

ASSESSING ADULT PROTECTIVE SERVICES CLIENTS' DECISION-MAKING CAPACITY

TRAINER'S MANUAL



MODULE 17

This training is a product of National Center on Elder Abuse (NCEA), which is funded, in part, by the U.S. Administration on Aging under Grant # 90-AM-2792. The project was developed by the National Adult Protective Services Association (NAPSA), and its contractor, the REFT Institute, Inc.

The National Center on Elder Abuse (NCEA) provides elder abuse information to professionals and the public; offers technical assistance and training to elder abuse agencies and related professionals; identifies promising practices; conducts short-term elder abuse research; and assists with elder abuse program and policy development. NCEA's website and clearinghouse contain many resources and publications to help achieve these goals.

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ASSESSING CAPACITY – TRAINER’S MANUAL

The National Center on Elder Abuse The Source for Information and Assistance on Elder Abuse

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HOW TO USE THIS TRAINING MANUAL

The course outline, provided in the next section of this manual, is the class schedule used during the piloting of this training. It can be used to help you determine how much time you might need to present each section. However, times will vary based on the experience and engagement of your audience.

Customizing the PowerPoint:

Once you decided on how you want to divide up your time in presenting this material, you may want to customize your PowerPoint. The Microsoft Office PowerPoint software allows you to hide any slides you don't want to use.

Hide a slide instructions

1. On the **Slides** tab in normal [view](#), select the slide you want to hide.
2. On the **Slide Show** menu, click **Hide Slide**.

The hidden slide icon appears with the slide number inside, next to the slide you have hidden.

Note: The slide remains in your file, even though it is hidden when you run the presentation.

Please note that this manual is set up so that the trainer script/ background material is on the same page as the accompanying PowerPoint slide making it easy to also customize your manual to match the slides you have decided to use, Just remove the unneeded pages.

You may also decide to add slides showing specific program information, policies or procedures for your agency or jurisdiction. This will increase the applicability of the training but care must be taken not to try and pack too much additional content into the training.

NOTE: If you wish, you can individualize the PowerPoint slides by adding information in the “notes” section of each slide

COURSE OUTLINE

Content	Total Time	Activities	Slides/handouts
Welcome and Introductions	20 min.	Lecture/introduction	Slides 1- 5 <i>Optional:</i> Handout #1 Appendix: APS Core Competencies
Overview & Key terms of capacity assessment	25 min.	Lecture Discussion	Slides 6-14
Factors affecting capacity	45 min.	Lecture Large group activity	Slide 15-24 Handout #2-6
BREAK	15 min.		
Case Study Activity #1	30 min.	Small group activity	Slides 25 Handouts: Case studies 1-5
Capacity Assessment Domains & Tools (lunch break)	75 min. + 60 min lunch	Lecture Discussion	Slide 26-41 Handouts: #7-12
Capacity Screening Skills	30 min.	Lecture Discussion	Slides 42-44 Handout #13
Case Study Activity #2	30 min.	Small group activity	Slide 45 Handouts: Case studies 1-5
BREAK	15 min.		
Cross cultural interviewing & Assisted Capacity	15 min.	Lecture Discussion	Slides 47-53 Handout #14
Case Study Activity #3	45 min.	Small group activity Large group discussions	Slide 54 Handouts: Case studies 1-5
Closing	15 min.	Q & A, <i>Optional:</i> Post-test, answers, and evaluation	Slide 55 <i>Optional:</i> Handouts #15-17
TOTAL TIME	7 hrs.		

TRAINING GOAL AND OBJECTIVES



Goal: The purpose of this workshop is to assist Adult Protective Services professionals in identifying the factors that affect their clients’ decisional capacity, and to identify when to seek a professional evaluation.

Objectives: Upon completion of this training session, participants will be better able to:

1. Define autonomy, capacity, and incapacity.
2. Describe factors that may influence client capacity.
3. Describe signs and symptoms that indicate capacity issues.
4. Identify key questions and approaches used to screen client capacity, including working with special populations.
5. Identify implications for case planning as a result of a finding of limited capacity.

