risk imperception. *(Dong)*
- Disorganization may be related to overall decision making deficits – worse deficits cause further deviation from optimal decisions in a complex, dynamic risk-taking task.
- Difficulty in integrating information and adjusting decisions accordingly. *(Sterzer)*

Psychosis plus dementia *(Gkintoni)*

- In people with psychotic diagnoses, dementia worsens symptoms like hallucinations and delusions.
- Co-occurrence of cognitive impairments with psychosis can worsen cognitive impairments, change disease progression, and affect therapy responses.



Psychotic disorders • Domains of cognitive impairment in schizophrenia: attention, memory, executive function, social cognition, and perceptual–motor function. <i>(Fang)</i> • Cognitive remediation improved executive function, did not significantly impact global cognition or MOCA test score. <i>(Golas)</i>	Neuromodulation for improving cognition in schizophrenia <i>(Hung)</i>	
	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 disorders <i>(Rootes-Murdy)</i> • Mean age of onset 40 years • Women up to 3x more than men • Women more erotomaniac type – men more paranoid type • Older adults, particularly women, are at a higher risk, possibly due to age-related brain changes and increased vulnerability to stressors. • May be dopamine circuit disruptions causing mixup of salient and non-salient information, error processing deficits, and cognitive biases.

Delusions impact on cognition *(Díaz-Caneja)*

Attention/ Memory:	Sustained attention, encoding and retrieving info, ability to learn and remember new things.
Executive Functions:	Planning, problem-solving, managing daily tasks, adapting to changing situations.
Social Cognition:	Misunderstanding social cues, misinterpreting others' intentions, difficulty forming and maintaining relationships.
Jumping to Conclusions:	Tendency to draw conclusions prematurely based on limited information, which can further reinforce their delusional beliefs.
Poor Insight:	Unable to recognize that their beliefs are unrealistic or unfounded

“Symptom domain and verbal memory performance affect global functioning... above and beyond the severity of the paranoid idea”

Personality disorders – upcoming training

Personality Disorders in the Older Adult Population

With Karen Kent, LMHC, GMHS

Wednesday, June 10th, 2026

9:00am- 4:00pm Pacific Daylight Time On Zoom

6 CEUs



Register at <https://soundgenerations.org/personality-disorders-in-the-older-adult-population-with-karen-kent-lmhs-gmhs/>

Impact on cognition and DM from

Neurocognitive Issues

Mental Health Issues

Other Issues and Factors

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

Medical conditions common in older adults

- 93% (age 65+) have at least one chronic condition
- 79% have two or more



Hypertension
(High Blood Pressure)
61%



High Cholesterol
55%



Arthritis
51%



Obesity
30%



Diabetes
24%



Cancer
20%



Heart Disease
16%



Depression
15%



COPD
12%



Asthma
9%

Graphic source: <https://www.ncoa.org/article/the-top-10-most-common-chronic-conditions-in-older-adults/>

Also see handout: *Medical Conditions Affecting DMC*

Medications in older adults - stats

(Ruscin, CDC)

- 90% regularly take at least 1 prescription medication.
- 43% take at least 5 different prescription meds.
- When over-the-counter and dietary supplements are included, these rates are even higher.
- Older adults who are frail, hospitalized, or in a nursing home take the most meds.
- Around 3.5% did not get or take meds due to cost.

Meds impact on older adults

- Normal changes with aging affects how meds work:
 - Liver and kidneys less efficient
 - Meds can build up to high levels or stay in the body for too long.
 - Leads to side effects and even toxicity.
- 15-25% of Rx use in older adults is considered unnecessary or inappropriate. *(APS)*
- 28% of hospitalizations related to meds. *(APS)*

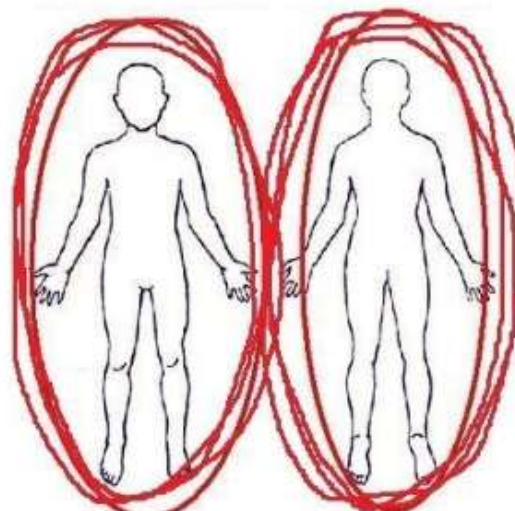
Beers List:

*American
Geriatrics Society
Beers Criteria for
Potentially
Inappropriate
Medication Use
in Older Adults*

Pain

- CMS study found 78% of Medicare enrollees have chronic pain
 - 82% of women
 - 74% of men
- Impacts mobility, quality of life.
- Often co-occurs with symptoms of depression and anxiety.

