

Decision-Making Capacity Assessment Program

Class 1: March 5, 2025

for Sound Generations Elder Education Institute by



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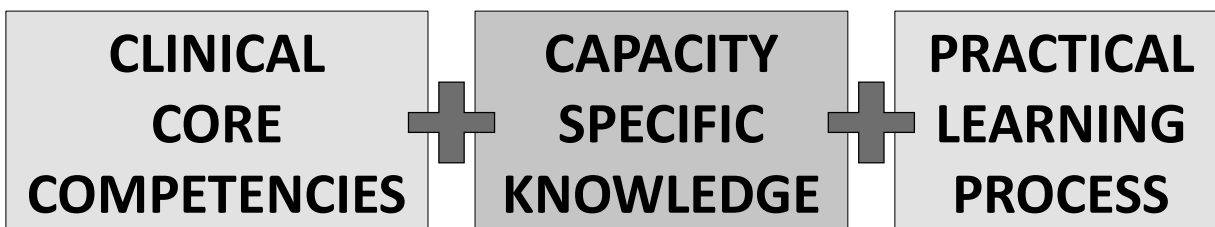
	Time	Topic
Agenda	830a	Intro, housekeeping, agenda, program overview
	900a	Guest speaker: Prosecutor Page Ulrey
	920a	Polls on your background and experience What have you seen? When is DMC a concern?
	945a	Break
	1000a	Legal/clinical concepts, history, models of DM
	1045a	Break
	1100a	Balancing values, dignity of risk, issue of insight
	12-1p	Break for lunch
	100p	Recap morning, questions, afternoon agenda
	110p	Specific types of decisions/capacity
	155p	Break
	210p	Case studies in breakout rooms, discussion
	300p	Break
	315p	Dynamic/fluctuating capacity Who decides? Assessment process, discussion
	425p	Recap, resources, future classes, other events

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,” but the only way to receive this designation is from each specific province’s Ministry of Justice and/or Solicitor General.

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.

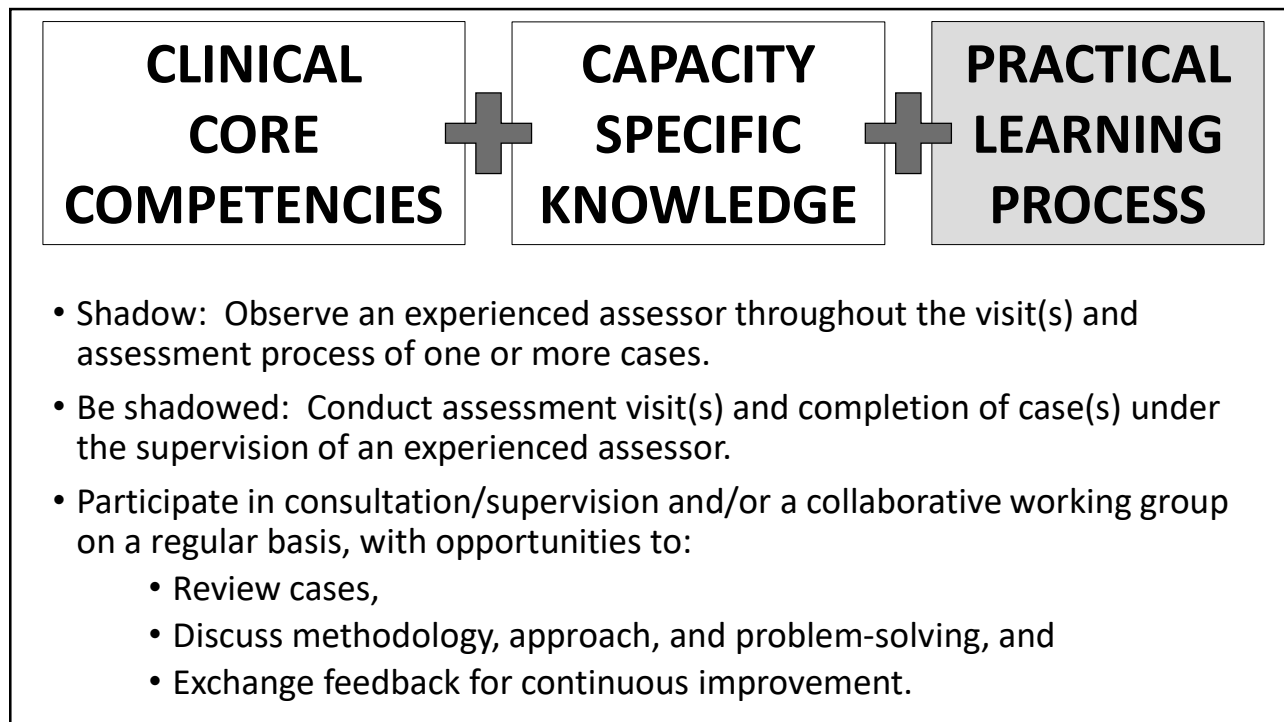


**CLINICAL
CORE
COMPETENCIES** + **CAPACITY
SPECIFIC
KNOWLEDGE** + **PRACTICAL
LEARNING
PROCESS**

- 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.
- Familiar with supports including interpreters, amplifiers for hearing impairment, magnifiers for low vision, PPE, etc.
- Document clearly in plain (non-jargon) language to explain the clinical visit and assessment process, observations, impressions, description of tests/results, findings, and recommendations.

**CLINICAL
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PROCESS**

- Knowledge about cognition and cognitive processes, and how they relate to the decision making process.
- Understanding of decisional 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.
- Ability to assess decision-making capacity for specific decisions, through interviews with the person as well as information from collateral contacts.