TRAINER GUIDELINES

Teaching Strategies

The following instructional strategies are used:

- ◆ Lecture segments
- ◆ Interactive exercises (e.g., case study, large and small group discussions)
- ◆ Question/answer periods
- ◆ Power Point Slides (slides with an * have notes on them in the appendices)
- ◆ Participant guide (encourages interaction with the content information), including resources
- ◆ Pre-/post-tests to assess learning (optional)
- ◆ Evaluation to assess training process (optional)

Materials and Equipment

The following materials are provided and/or recommended:

- ◆ Computer with LCD (digital) projector
- ◆ CD-ROM containing slide presentation for module
- ◆ Easel/paper or post-it sheets/markers/masking tape
- ◆ *Trainer Guide*: This guide includes the course overview, introductory and instructional activities, and an appendix containing reference materials.
- ◆ *Participant Guide*: This guide includes a table of contents, course introduction and all training activities.
- ◆ Nametags/name tents

ASSESSING CAPACITY – TRAINER’S MANUAL

COURSE OUTLINE

9:00am	Welcome and Introductions
9:20	Overview & Key Terms
9:45	Factors Affecting Capacity
10:30	Break
10:45	Case Study Activity #1
11:15	Capacity Assessment: Domains & Tools
12:00pm	Lunch
1:00	Capacity Assessment: Domains & Tools
1:30	Capacity Screening Skills
2:00	Case Study Activity #2
2:30	Break
2:45	Cross-Cultural Interviewing
3:00	Case Study Activity #3
3:45	Closing/Evaluations
4:00	End of Training

INTRODUCTION TO TRAINING MANUAL

Trainer Instructions - The following guidelines will assist you in preparing for a successful training:

1. Limit class size to 30 persons
2. Set up the classroom into "pods" (e.g. table groups) of 5-6 participants
3. Prepare flip charts
4. Review Case Study Activities 1-3

PRESENTATION



WELCOME AND INTRODUCTIONS



TIME ALLOTTED: 20 minutes

Slide 1:



Adult Protective Services
Core Competencies
MODULE # 17

ASSESSING ADULT PROTECTIVE
SERVICES CLIENTS' DECISION
MAKING CAPACITY

Developed by the National Center on Elder Abuse
and National Adult Protective Services Association

NAPSA NATIONAL ADULT PROTECTIVE
SERVICES ASSOCIATION

NCEA
National Center on Elder Abuse
Administration on Aging

Version 2 - Revised July 2015

- ◆ **Welcome** to Assessing Adult Protective Services Clients' Decision-Making Capacity.
- ◆ Introduce yourself by name, job title, organization and qualifications as Trainer.
- ◆ **REVIEW GUIDELINES:**
 - There will be two 15-minute breaks and an hour for lunch today: ...
 - Use the restrooms whenever you need to do so. The restrooms are located at....
 - **Please turn off your cell phones for the duration of the training.** If you must make or receive a call, please leave the training room and return as quickly as possible. Check the course outline to see what you have missed.

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL

◆ PARTICIPANT INTRODUCTIONS:

Ask participants to:

- make a brief self-introduction including name, job title, organization
- respond, in 1 or 2 sentences, to the following question:



What are your challenges when trying to determine capacity or to decide when it is time to call in the experts?

NOTE: Record answers onto a flip chart, so you can refer to them as the day goes on. This will provide information on the participants’ expectations. It will also get them involved from the beginning, validate their issues, and help to guide the Trainer’s focus.

OPTIONAL: REMIND Participants **OPTIONAL HANDOUT #1: Pre-test**

- Prior to this event, you were sent written confirmation of your registration for the training, along with a pre-test. You were asked to complete the pre-test before coming to the training.
- At the end of today’s training, please complete the post-test.
- The assigned numbers on the tests are used to compare your knowledge before attending the training and after you have completed it.
- The tests are used only to measure the effectiveness of the training.

TRAINER NOTE: Both the Pre and Post Tests and answer key can be found in the Appendix Guide.

Adult learners often want a measure of how much they have learned from a workshop. Pre and post-tests are useful tools for them to assess their own learning. Workshop sponsors and Trainers also find this tool useful to assess their impacts. As the Trainer, it is your choice whether and how to use the pre and post-tests. Modify the directions you give participants based on your decision.

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT #1 (Optional) Pre-test

Test # _____

1. What is the difference between an APS assessment of capacity and a professional capacity evaluation?
2. True or False (circle one) “Incapacity” is a medical term used to describe a person’s inability to make decisions.
3. Autonomy involves all of the following except one (please circle the incorrect option):
 - a) The person’s rights
 - b) The person’s choices
 - c) The person’s responsibilities
 - d) The person’s capacity
4. Once a person is judged incapacitated, he or she may lose the right to: (Circle the correct answer[s].)
 - a) Make decisions regarding medical care
 - b) Have a guardian appointed by the court
 - c) Have a conservator appointed by the court
 - d) Enter into contract agreements
 - e) Chose his/her place of residence
5. List 4 factors that may influence the decision-making capacity of an adult.
 - a)
 - b)
 - c)
 - d)
6. What are the four (4) components used when assessing a person’s capacity?
 - a)
 - b)
 - c)
 - e)
7. List a strength and a limitation of a standardized capacity assessment tool, such as the Folstein Mini-mental Status Examination.
8. List 3 questions that could be asked of the client when assessing his or her capacity.
 - a)
 - b)
 - c)
9. On the back of this page, list two special accommodations that are necessary when assessing the capacity of: 1) a person with a disability (such as a hearing impairment), or 2) who speaks no English, or 3) who is non-verbal.