Circle where it hurts



Physical/mobility factors *(Cao, Martins)*



- Mobility limitations and decline significantly correlate with cognitive decline.
- Cognitive impairment significantly linked to lower muscle strength, reduced functional mobility, reduced cardiorespiratory fitness.
- Environment, autonomy, and engagement in daily activities influence cognitive impairment.

Environmental factors *(Baniassadi)*

- 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.”

-- Study author Amir Baniassadi PhD,
Marcus Institute for Aging Research

Literacy / language



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

Social / cultural / spiritual factors

“Traditional capacity assessment tools, developed primarily within Western medical paradigms, may not adequately capture the complexity of decision-making processes in diverse cultural contexts. Research indicates that **cultural beliefs, values, and practices significantly influence how individuals understand illness, death, and medical decision-making.**”

(Francis et al, 2025)

Spirituality and cognition

Spiritual well-being more positively related to cognitive flexibility in older adults than younger people. *(Halder)*

Religious attendance by race: *(Sauerteig-Rolston)*

- For Hispanic older adults, associated with a slower rate of cognitive decline.
- For non-Hispanic white older adults, associated with lower initial levels of cognitive function.
- No association for non-Hispanic Black respondents.



Loneliness



***Distressing feeling of social needs unmet
by quantity and particularly quality
of one's social relationships***

- Different from but may coincide with social isolation, a depressive episode, or both. Endorsed by 25% of older adults. *(Camacho)*
- Loneliness by itself, aside from other factors, raises dementia risk comparable to having a single APOE4 gene. *(Oken)*
- For every one-point increase in loneliness, the risk of developing dementia increased by 40%. *(Camacho)*

Loneliness and cognitive impairment

- Bidirectional association between loneliness and memory function. *(Yin)*
- 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)*
- Loneliness is associated with cognitive decline and volumetric reduction in the frontal white matter. *(Lee)*



And GRIEF

<https://www.instagram.com/p/DPL8iFRjrjf/?igsh=MWo0bjnYjBrdGZzdg%3D%3D>



“The tiredness you’re feeling after a loss isn’t laziness. It’s not weakness. It’s your body doing some of the hardest biological and psychological work humans are capable of. Your brain is literally rewiring itself to function in a world without your world as it was.

Your nervous system is stuck in overdrive. Your cells are struggling to produce energy. Your heart is sending actual distress signals to your brain. This is real, measurable, physical work happening inside you.”

CASE STUDIES

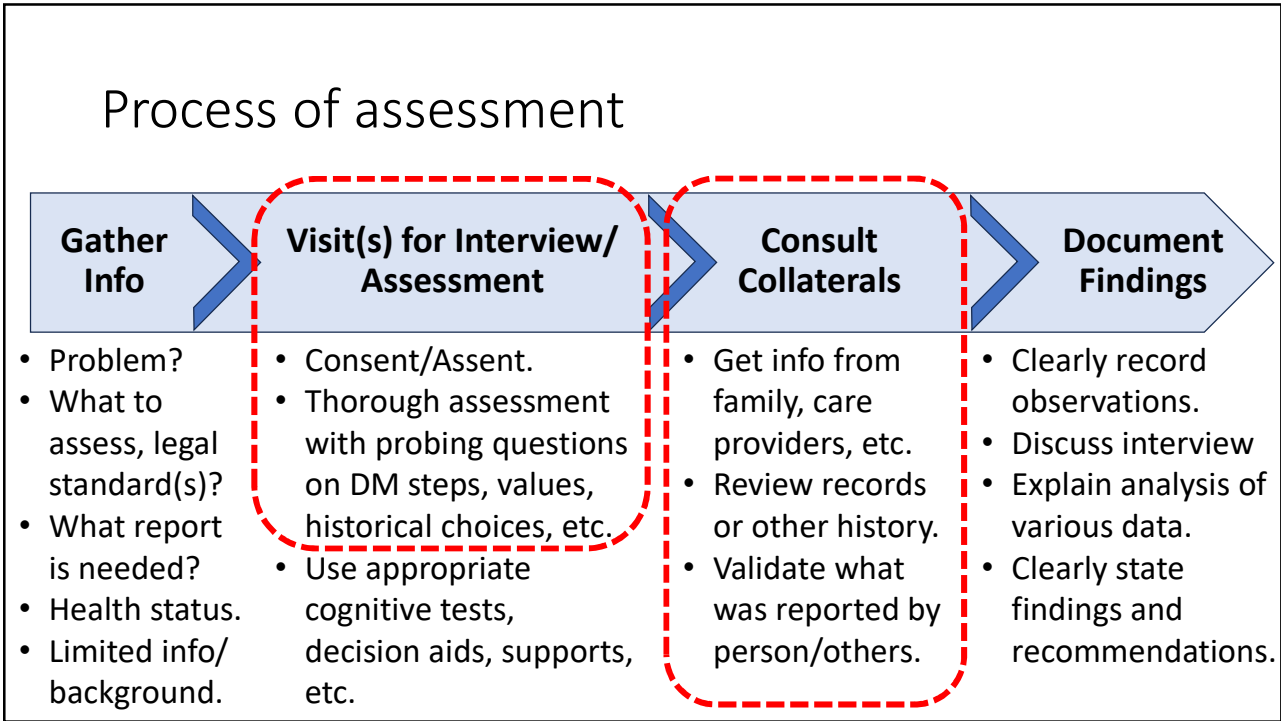
- Case studies PDF in the chat
- Room 1 = Case 1, etc.
- One person read case out loud, another take notes to report back to everybody
- 20 min in breakout rooms
- Then 15 min break