**“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.

Guest speaker



Page Ulrey is a Senior Deputy Prosecuting Attorney for the King County Prosecutor's Office. She graduated from Amherst College and Northeastern University School of Law.

She began her career at the King County Prosecutor's Office in 1998, and in 2001 was appointed to the newly-created position of elder abuse prosecutor in the Criminal Division. In that position, she prosecutes cases of elder and vulnerable adult neglect, financial exploitation, sexual assault, physical assault, and homicide, and co-leads her office's elder abuse Multi Disciplinary Team.

Page conducts training and curriculum development on elder abuse prosecution and investigation around the country and internationally. She has testified before the U.S. Senate Special Committee on Aging and has twice spoken at White House conferences on Elder Justice.

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?

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
- Moving into residential care
- Driving accidents
- Resistance to help
- Abuse, exploitation, neglect

“System” triggers

- Investigations by law enforcement or Adult Protective Services
 - Abuse, exploitation, scams, neglect, self-neglect
 - 83.6% increase in elder abuse during pandemic
 - 1 in 5 (21.3%) older adults reported elder abuse (Chang & Levy, 2021)
- Guardianship process
- Legal/status issues – decisions, documents, healthcare crisis

Some of the next big things?

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

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.

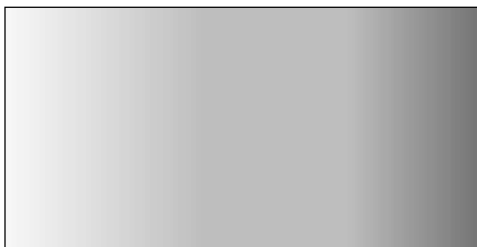
Clinical definition of capacity

- 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.

Clinical vs legal perspectives

Clinical view:

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



Legal view:

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



Clinical and legal together

- Clinicians and legal professionals look at capacity in analogous ways.
- 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.

Legal history – first, some background

American law is broadly divided into four areas: *(ABA/APA)*

- ***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.

Even before all that...

- “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)

U.S. legal history related to capacity issues

- Generally found in common law, statutes, courts – vs legislation.
- 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
- 1957: Salgo case in California led to specific standards for disclosing risks in consent process

(from Appel, 2024)

Later focus on human/civil rights

(from 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 “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
- 2003: Vermont Hargrave case upheld right of agent to refuse psych treatment on patient’s behalf, even if that meant permanent hospitalization
- 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) focuses on jurisdiction in adult guardianship cases.
- 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 45 states, DC, and Puerto Rico

← adopted by Maine and Washington

UGCOPPA definitions

- Functional incapacity: “lacks ability to meet essential requirement for physical health, safety, or self-care even with appropriate technological assistance.”
- Cognitive incapacity: “unable to receive and evaluate information or make or communicate decisions.”
- Guardianship required when it is “necessary to provide continuing care and supervisions.”
- 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.”

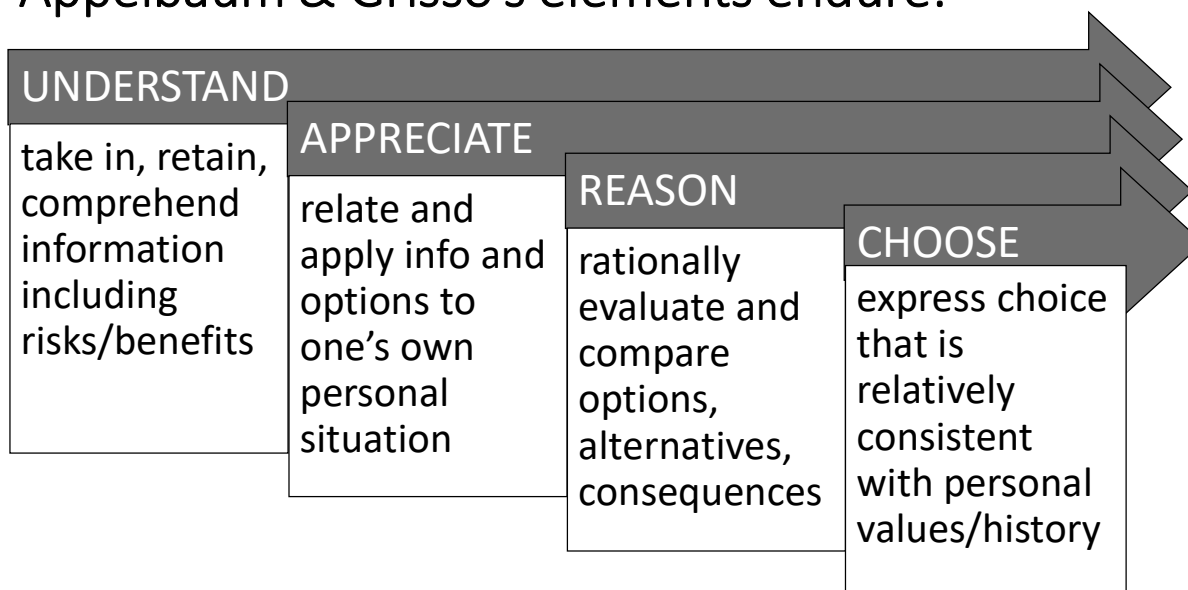
Selected statutes on capacity/guardianship

California	Conservatorship – under Probate Code 1800 Mental health conservatorship – under Welfare and Institutions Code 5350
District of Columbia	Under Title 21 Fiduciary Relations and Persons with Mental Illness: Chapter 20 Guardianship, Protective Proceedings, and Durable Power of Attorney.
Ohio	Under courts/probate, ORC Chapter 2111.
Washington	Adopted UGCOPPA under RCW 11.130.