ASSESSING CAPACITY – TRAINER’S MANUAL

Slides 2 & 3


This training is a product of the National Center on Elder Abuse (NCEA), which is funded in part by the U.S. Administration on Aging under Grant # 90-AM-2792. The project was developed by the National Adult Protective Services Association (NAPSA), and its contractor, the REFT Institute, Inc.

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NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

- NAPSA is the only national organization which represents APS professionals, programs and clients
- NAPSA is the National Voice of APS
- NAPSA is a partner in the National Center on Elder Abuse
- NAPSA has members in all 50 states
- <http://www.napsa-now.org/>



NAPSA
National Adult Protective Services Association

TOPIC: Funders & NAPSA

- ◆ The National Center on Elder Abuse (NCEA) underwrote this module. NCEA is a Center for information and assistance on elder abuse.
- ◆ This training was developed by NAPSA with the REFT Institute. **Joanne Otto** was the project director.
- ◆ National Adult Protective Services Association:
 - NAPSA is the only national organization which represents APS professionals, programs and clients
 - NAPSA is the National Voice of APS
 - NAPSA is a partner in the National Center on Elder Abuse
 - NAPSA has members in all 50 states
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ASSESSING CAPACITY – TRAINER’S MANUAL

Slide 4

APS CORE COMPETENCIES

- 23 NAPSA Core Competencies were identified and developed into trainings for APS staff.
- This module is #17: *Assessing APS Clients’ Decision-Making Capacity.*

For more information about APS Core Trainings, visit <http://www.napsa-now.org/resource-center/training/core-aps-competencies/>

**NAPSA Core
Competency List in
participant manual
on page 90**

TOPIC: NAPSA APS Core Competencies

- ◆ This training is part of 23 practice-based modules that comprises a full set of core competencies for Adult Protective Services (APS) caseworkers.
- ◆ These NAPSA core competencies were identified by APS practitioners in a series of national meetings and work sessions held from 2003 to 2005.
- ◆ The 23 core training modules were developed by the National APS Training Partnership led by NAPSA and MASTER/Academy for Professional Excellence.
- ◆ The trainings cover the basic information that all APS caseworkers need to know in order to intervene in the lives of the elderly and persons with disabilities, who are victims of abuse, exploitation or neglect.
- ◆ Module 17 is general enough to be useful to anyone who is conducting basic APS training.
- ◆ More information about NAPSA Core Competency trainings can be found at <http://www.napsa-now.org/resource-center/training/core-aps-competencies/>

SLIDE 5

The slide is titled "TRAINING GOAL" in a light blue font at the top. Below the title is a dashed horizontal line with a small circle in the center. The main body of the slide is a light blue rectangle containing the text: "To assist Adult Protective Services professionals in identifying the factors that affect clients' decisional capacity and to know when and how to seek a professional evaluation." In the bottom right corner of the slide, there is a small, faint text that reads "Slide 4".

TOPIC: Training Goal

- ◆ The goal of this training is to assist Adult Protective Services professionals in identifying the factors that affect clients' decisional capacity, and in knowing when and how to seek a professional evaluation.
- ◆ Trying to decide if clients have the ability to make informed decisions about their situations and care is one of the greatest challenges faced by APS workers.
- ◆ APS caseworkers are able to assess clients' situations and how they are functioning. They do this very well.
- ◆ Only those licensed clinical social workers who have received specialized training, have gained special experience or both, have the credentials to conduct **professional** capacity evaluations.
- ◆ Others who may be qualified are psychologists, geriatricians, or psychiatrists.

The goal of this training is NOT to enable APS caseworkers to conduct professional capacity evaluations.

SLIDE 6

LEARNING OBJECTIVES

- Define autonomy, capacity, and incapacity.
- Describe factors that may influence client capacity.
- Describe signs and symptoms that indicate capacity issues.
- Identify key questions and approaches used to screen client capacity, including working with special populations.
- Identify implications for case planning as a result of a finding of limited capacity.

TOPIC: Learning objectives.