Discuss:

- *What factors are impacting capacity?*
- *What else would you want to ask or know?*
- *If time – what types of supports might be options?*

Work process topics: about doing this work

Assessment Process & Approaches
Less Restrictive Alternatives and Supported Decision Making

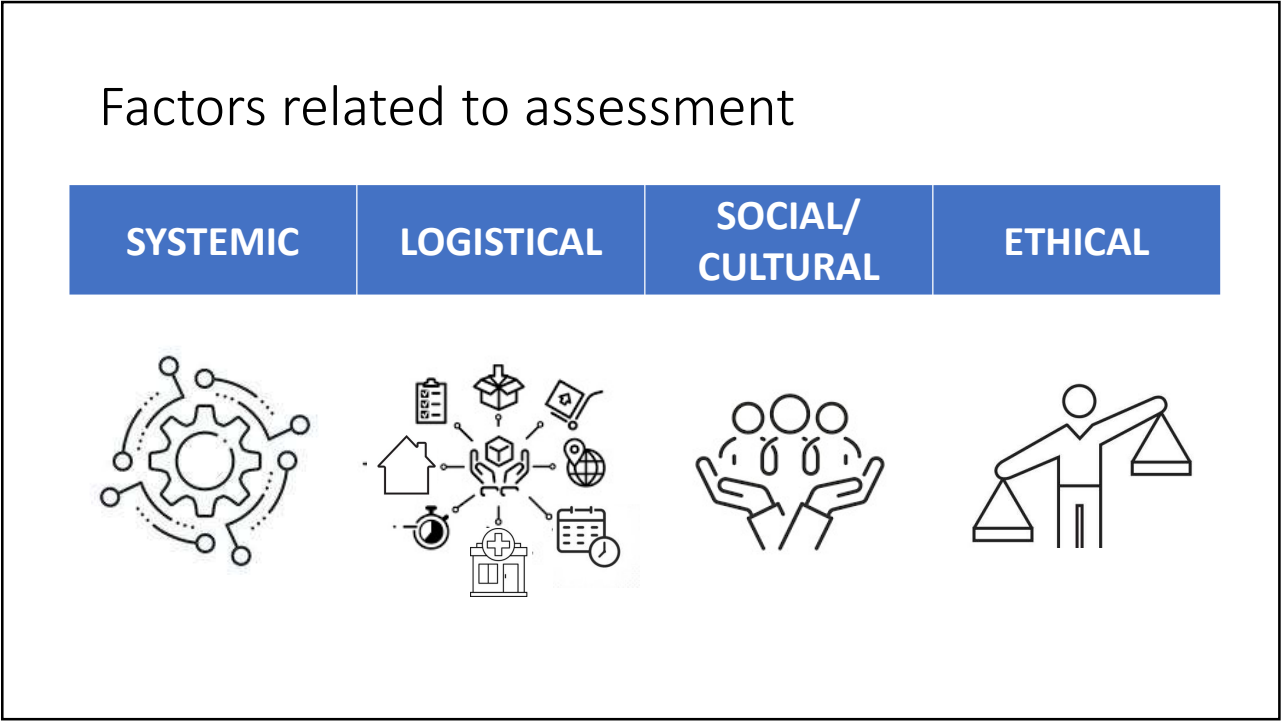


Consent vs assent

CONSENT is formal agreement given by an individual who has the capacity to make an informed decision.

ASSENT is an agreement given by a person who is not legally empowered to give consent, such as a child or an adult with impaired decision making abilities.