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”

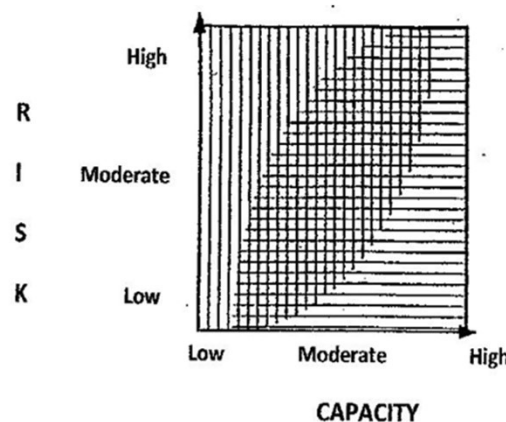
Appelbaum & Grisso’s elements endure:



Scholarship on assessing capacity

- 2008: ABA/APA published *Assessment of older adults with diminished capacity: A handbook for psychologists*.
- 2010: Barbara Soniat & Monica Melady Micklos book, *Empowering social workers for practice with vulnerable older adults* – included capacity-risk model for assessment (at right).
- 2020: Jennifer Moyer edited book, *Assessing capacities of older adults: A casebook to guide difficult decisions*.

Capacity-Risk Model for Assessment ©



Common principles: US, UK, Australia, Canada

Mental capacity acts and 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.
- When others are involved in decision making, the person's best interest and preferences at the forefront, and must infringe the least amount possible upon that person's basic rights and freedoms.

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 (1972)
Dignity of Risk*

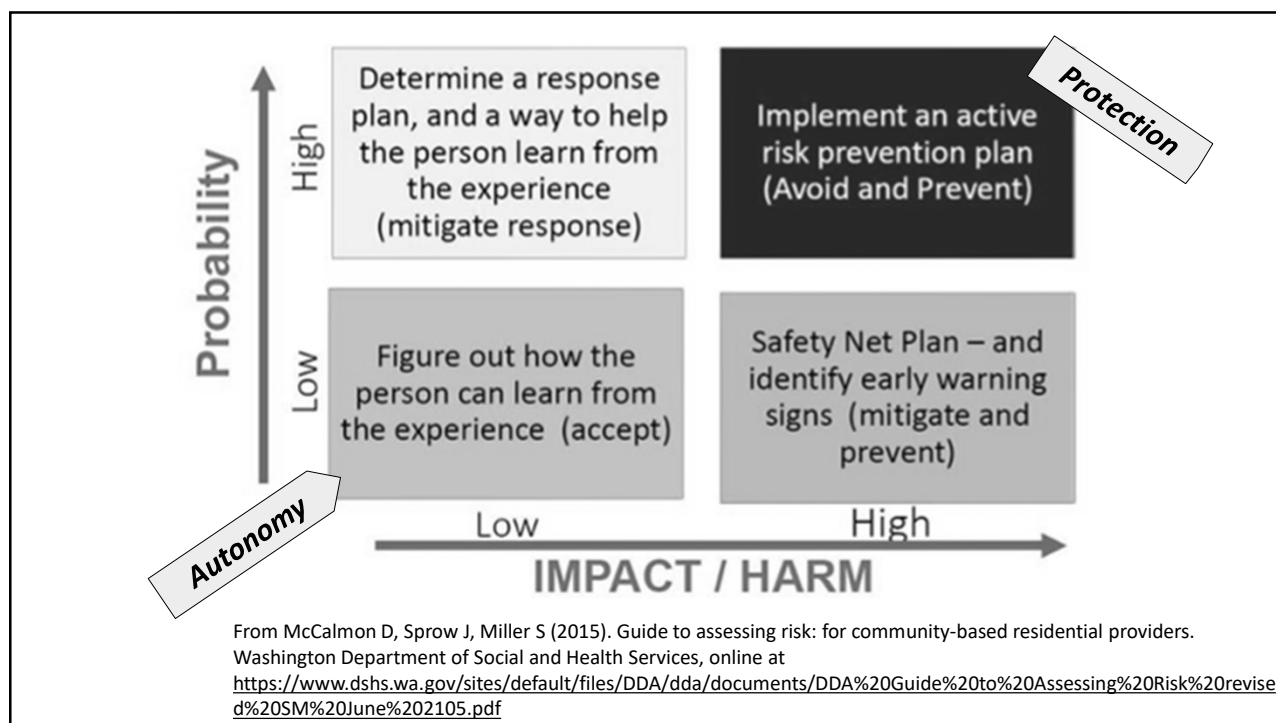
From McCalmon D, Sprow J, Miller S (2015). Guide to assessing risk: for community-based residential providers. Washington Department of Social and Health Services, online at <https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/DDA%20Guide%20to%20Assessing%20Risk%20revised%20SM%20June%20202105.pdf>

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 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? *(Soniati & Melady-Mickos, 2010)*
- Is there such a thing as acceptable or safe risk? *(Soniati & Melady-Mickos, 2010)*
- 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?