The learning objectives which will be covered in this training module:

1. Define autonomy, capacity, and incapacity.
2. Describe factors that may influence client capacity.
3. Describe signs and symptoms that indicate capacity issues.
4. Identify key questions and approaches used to screen client capacity, including working with special populations.
5. Identify implications for case planning as a result of a finding of limited capacity.

OVERVIEW & KEY TERMS OF CAPACITY ASSESSMENT




TIME ALLOTTED: 25 minutes

SLIDE 7

WHAT IS AUTONOMY?

- ▶ Autonomy is the highest principle in legal, psychological and medical issues.
- ▶ “Autonomy” means the right to make one’s own decisions.

Source: Kemp 2005



TOPIC: What is autonomy?

- ◆ “Autonomy” means the right to make one’s own decisions (Kemp 2005).
- ◆ Understanding the concept of autonomy is essential for APS caseworkers, since one of your primary responsibilities is to honor and protect your clients’ autonomy whenever possible.
- ◆ Knowing how a client demonstrates the ability to make informed decisions is information you must have in order to understand if there are problems in this area.

TRAINER NOTE: Kemp, Bryan, Ph.D. has worked in geriatrics, geriatric mental health and rehabilitation for over 30 years, evaluating clients who are alleged victims of elder abuse and lecturing on evaluation of client capacity, causes of vulnerability and financial abuse.

SLIDE 8

WHAT IS DECISIONAL CAPACITY?

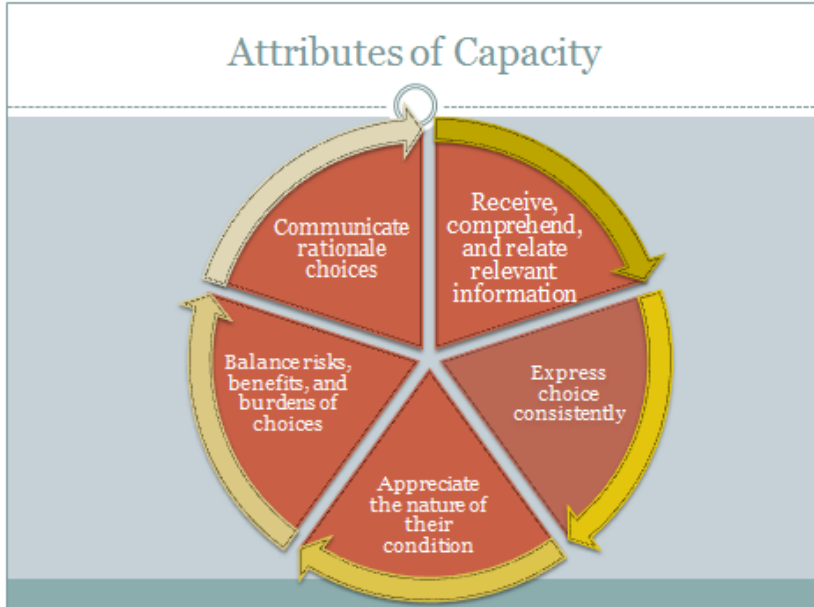
Decisional capacity is the ability to adequately process information in order to make a decision based on that information.

Source: Kemp 2005

TOPIC: What is decisional capacity?

- ◆ Decisional capacity is a complex concept.
 - Decisional capacity is the ability to adequately process information in order to make a decision based on that information (Kemp 2005).
- ◆ The definition used here has been chosen because it is simple, comprehensive and easy to remember.
- ◆ Types of decisions – include medical/personal care; sexual/relationship; contractual; testamentary (e.g. creating a will); and research participation

SLIDE 9



TOPIC: The attributes of capacity

- Communicate rationale choices
- Receive, comprehend, and relate relevant information
- Express choice consistently
- Appreciate the nature of their condition
- Balance risks, benefits, and burdens of choices

SLIDE 10

CAPACITY MAY VARY...

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



Source: Kemp 2005

TOPIC: Capacity may vary...

- ◆ A person’s decision-making abilities may vary for a number of reasons.
 - As a result of physical or mental stress.
 - According to the complexity of the decision.
 - From day to day.
 - From morning to evening
- ◆ These reasons must be considered in assessing how a person is functioning.

SLIDE 11

CAPACITY EVALUATION

A complete capacity evaluation usually includes:

- A physical examination
- A neurological examination
- Short and long term memory assessment
- Assessment of executive function
- Exam for existing psychological disorders
- Diagnosis of any existing addictive syndromes.

Source: Oklahoma APS 2005

TOPIC: Capacity Evaluation

◆ To fully evaluate capacity, all of the following should be included:

- A physical examination,
- A neurological examination,
- Short and long term memory assessment,
- Assessment of executive function

Executive function describes a 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.