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.



SYSTEMIC

LOGISTICAL

SOCIAL/
CULTURAL

ETHICAL

Awareness of other factors and involved parties in the person’s life.

Legal/systems	Law enforcement Adult Protective Services Guardianship/conservatorship process Other court proceedings
Legal/status	Important decisions Documents to complete
Health/medical	Recent hospitalization New diagnosis Unmanaged conditions Access to care, medications, services



SYSTEMIC	LOGISTICAL	SOCIAL/ CULTURAL	ETHICAL
----------	------------	---------------------	---------

Factors to take into consideration before and at the visit

- Visits at person’s home:
 - Comfortable or distracting?
 - Things/people that impact autonomy and engagement?
 - Safety issues for you?
- Visits at hospital, clinic, or elsewhere in community:
 - Do they feel at ease or insecure?
 - Private, calm space?



SYSTEMIC	LOGISTICAL	SOCIAL/ CULTURAL	ETHICAL
----------	------------	---------------------	---------

Factors to take into consideration before and at the visit

- Schedule – time and day when the person is at their best.
- Supports – people:
 - Family, friends, caregivers that help them feel ok.
 - These can be helpful informants for you as well.

SYSTEMIC

LOGISTICAL

SOCIAL/
CULTURAL

ETHICAL

Factors to take into consideration before and at the visit

- Supports to bring with you:
 - Multiple copies of tools/tests.
 - Thicker pens, markers, clipboard.
 - Communication aids like pocket-talkers.
 - Large print materials.
 - Page-size magnifiers.



SYSTEMIC

LOGISTICAL

SOCIAL/
CULTURAL

ETHICAL

Factors to take into consideration before and at the visit

- Physical impairments:
 - Mobility limitations/decline and cognitive decline are significantly correlated.
 - Impact on testing of fine motor skills, strength, and flexibility, endurance – accommodate as needed.
- Sensory impairments:
 - Can they see and hear you?
 - Do they have their glasses, hearing aids?



SYSTEMIC	LOGISTICAL	SOCIAL/ CULTURAL	ETHICAL
----------	------------	---------------------	---------

Respect for a person’s personal identity, culture, and social role

- Language – for non-native English speakers:
 - Fluency/comfort with English, or
 - Access to qualified interpreters.
- Literacy
 - Education level is kind of an indication, but not...
 - Reading comprehension
 - Financial literacy
 - Health literacy



SYSTEMIC	LOGISTICAL	SOCIAL/ CULTURAL	ETHICAL
----------	------------	---------------------	---------

Respect for a person’s personal identity, culture, and social role

- Background and history – how their experience influences their interactions with others.
- Positive supports, or negative factors:
 - Family and culture of origin.
 - Current family/cultural context.
 - Community connections – friends, neighbors, senior centers, spiritual orgs, etc.



SYSTEMIC

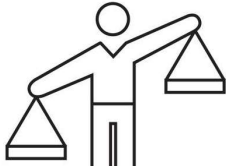
LOGISTICAL

SOCIAL/
CULTURAL

ETHICAL

Both person centered and clinically/professionally appropriate.

- We’re obligated to present the assessment and testing process in an honest way.
- Involve whoever requested the assessment to facilitate/support the visit.
- Be strategic with language and framing, without false reassurance.
- Try for consent, or at least assent.