“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 AD, Lai JM, Kunik ME, Dyer CB. (2008) Assessing capacity in suspected cases of self-neglect. *Geriatrics*. Feb;63(2):24-31. from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847362/>)

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

- Insight in the context of decision making refers to a person's ability to 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	May not recognize impairments
Identify problems and deficits	Can't see severity of impairments
Recognize the need for assistance	Deny need for assistance
Clearer decision making	Hinders decision making
Better engagement with appropriate supports	May resist appropriate supports or have 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

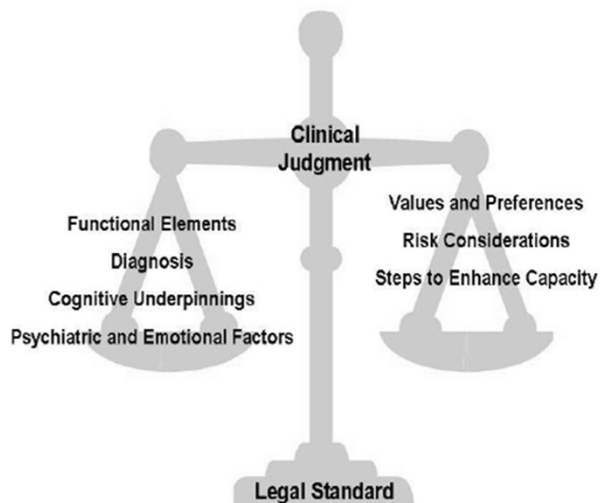
- Høyer (cited by Allen): “[T]hose agreeing with their treating psychiatrist have insight, those who disagree have not.”
- Allen: “Is this really what insight boils down to? Agreeing with your doctor because s/he knows best?... The term, insight, does not appear in any mental health or capacity legislation...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

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.

Legal standards

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



From the ABA/APA Handbook for Psychologists

Various types of capacity

Legally defined:

- capacity to consent to medical care
- capacity to execute/sign DPOA document
- capacity to execute/sign a health care advance directive
- capacity to consent to sexual relations
- testamentary capacity – to make a will
- contractual capacity – execute/sign contracts
- donative capacity – to make a gift
- financial capacity

Others

- capacity for independent living
- capacity to drive
- capacity to return to work
- capacity to serve as healthcare or legal agent for others

Capacity for types of medical decision making

- Consent for treatment
 - Refusal of treatment
- Clinical ethics work on DMC: thresholds may differ for consent vs refusal*
- Across states' legal standards, core element is the ability to understand the nature and purpose of the proposed treatment or procedure, its potential benefits and risks, and the benefits and risks of the alternative approaches.

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 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)

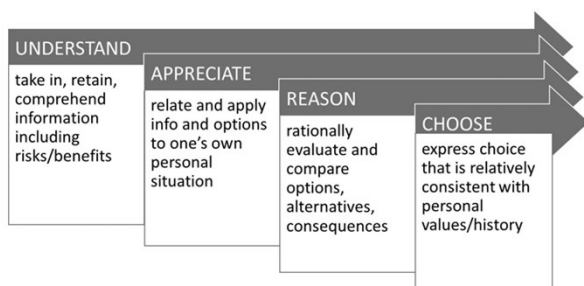
Risk factors for impaired medical DMC

- 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

(from Barstow)

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)

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

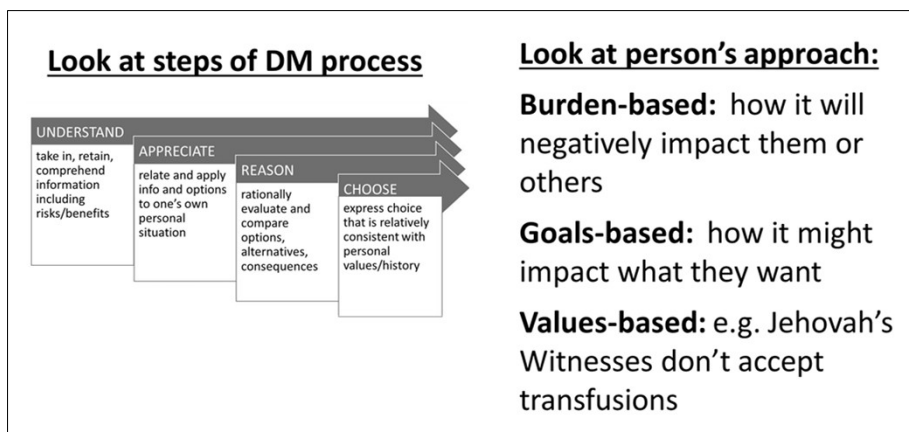
Questions to determine the patient's ability to communicate and express a choice clearly

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?

Similar process to look at other decisions

- View DM in context of type of decision, statutory/legal definitions



About power of attorney documents

- Document specifying “powers” or areas of authority granted to another:
 - Finance
 - Health care
 - May be combined in one document
- Agent or “attorney in fact” – the person named in the document to have authority under the powers specified in the document.
- “POA” – typically only in effect while person has capacity.
- “DPOA” – Durable, remains in effect if/after person loses capacity.
- “Execute” – signing actual document under process required.

Capacity to execute (financial) POA

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

Guidance from Australia

Australia's Office of the Public Advocate (2003) suggested DPOA standards that the person:

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 to execute health care POA

- Differs from capacity for medical decisions.
 - Not well defined in most states – they have statutes on HC advance directives and POAs, but capacity not addressed.
 - Utah: important distinction, that one 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.

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.

Capacity to execute (HC) advance directive

- Most states have advance directive statutes and case law, but
- Unfortunately, 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 guardians and healthcare proxies 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

- 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)

Consent to sexual relations

- Not universally defined, different language in various states.
- Most widely accepted criteria (consistent with those applied to consent to treatment), are:
 - *Knowledge* of relevant information, including risks and benefits;
 - *Understanding* or rational reasoning that reveals a decision that is consistent with the individual's values; and
 - *Voluntariness*, a stated choice without coercion.
- Need to consider factors of “possible coercion, unfair persuasion, or inappropriate inducements.” (*ABA/APA Handbook for Psychologists*)

Peter Lichtenberg's framework

- 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, Gerontologist, 30, 117-120

Testamentary capacity – signing a will

Most states define under probate laws.

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 these elements to one another and say how they want their estate to be handled.