◆ However, all of these components may not be available to clients in your area. Resources are limited. It is very important that your client have the most comprehensive evaluation possible.

◆ Later we will identify which professionals are qualified to conduct capacity evaluations.

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL

TRAINER NOTE: The Oklahoma Adult Protective Services, Aging Division, compiled the resources in the New Worker Academy 2005 from materials given to new APS workers. It addresses investigatory practices, risk and capacity assessment and interviewing techniques.

The following complete definition of executive function comes from the Encyclopedia of Mental Disorders <http://www.minddisorders.com/Del-Fi/Executive-function.html>

The term executive function describes a set of cognitive abilities that control and regulate other abilities and behaviors. Executive functions are necessary for goal- directed behavior. They include the ability to initiate and stop actions, to monitor and change behavior as needed, and to plan future behavior when faced with novel tasks and situations. Executive functions allow us to anticipate outcomes and adapt to changing situations. The ability to form concepts and think abstractly are often considered components of executive function.

SLIDE 12

WHAT IS INCAPACITY?

- ▶ The inability to receive and evaluate information
- ▶ Or to make or communicate decisions so that an individual is unable to meet essential requirements for:
 - ▶ physical health
 - ▶ safety
 - ▶ or self-care
- ▶ Even with appropriate technological assistance.

Source: American Bar Association 1997, 1998

TOPIC: What is incapacity?

Incapacity is related to decisional capacity. It is:

- ◆ The inability to receive and evaluate information
- ◆ Or to make or communicate decisions to such an extent that an individual is unable to meet essential requirements for :
 - physical health,
 - safety,
 - or self-care,
- ◆ even with the appropriate technological assistance.

TRAINER NOTE: The American Bar Association’s National Conference of Commissioners on Uniform State Laws passed the Uniform Guardianship and Protective Proceedings Act in July 1997. It was approved and recommended for enactment in all states that year. In June 1998, a Prefatory Note and Comments were added. This definition of incapacity resulted from that process.

SLIDE 13

INCAPACITY

○

- ▶ Legal incapacity is a judgment about one’s legal rights and responsibilities.
 - ▶ May be partial or complete.
 - ▶ Must be supported by evidence over time.
 - ▶ Must result in substantial harm.

- ▶ Clinical incapacity is a judgment about one’s functional abilities.

Source: Quinn, 2005

TOPIC: Incapacity

There are two basic types of incapacity judgments:

- ◆ Legal incapacity is a judgment about one’s legal rights and responsibilities.
- ◆ Clinical incapacity is a judgment about one’s functional abilities.

TRAINER NOTE: Quinn, Mary Jo 2005. 114-116 and 275-277.
Mary Joy Quinn has been the Director of the Probate Court of San Francisco Superior Court since 1989. She has a nursing degree and MA in psychology. Ms. Quinn co-authored *Elder Abuse and Neglect: Causes, Diagnosis and Intervention Strategies* with Susan Tomita, the *Handbook for Conservators* and most recently *Guardianships of Adults: Achieving Justice, Autonomy, and Safety*.

SLIDE 14

JUDGMENT OF INCAPACITY

- ▶ The client may lose the right to:
 - ▶ make decisions about medical treatment and personal care
 - ▶ marry
 - ▶ enter into contracts
 - ▶ testify in court
 - ▶ participate in research
 - ▶ choose where to live



TOPIC: Implications of a judgment of incapacity

- ◆ The implications of a judgment of incapacity are life changing. Individuals may have many of their most basic rights curtailed.
- ◆ This is a very serious decision. Requesting a judgment of incapacity from a court should be the very last resort for APS workers.
- ◆ Client may lose the right to:
 - make decisions about medical treatment and personal care,
 - marry,
 - enter into contracts,
 - testify in courts,
 - participate in research,
 - choose where to live.

Think about some of your clients who received a judgment of incapacity.



ASK: What were the results for them?

SLIDE 15

ASSESSING INCAPACITY

- Age, eccentricity, poverty or medical diagnosis **alone** do not justify a finding of incapacity
- Can be influenced by **medical conditions** such as:
 - medication and medication interactions, sensory deficits, substance abuse, mental illness
- Can be influenced by **situational factors** such as:
 - substance abuse, depression, social setting, nutrition

Source: Quinn 2005

TOPIC: Assessing incapacity

Incapacity is not easily determined. The assessment is influenced by both the experience of the interviewer as well as the tests that are used.

- ◆ Age, eccentricity, poverty or medical diagnosis **ALONE** do not justify a finding of incapacity.