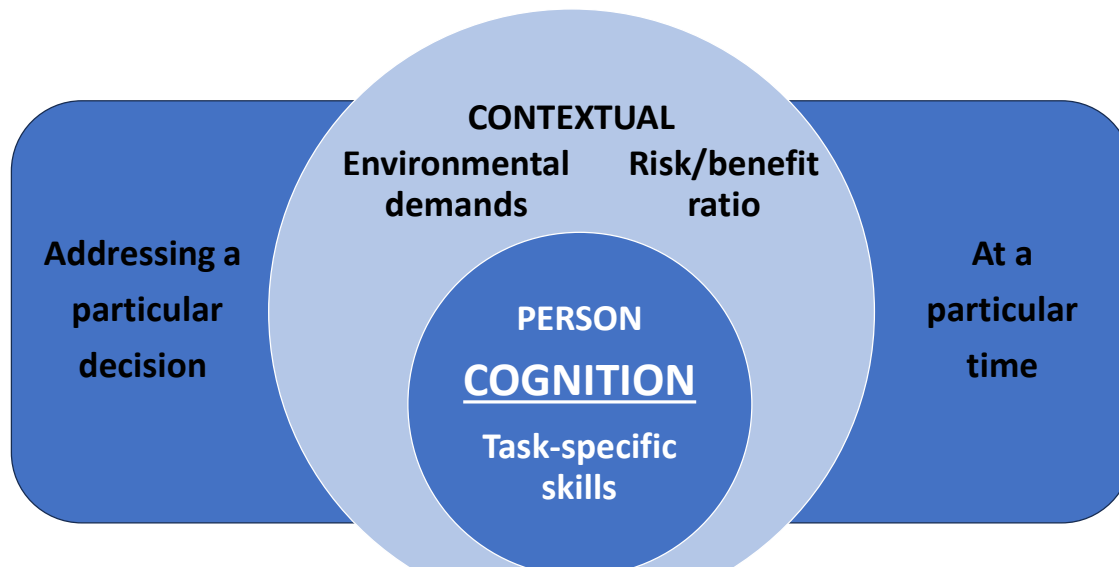


Assessment approaches

- Bio-psycho-social with focus on capacity question/situation
- APS training guidance
- 5M framework

Also refer back to the ABA/APA handbooks for what assessments in general should cover, as well as what to include for specific capacity questions.

Bio-psycho-social / Person In Environment



APS guidance: capacity eval should include

(APS Module 17)

- A physical and neurological examination.
- Short- and long-term memory assessment.
- Assessment of executive function:
 - Set of abilities that control and regulate someone's ability to anticipate outcomes and to adapt behavior to changing situations.
- Examination for any existing psychological disorders.
- Diagnosis of any existing addictive syndromes.
- All should be included; if unavailable, the most possible.

Assessment of geriatric wellbeing – 4/5M’s

- **4M model:**
 - Developed in 2017 by the Institute for Healthcare Improvement, to support Age-Friendly Health Systems.
 - Goal is to ensure older adults receive care based on four evidence-based elements
- **4M-BH model** tailored for use by mental health and substance abuse clinicians in diverse settings.
- **5M model** developed by geriatric specialists, adds Multicomplexity.

What **M**atters
Medication
Mentation
Mobility

+

Multicomplexity

Multicomplexity	Geriatrics healthcare professionals ¹ focus on these 4Ms...	When caring for older adults, all health professionals should consider...
Multicomplexity describes the whole person, typically an older adult, living with multiple chronic conditions, advanced illness, and/or with complicated biopsychosocial needs.	Mind	Mentation Dementia Delirium Depression
	Mobility	Amount of mobility; function Impaired gait and balance Fall injury prevention
	Medications	Polypharmacy; deprescribing Optimal prescribing Adverse medication effects and medication burden
	What Matters Most	Each individual's own meaningful health outcome goals and care preferences

Graphic source: https://www.healthinaging.org/sites/default/files/media/pdf/HIA-TipSheet%20Geriatric%205Ms.July20_0.pdf

Collateral information

- Get info from family, care providers, etc.
- Review records or other history (depending on situation).
- Validate what was reported by person and others.
- Look at consistency in person’s decisions/functioning over time.
- Privacy: you may not be able to share info, but others may be able to provide you with info/records.

Collateral information

- Collaterals corroborate. Use whenever possible!
- **Not everyone will have an “identified informant”** (spouse/partner, family, friend, caregiver).
- Consider neighbors, apartment staff, community contacts, anyone that has had more than occasional contact with the person.

*Person’s
report and
presentation*

+

*Clinician’s
observations*

+

*Informant
information*

=

*most robust
picture of the
person’s
situation.*

Records: types you might review

- Medical records
 - Primary care and appropriate specialty
 - Especially most recent visit note
 - List of medications, diagnoses
- DPOA document(s) if they have them
- Care plan – if living in facility or receiving care services
- Any other documents related to capacity question at hand:
 - Advance directives, POLST/MOLST
 - Bank/financial records



Less restrictive alternatives and Supported Decision Making

Less restrictive alternatives

- Guardianship and/or conservatorship should be last resorts as they:
 - remove legal rights, and
 - restrict independence and self-determination.
- Less restrictive alternatives can include a range of strategies, from supported decision making to other formal and informal arrangements.

Guardianship / Conservatorship should be used only when there are no suitable less restrictive options.

LR Alternatives – informational help

- **Education interventions:** Supplementing or simplifying information with alternate forms of communication, e.g., visual aids. *(Tymchuk)*
- **Care navigation:** Support with understanding and accessing information and resources
 - Medicare GUIDE programs
 - Alzheimer’s Association

Documented benefits:

Improved DMC in severely depressed patients. *(Lapid)*

Assists psychiatric patients in achieving capacity to consent. *(Palmer)*

LR Alternatives: in-home functional help

- Home modifications such as ramps, grab bars, stair lifts, lighting.
 - OT home safety evaluation can help optimize environment
- Assistive devices: day/date clocks, medisets, smart home tools, reminder services (e.g. Skylight calendar system)
- In-home support for personal care, meals, medication, transportation, companionship, etc.