Capacity at time of signing is most important

- Can lack capacity before or after, and have a “lucid moment” and be ok to sign.
- If have capacity but affected by an “insane delusion” at the time of signing, then 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, in a reasonable manner, 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 (counting money, balancing checkbook, paying bills),
 - Judgment skills for financial self-interest,
 - Values that guide personal choices.
- "Highly cognitively mediated"
- Financial knowledge and skills vary widely for cognitively normal people, and are associated with education and socioeconomic factors.

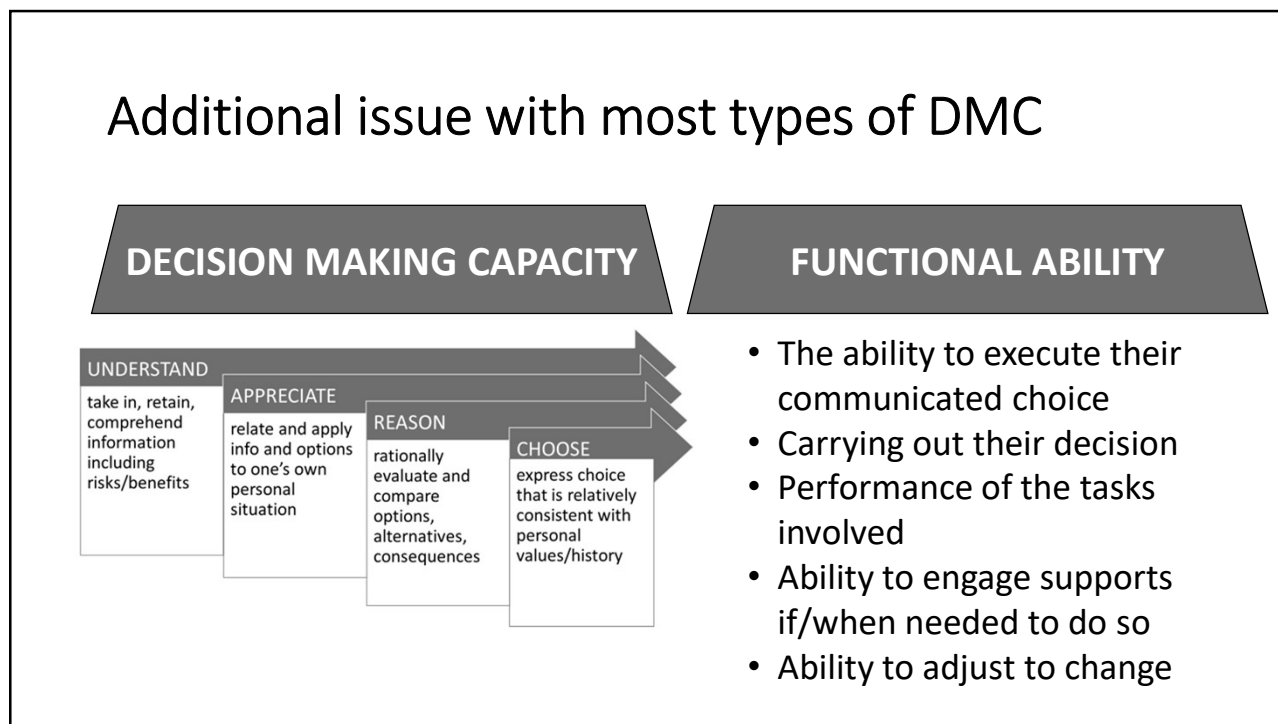
Conservatorship vs financial capacity

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.

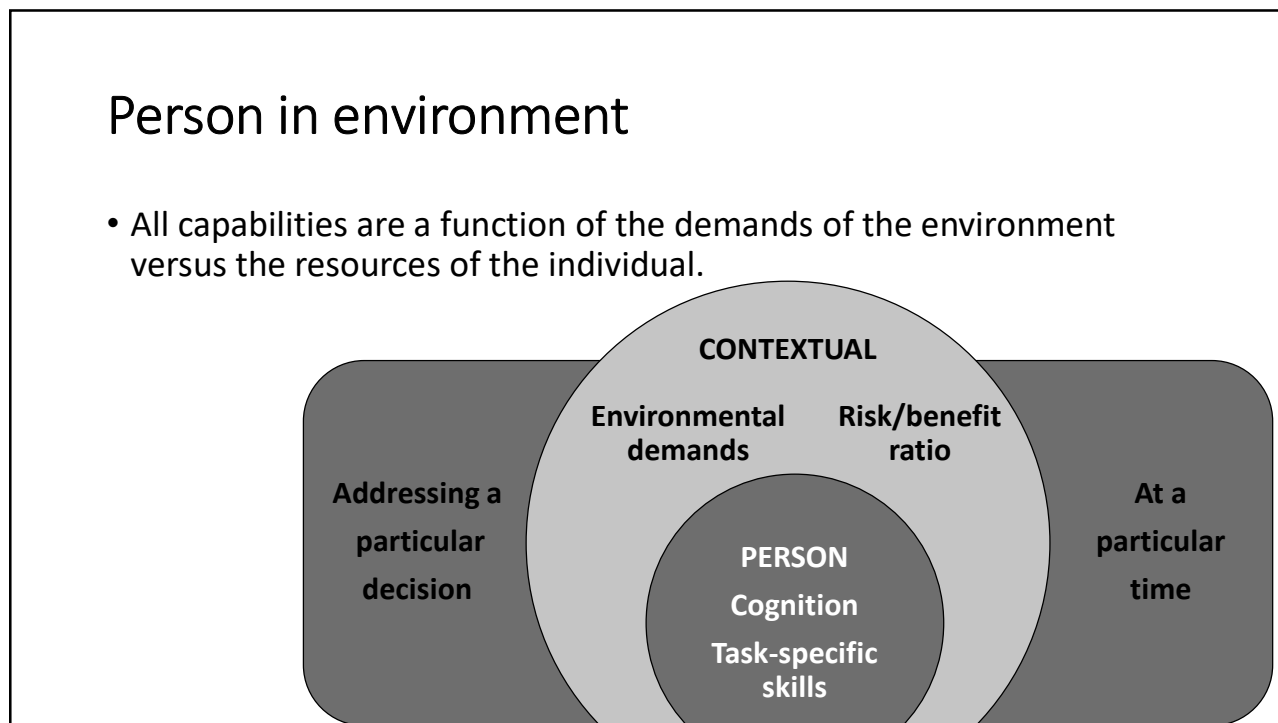
(from ABA/APA Handbooks)