Measurement of decisional capacity happens only at a specific point in time.

- ◆ It is influenced by **medical conditions** such as:
 - medication and medication interactions
 - sensory deficits
 - substance abuse
 - mental illness
- ◆ Assessments are also influenced by **situational factors** such as:
 - substance abuse,
 - depression,
 - social setting,
 - nutrition

Physicians, lawyers, social workers and judges all struggle with the concept. There is no gold standard for determining incapacity.

FACTORS AFFECTING CAPACITY



TIME ALLOTTED: 45 minutes

SLIDE 16

Medical Conditions

These medical conditions can impact cognition:

- Dehydration
- Congestive heart failure
- Chronic lung disease
- Urinary tract infection
- Diabetes
- Mini-stroke



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

HANDOUT #2:
Factors affecting decisional impairment in participant manual pg 18

TOPIC: Medical Conditions

- ◆ There are many factors that affect a person’s decision-making capacity including medical conditions, some which are listed on the slide.
- ◆ In **Handout #2**, you will find a number of physical, psychological, and situational factors which may cause a person to appear to lack capacity. When these situations are successfully addressed, there may be a dramatic improvement in the person’s ability to make informed decisions.



ASK: What other factors might affect a client’s ability to make decisions?



ASK: What are some examples of situations from your own experiences in which medical, psychological and/or situational factor diminished the client’s decision-making ability and resulted in the adult’s inability to make informed decisions?

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL

TRAINER NOTE: Joanne Otto, MSW, authored this curriculum module: Assessing APS Clients’ Decision-Making Capacity. She served as Executive Director of the National Association for the Adult Protective Services Association, as administrator of the Colorado Adult Protection/Elder Rights Program, as an editor for the journal *Victimization of the Elderly and Disabled* and as co-lead investigator of the 2005 Survey of State Adult Protective Services Agencies.

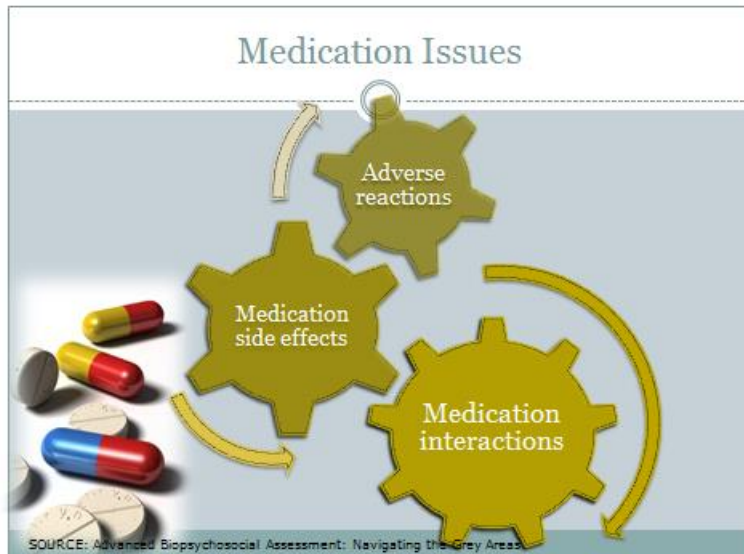
Ms. Otto drew from the following authors for the content of Handout #2.: DeGeest, Dieffenbach, Dyer, et al, Blum and Eth, Brandl, McGreevey, Polomano, and Van Cleyenbreugel

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT #2: Factors Affecting Decisional Impairment in APS Clients