VA and Medicare GUIDE
programs often cover respite

- Home healthcare services.
- Private caregivers or assistance services – maybe as supplement.
- VA supports for veterans and spouses.
- Respite services for caregivers.

LR Alternatives: supports in community

- Senior centers and community centers
- Faith communities
- Dementia-friendly programs – memory cafés, tandem support groups
 - Seattle/Puget Sound MOMENTIA

All of these may provide:

- Social and educational programming
- Meals
- Art and music
- Outings with transportation
- Exercise programs

LR Alternatives: supports in community

- Virtual villages / neighborhood networks
- Adult day health programs – PACE, VA, others
- Supportive / assisted living
 - Independent living with meals and some services
 - Assisted living – varying levels and types of help
 - Dementia or memory care – usually secure/locked units

LR Alternatives: financial

- DPOA for finance.
- Joint accounts or authorized signers (consider legal/asset impacts).
- Automatic bill payment, or bill paying services: through bank account or specific billing account.
- Fiduciary or Daily Money Manager: a professional that manages most or all financial affairs.
- Trust, Special Needs Trust, ABLE accounts: set up with legal support.
- Representative payee for Social Security or VA Fiduciary: appointed, typically have to petition SSA, VA, etc.

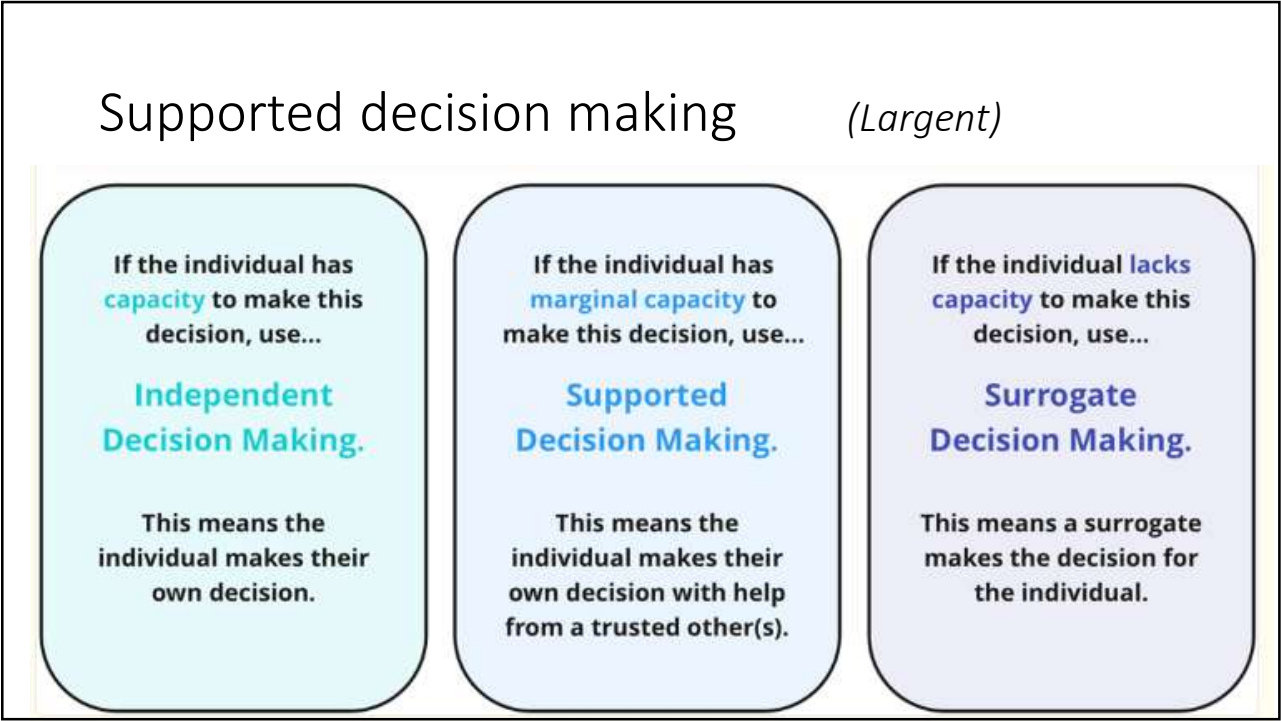
LR Alternatives – legal, logistical

- DPOA for health, finance, or both.
- Advance directives – including mental health and dementia directives.
- Protective arrangements – can be tailored to the situation.
- Legal advocate or guardian ad litem (related to court, elder abuse).
- Case management, care management, or care coordination services.
- State/local agency or department services and supports:
 - Developmental Disabilities
 - Deaf, Blind, Disabled, Veterans, or Aging
 - Vocational Rehabilitation

Supported Decision Making

We all use supported decision making every day!