Additional issue with most types of DMC



Person in environment

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



Others – not legally defined in statutes

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

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

Generally 4 factors involved in these capacity questions:

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

Others

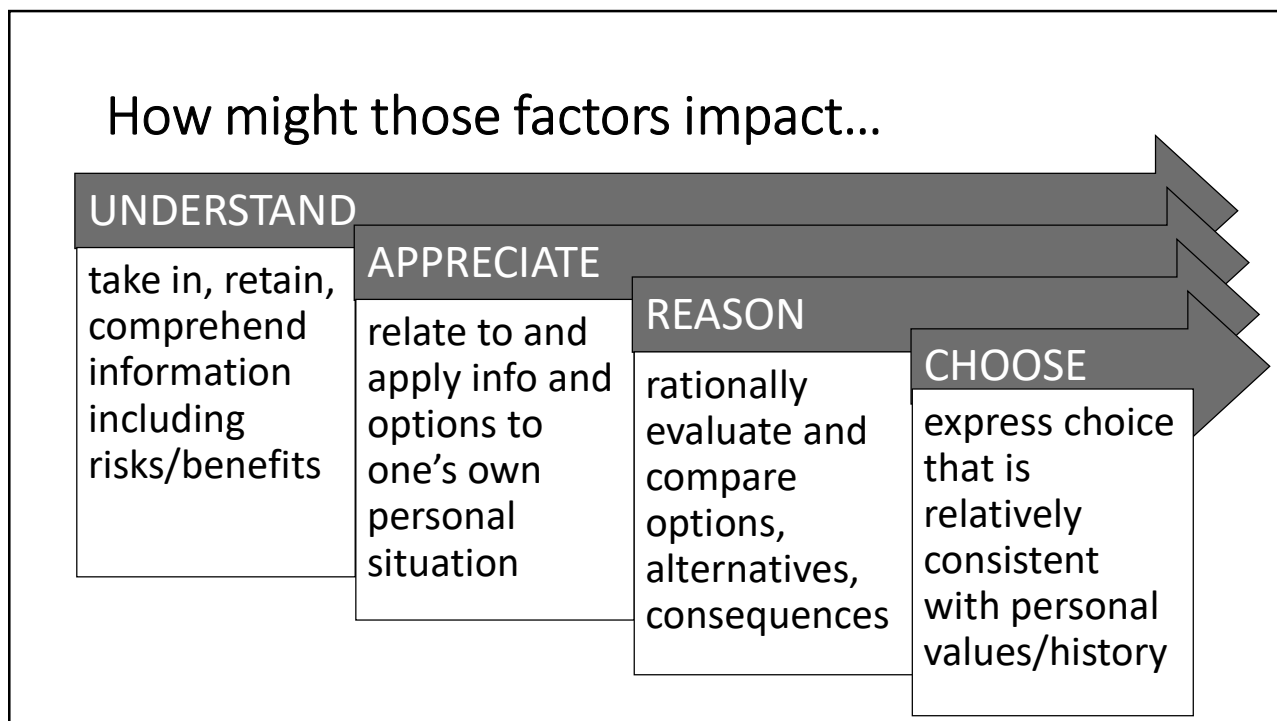
- Ability to serve as agent/POA for others – not legally defined.
 - Agent must be “fit” to carry out role.
 - Being an agent for someone else requires abilities at or above those needed to manage the tasks for one’s self.
 - Have to act in person’s best interests on top of the tasks of the role.
- Other legal acts have specific definitions of capacity based on statutes and court decisions in different jurisdictions, e.g. capacity to marry, to engage in mediation, to testify, to sue and be sued, or to vote.

Case studies in breakout rooms

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 | • Pain |
| • Medications and their side effects | • Fatigue |
| • Mental health symptoms | • Stress |
| | • Environment |
| | • Times of day |



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.

choice to undergo experimental chemotherapy = high risk, requires higher degree of decisional ability.

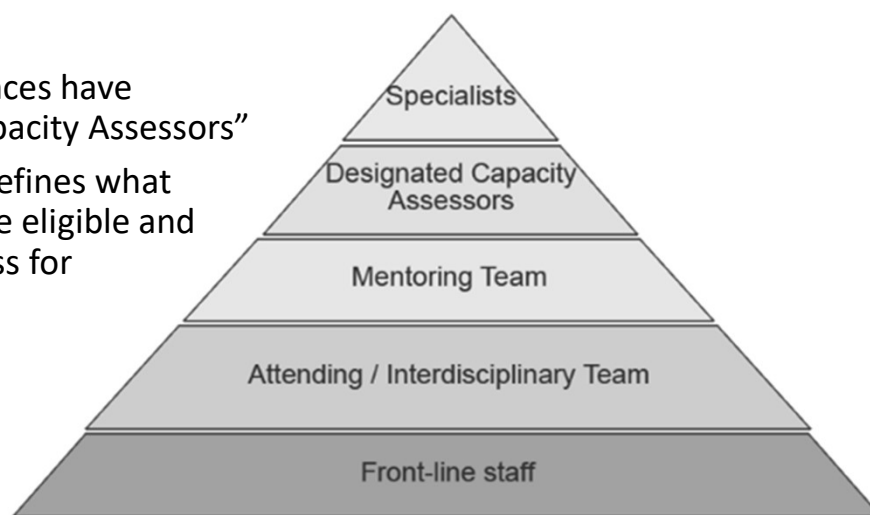
choice to take a vitamin = low risk, requires lower degree of decisional ability.