Chronic Pain	May become the focus of attention and inhibit the ability to listen. A recent study found a relationship between untreated pain and increased depression among the elderly.
Dehydration	Can cause altered mental status, agitation or lethargy, lightheadedness and confusion. Speech difficulty, sunken eyes, weakness and lethargy are often attributed to other conditions. Chronic and acute-medical conditions, malnutrition and severe hot and humid weather can all cause dehydration.
Delirium	An acute, <u>reversible</u> disorder. It occurs suddenly, over a short period of time and fluctuates during the day. It may be caused by existing cognitive impairment, severe physical illness, stroke, Parkinson’s disease or dehydration, and can be aggravated by acute pain. Symptoms include changes in the way the patient uses information and makes decisions, inability to focus, and uncharacteristic behavior. The patient reports feeling “mixed up.”
Dementia	Involves a significant, persistent decline in functioning over a period of time. Depending on the type of dementia, the patient may lose memory as well as some or all of cognitive functions such as language, motor activities, ability to recognize familiar stimuli, and/or executive functioning. Accurate diagnosis requires a detailed history as well as physical and neurological examinations. Some dementias are reversible.
Depression	The patient reports feeling sadness, emptiness, detachment, loss of interest in usual activities, sleep disturbances, and/or weight loss. Speech is slowed, diminished or repetitive. Patient may show anxiety or panic. Condition persists for more than two weeks and is not related to situational loss.
Disease	Thyroid, diabetes, cancer, Parkinson’s, heart disease, stroke and AIDS may cause diminished capacity as the diseases progress.
Grief	Intense grief reaction may result in temporary confusion, dependency, exhaustion and inability to make decisions.
Hearing/Vision Loss	Can mimic or exacerbate cognitive impairment. Communication difficulties due to sensory or physical impairments are often mistaken for confusion.
Low Blood Pressure	Can be due to medication error, causing dizziness, weakness and falling which could result in head injury.
Low IQ	May affect patient’s understanding of choices, risks and benefits.
Malnutrition	Protein energy malnutrition and low levels of vitamin D lead to weakness and diminished ability to provide self-care and ultimately to decreased cognition.
Medication Mismanagement	Drug interactions and adverse reactions are common and can be serious. May be due to patient’s visual or cognitive impairment, inability to afford prescriptions, or functional illiteracy. Medication misuse frequently causes mental impairment. Antibiotics and cardiovascular drugs are the most frequent causes of adverse effects.
Physical Illness	May result in electrolyte imbalances that cause confusion and prevent rational decision making.
Psychosis	Difficult to detect. Symptoms include delusions, hallucination, and agitation.
Substance Abuse	Older adults become inebriated with lower levels of alcohol consumption—leads to malnutrition and alcohol dementia. Also, alcohol intake in conjunction with certain medications can have a greater impact on older individuals than younger individuals.
Stress/Anxiety	Anxiety disorder is more prevalent than depression among the elderly. Older women are more at risk than men. May be the result of family violence or Post Traumatic Stress Disorder.
Traumatic Brain Injury	May be the result of physical abuse or a fall. Falls are the most common injury in the elderly due to weakness, environmental hazards, dizziness, alcohol, medications or stroke. A patient with sudden changes in mental status after a fall may have subdural hematoma.
Urinary Tract Infection	Most common infection in the elderly. Can present as acute change in cognitive status. May result in delirium.

SLIDE 17



TOPIC: Medication issues

- Seniors represent just over 13% of the population, but consume 30-40% of prescription drugs and 35% of all over-the-counter drugs
- On average, individuals 65 to 69 years old take nearly 14 prescriptions per year, individuals aged 80 to 84 take an average of 18 prescriptions per year
- 15% to 25% of drug use in seniors is considered unnecessary or otherwise inappropriate
- Adverse drug reactions and noncompliance are responsible for 28% of hospitalizations of the elderly and 36% of all reported adverse drug reactions involve an elderly individual

Given these statistics, knowledge of medications is crucial. It is important to obtain a list of medications from clients, observe medications in the home (including over the counter remedies and herbal supplements), and ask client what she/he is taking, for what, and how often. This will give insight into the client's understanding of the drug, the illness, relationship with the prescribing physician, how many physicians may be prescribing, etc.

You may suggest that clients use the Physician's Desk Reference (PDR) which gives information on all prescription medications including photos, descriptions, uses, and interactions. Suggest that they have a good medical dictionary available – this will help when they speak to physicians and nurses.


Medications work through absorption (getting into the body), distribution (where it goes in the body), metabolism (how it is handled in the body) and excretion (how it is eliminated from the body). If client is taking 4 medications or more, it is likely that there are serious interactions. In addition all medications have side effects. Some are minor but some can be very serious.

SOURCE: *Advanced Biopsychosocial Assessment: Navigating the Grey Areas*

ASSESSING CAPACITY – TRAINER’S MANUAL

SLIDE 18

ACTIVITY: Differentiating the 3 D's		
Question 1	Question 2	Question 3
What are the indicators that client may have a mental status problem?	Does the client appear to have dementia, delirium or depression?	What more information do you need and how would you get it?



HANDOUT #3:
3 D's Case Studies
Participant manual pg 20

TOPIC: Activity: Differentiating the 3 D's

TIME ALLOTTED: 10 MINUTES

Before discussing Dementia, Delirium and Depression complete this activity as a large group. Refer participants to **Handout #3**.

Have a volunteer read the case aloud and process the following questions taking into account all client issues (culture, education, language) when deciding how to conduct your assessment.

1. What are the indicators that client may have a mental status problem?
2. Does the client appear to have dementia, delirium or depression?
3. What more information do you need and how would you get it?