- SDM is where a person with marginal capacity identifies a trusted person or network of persons to aid them in making their own decisions. *(Largent)*
- Even where not formally recognized, it can be practiced informally, helping balance **respecting autonomy** and **recognizing vulnerability**.



SDM: unique, not “one size fits all”

A person’s support networks, ways of communicating, strengths/needs, and preferences.	
FORMAL	INFORMAL
• May have regular SDM team meetings and written SDM Agreements. • May rely more on professionals for support and coordination.	• May strategically use release-of-information forms and educate providers about decision-making rights and supports. • May rely more on family and friends and/or network of supports.

SDM Agreement

- A document that defines the SDM relationship in writing.
- May be needed under state law or as a reasonable modification for a person's disability.
- While having an SDM agreement is not required to use SDM informally, it can help to establish a clear, common understanding.
- For third parties – doctors, hospitals, banks, schools, service providers, governmental agencies
- Defines
 - Who a person's supporters are
 - What decisions the person wants help with
 - How the person wants to be helped with decision-making.

SDM Agreement: legal requirements

- Laws vary across states
- Generally contain requirements for
 - who can serve as a formal supporter,
 - what that formal supporter's responsibilities are, and
 - what the SDM agreement should look like.
- Laws also usually limit the liability of third parties who reasonably rely on the agreement, which can help make them more comfortable and willing to honor the agreement.

Supported Decision Making by state

(as of April 2026)

- Recognized by law in 40 states and DC, with provisions in other states via court rules, state regulations, or policy.
- Comprehensive SDM Agreement Legislation in 24 States and DC:
AL, AK, AZ, CA, CO, DE, FL, HI, IL, IN, KS, LA, MD, NV, NH, NM, NY, ND, RI, TX, UT, VA, WA, WI.

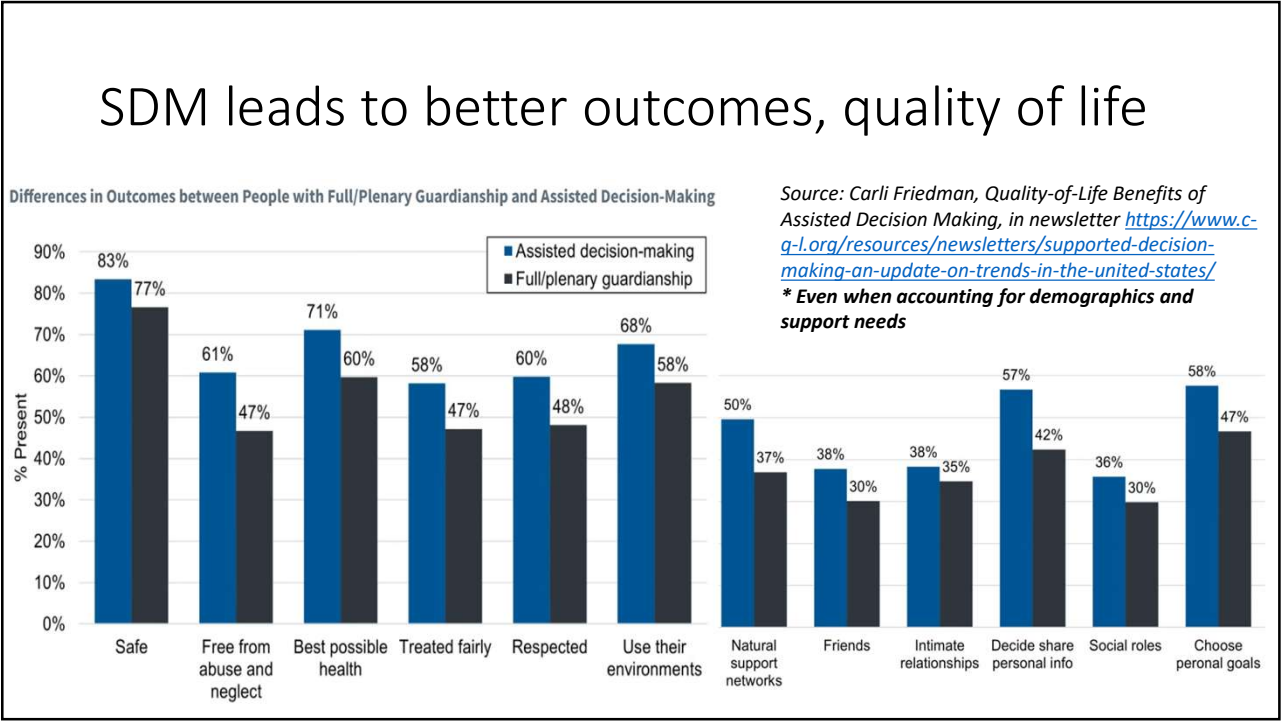
Source: <https://supporteddecisions.org/resources-on-sdm/state-supported-decision-making-laws-and-court-decisions/>