Who decides?

- Among states – different statutes and guardianship processes have different requirements.
- A growing number of states provide for a comprehensive, interdisciplinary team approach—such as an evaluation by a physician, psychologist, and social worker or mental health clinician.
- UGCOPAA calls for examination by “a physician, psychologist, or other individual appointed by the court who is qualified to evaluate the respondent’s alleged impairment.”

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)

Legal/clinical landscape changes

LAWS – in WA	CLINICAL IMPACT ON PROCESSES	APS / COURTS
<ul style="list-style-type: none"> • Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act, RCW 11.130, effective Jan 2022 • Changes to protection order laws under RCW 7.105, effective July 2022 	<ul style="list-style-type: none"> • Prior – doctors were more willing to sign forms, e.g. saying someone needed guardianship • Now – more liability, less time with patients, fewer specialists 	<ul style="list-style-type: none"> • Difficulty finding guardians, specialists to evaluate • Need to demonstrate lack of capacity to justify action

Increasing need

- The demand for capacity assessment among older adults is only increasing as this population continues to grow.
- The majority of medical health providers judge their training in assessing capacity as “insufficient” (Seyfried, et al., 2013).
- There is low consistency in how professionals evaluate decision-making capacity.

It’s an issue of JUSTICE when people don’t have access (or equal access) to competent professional services.

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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*

Throughout the country, access to professional capacity assessments is inconsistent. Capacity assessments are often a critical factor in case management of elder abuse investigations. This unmet need for many Adult Protective Services (APS) programs hampers their ability to protect older adults from mistreatment and preserve self-determination when appropriate. In June 2019, electronic surveys regarding access to capacity assessments were sent to APS leadership in all 58 California counties. A similar survey is planned for each US state in June 2020. In California, with 100% response rate, 53% of counties had no access to assessments and 56.1% had no funding for assessments. Most assessments were completed by physicians or psychologists. Seventy-three percent of counties reported that primary care physicians complete requests for capacity declarations less than half the time. Physicians decline to complete capacity declarations because they don’t know how to do the assessments (22.4%) and are concerned about being called into court (28.5%). Findings from the national survey will be presented along with maps illustrating capacity assessment accessibility. Factors that appear to influence accessibility positively (forensic centers) and negatively (lack of funding and lack of trained evaluators) will be discussed along with policy implications.

Keys to doing this work

- Scope of practice, competence
- Ethical, legal, judicial issues

Is assessing DMC within your scope?

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

- 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

Remember your Ethical ABC's (adapted from Moberg & Kniele, 2006)

- **A**ttain professional competence.
 - Know your scope of practice as well as your scope of **competence**.
 - Be aware of what you don't know.
 - Have the adequate knowledge/training for your work.
- **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.

Evaluating your own clients?

- A provider or therapist may be asked to conduct a capacity assessment of their patient/client explicitly because they "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
 - Risk to the therapeutic relationship

Legal and judicial issues

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

Doesn't Medicare cover DMC assessment?

- The Medicare Annual Wellness Visit is supposed to include cognitive assessment.
- Medicare pays approximately \$268 for primary care providers (MD and DO physicians, nurse practitioners, clinical nurse specialists, physician assistants) to do a cognitive assessment of patients that present with cognitive impairment.
- These appointments are supposed to take 60 minutes, to include IADL/BADL, decision making capacity, Functional Assessment Staging Test, Clinical Dementia Rating, medication review, safety for home/driving, and advance care planning.
- See <https://www.cms.gov/medicare/payment/fee-schedules/physician/cognitive-assessment>

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)*

What should (hopefully) happen before DMCA

- Problem solving:
 - Involve patients and families
 - Seek perspectives from other team members
 - Consider formal resources
 - Mobilize informal resources
- Medical assessment to ensure issues are identified, addressed – particularly any affecting cognition.
- Less restrictive alternatives, supported decision making, etc.

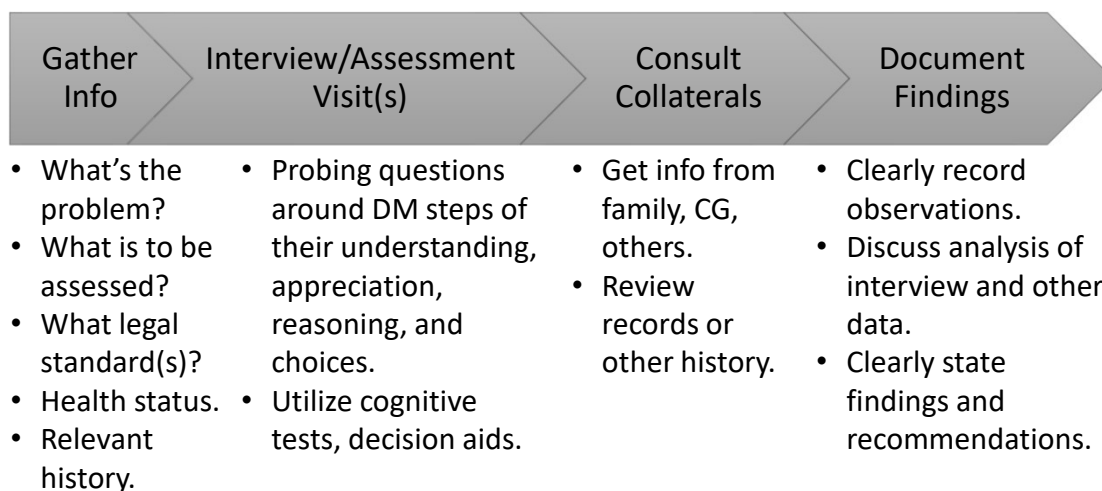
Issue(s) may be resolved without needing a formal capacity assessment

Why proceed to capacity assessment?

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

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

Process of assessment



“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.

You’re 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)

What 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.
- Also ask what is the legal standard for the evidence:
 - Beyond a reasonable doubt – highest and most demanding
 - 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”
- You don’t have to make the legal argument that a lawyer would, but it will help you see what to pay attention to during the visit.

Ask ahead about documentation

- What kind of report or documentation is needed, expected?
- 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.

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

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

Example (ABA/APA Handbook for Lawyers)

Common Elements of a Clinical Evaluation Report	
Element	Summary
1. Demographic Information	Age, race, gender, education, etc.
2. Legal Background and Referral	Legal issue at hand, referral question
3. History of Present Illness	Medical history, current symptoms, etc.
4. Psychosocial History	Occupation, current living situation, family history of psychiatric and medical illness, etc.
5. Informed Consent	Statement of client's consent to the evaluation
6. Behavioral Observations	Appearance, speech, mood, etc.
7. Tests Administered	List of tests given
8. Validity Statement	Opinion of extent to which test results are valid
9. Summary of Testing Results	Test scores, standard scores, performance ranges as compared to age-matched normative data
10. Impression	Diagnosis; Clinical interpretation of test results; Clinical interpretation of psycho-legal capacities
11. Recommendations	If appropriate, statements of recommended clinical action (e.g., treatment to help symptoms)

Example (*ABA/APA Handbook for Psychologists*)

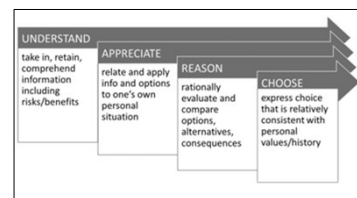
A Framework for Capacity Assessment

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

- Remember, your audience likely knows less about capacity assessment than you do.
- Define clinical terms and explain clinical concepts in plain language.
- Explain diagnostic criteria and its significance, e.g. dementia.

Walk them through your reasoning

- Describe your visit – direct quotes from the client can be very helpful.
- Explain significance of bio-psycho-social/functional issues and cognitive testing scores.
- Describe the tasks of the DM process and how data from the assessment fits in.
- Align functioning/evidence to the requirements of DMC and how this compares with risk analysis.
- Explain how these elements lead to your findings, recommendations.



Where different interpretations or arguments could be made, it's helpful to call that out and explain why you decided against that.

Prepare to testify

- You likely will never have to testify about your report, BUT...
- If you do, you'll be testifying (largely) to your report.
- If you remember something to say in court that's not in your report, that will be called into question – why didn't you document that at the time of your visit/report?
- Your assessment report or documentation has to put together the path of your reasoning that led to your findings.
- You'll be asked not only about the data in your report, but how you analyzed it and came to the conclusions you did.

Wrap up

- Resources provided
- CEUs
- How did today feel, in terms of timing / breaks?

Our next classes

April 2	Cognition and mental health in capacity
May 7	Cognitive testing and other assessment tools
June 4	Case studies and discussion, next steps

Coming up – mark your calendars

Capacity Consultation Group	Older Adult Mental Health Consult Group
<p>Hosted by Dr Adria Navarro of USC 12noon to 1pm on zoom on the 4th Thursdays March 27, April 24, May 22, June 26, July 24, Aug 28, Sept 25, and Oct 23 (Nov/Dec TBD)</p> <p>(to sign up, email Adria.Navarro@med.usc.edu)</p>	<p>Sponsored by GRAT/ACCS 12noon to 1:30pm on zoom on selected Tuesdays Feb 18, Apr 15, Jun 17, Aug 19, and Oct 21</p> <p>Register at https://us02web.zoom.us/meeting/register/tZYuduChrzMtHdwZFNfXLh8vnk_CDP_b6Nq6J#/registration</p>

There's more...

March 27:	Pierce County Guardianship Summit (in University Place, WA) https://www.piercecountywa.gov/8688/Guardianship-Summit
June 15:	World Elder Abuse Awareness Day https://www.napsa-now.org/world-elder-abuse-awareness-day/
Sept 8-10:	National Adult Protective Services Assn conference (in Bellevue) https://www.napsa-now.org/annual-conference/
Sept 11:	NAPSA Financial Exploitation Summit (in Bellevue) https://www.napsa-now.org/calendar/financial-exploitation-summit-2/

And FYI

- **Tomorrow March 6:** National "Slam the Scam" day is on March 6, as part of National Consumer Protection Week. The Social Security Administration's website offers [printable resources and social media toolkits](#) to raise awareness.
- **By March 15:** The Agency for Healthcare Research and Quality (AHRQ) is [seeking comment](#) on ageism and its effect on healthcare quality. Responses will be used to identify solutions to address ageism and improve older Americans' health. Comments are due by March, 15, 2025.
- March is the annual celebration of the Senior Nutrition Program. ACL offers [materials](#) to commemorate this anniversary, and is hosting a virtual celebration event on March 19 at 2:00 PM ET. Register for the event [here](#).