SDM by state, continued

(as of April 2026)

- Less Restrictive Option for Guardianship: in 18 states and Uniform law
 - CA, FL, ID, IN, KS, ME, MN, MO, MT, NV, NH, NC, ND, OK, PA, VA, WA, WI
- Related to health care decisions: 3 states
 - DE, MD, UT
- Related to organ transplants: 23 states
 - AL, AZ, AR, DE, FL, GA, KS, LA, MD, MN, MS, MT, NV, NC, OH, OK, RI, SC, VA, WA, WB, WI, WY

Source: <https://supporteddecisions.org/resources-on-sdm/state-supported-decision-making-laws-and-court-decisions/>



- ### SDM: factors to consider
- Cultural approaches to decision making and supports
 - Power dynamics in relationships
 - Financial pressures
 - Spiritual/religious values
 - Guidance from social or spiritual leaders

Coming up – mark your calendars

Capacity Consultation Group	Older Adult Mental Health Consult Group
Sponsored by ACCS 12noon to 1:30pm Pacific time on zoom Tuesdays: July 21, Sept 15, and Nov 17. Registration is required: https://tinyurl.com/ysrywebv	Sponsored by GRAT/ACCS 12noon to 1:30pm Pacific time on zoom Tuesdays: June 16, Aug 18, and Oct 20. Register for one or all meetings at https://us02web.zoom.us/meeting/register/MaxDVsm0S7mH66y7zecILQ

Treatment Advocacy Center webinars

Focused on real world challenges and solutions for the SMI (severe mental illness) community.

Competency Solutions- June 10, 7 pm ET:

- Judge Cynthia Lu, Kristine Riley, Heather Neil
- Washoe Co, Nevada AOT team

Family Solutions- July 1, 7 pm ET:

- Bob Krulish - mental health educator, advocate, and author
- Shomari Smith - creator of SMI focused app, Kairos

Treatment Solutions- August 3, 6 pm ET

- Dr. Susan Partovi - street medicine doctor and author of “Renegade MD”
- Dr. Sarah Kopelovich - Associate Professor at University of Washington

Register:

https://us02web.zoom.us/webinar/register/WN_dvFTtvDYTFcu2WMO1UDIfw#/registration



- Every year on **June 15**, World Elder Abuse Awareness Day (WEAAD) provides an opportunity for all of us to promote dialogue and action on the issue of elder abuse, neglect, and exploitation.
- National Weekend of Prayer & Action for Elder Justice: June 12-14
- Resources online at <https://ncea.usc.edu/>

NCEA

National Center on Elder Abuse

ISSUE BRIEF

How Can Restorative Justice Help in Family Guardianships?

Introduction: Guardianship and Family Disputes

Guardianship benefits and drawbacks. Guardianship is a legal device in which a court appoints someone to make decisions about the care and/or finances of an adult who has found unable to make such decisions for themselves. The aim is to protect the adult from harm. Guardianship can be a lifesaving solution for elder abuse, neglect, or exploitation, often in crisis situations. But there are downsides.

NCEA

NATIONAL CENTER ON ELDER ABUSE

RESEARCH SHORT

Ageism

Ageism is the stereotyping, prejudice, and/or discrimination of individuals on the basis of their age. It is one of the most prevalent, least recognized, and tacitly normalized within society.

Over 50% of older people aged 50 to 80 surveyed reported experiencing everyday ageism.

Ageism looks like this

Individual Level:
Private communications and social exchanges that demean older people.

Societal Level:
Stereotype portrayals of older people in public discourse, media depictions, and everyday culture.

Institutional Level:
Policies, practices, and procedures that reinforce and perpetuate misassumptions.

NCEA

NATIONAL CENTER ON ELDER ABUSE

Fact Sheet

Psychological Recovery and Resilience After Financial Exploitation

What is elder financial exploitation?

Elder financial exploitation is the misappropriation or misuse of an older person's money, property, or assets for another person's use or benefit. It consists of both elder financial abuse and elder financial fraud and scams. Elder financial abuse is committed by a trusted other, or someone known to the older person, such as a family member or surrogate decision-maker. Frauds and scams are typically perpetrated by strangers.

Our next classes

June 3	Cognitive testing and other assessment tools
June 17	Case studies and discussion, next steps