SOURCE: *Advanced Biopsychosocial Assessment: Navigating the Grey Areas*

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT #3 – 3 D’s CASE STUDIES

Case Study #1 – Rosemary Cellini

Mrs. Cellini, age 83, was referred to APS because she was found outside mumbling to herself. When her neighbor approached her, she quieted down but didn’t make any sense. She appeared to have lost weight as well. The neighbor stated that she talked to Mrs. Cellini last week when she returned from a brief hospitalization and she seemed ok at that time. Now, Mrs. Cellini doesn’t even recognize her own house.

When you visit, she appears confused and disoriented. She is quite thin and has a bruise on her forehead, but cannot explain what happened. She talks about her mother and how she just went to the store and how much she loves her. (You had heard from the neighbor that client’s mother lived in Italy and died 10 years before). It is difficult to follow her conversation as she often stops in mid- sentence and she seems distracted. The house is in good repair but is untidy.

There is very little food in the refrigerator and there is about a week’s worth of dirty clothing on the floors. Mrs. Cellini has current medication in her house for hypertension and diabetes.

1. What are the indicators that client may have a mental status problem?
2. Does the client appear to have dementia, delirium or depression?
3. What more information do you need and how would you get it?

Case Study #2 - Proful Dixit

Mr. Dixit, age 77, was referred to APS by the Health Department because they had received complaints about the environmental conditions in the home which have deteriorated over the last year. Although there were some minor violations, the concern was the client who was found dirty and disheveled. The officer stated that Mr. Dixit seemed embarrassed and nervous. When the officer told him about the violations, he seemed not to understand what the issues were, but smiled and said his son would take care of everything.

When you visit, Mr. Dixit greets you pleasantly but does not volunteer information. The house appears to be in the same condition as described by the Health Officer. Mr. Dixit is surrounded by newspapers, magazines, and take-out food containers. His clothing is urine stained, but he does not appear to notice it.

There are several cats in the home. He seems to have difficulty understanding what you are saying, but nods his head politely. Mr. Dixit has medication for arthritis, high cholesterol and Parkinson’s.

ASSESSING CAPACITY – TRAINER’S MANUAL

1. What are the indicators that client may have a mental status problem?
2. Does the client appear to have dementia, delirium or depression?
3. What more information do you need and how would you get it?

Case Study #3 – Mary Jo Jackson

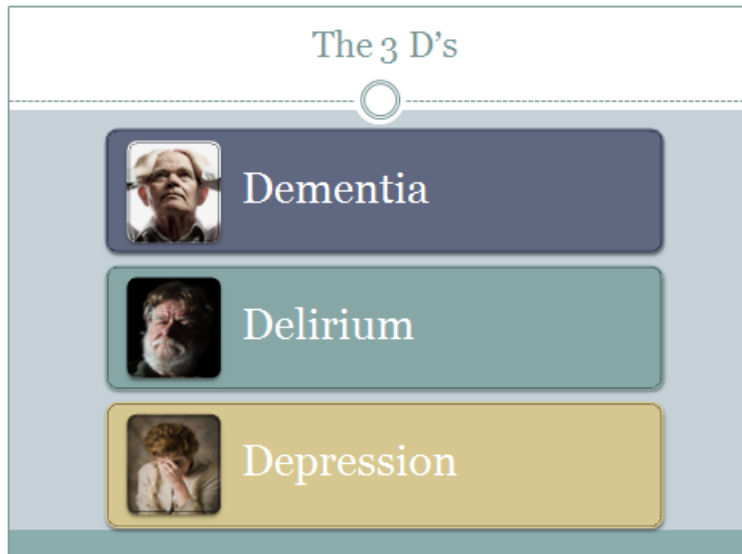
Mrs. Jackson, age 73, was referred to APS after the police did a welfare check requested by Mrs. Jackson’s daughter who lives out of state. Initially, Mrs. Jackson failed to answer the door for the police. Then, she appeared to be confused about why the police were there and refused any assistance.

When you visit, Mrs. Jackson is appears to have difficulty focusing on your conversation. You have to repeat your questions as she often doesn’t respond immediately and then seems to have lost the thread of the conversation. When you ask Mrs. Jackson about her family, Mrs. Jackson seems uninterested in discussing her past or her daughter’s current concerns. She says she’ll call her daughter “later”, when she feels up to it. The house is in reasonable repair but is very untidy.

There is little food in the home and the client appears unconcerned getting more food in. She asks to you leave because she doesn’t feel up to answering questions.


1. What are the indicators that client may have a mental status problem?
2. Does the client appear to have dementia, delirium or depression?
3. What more information do you need and how would you get it?

SLIDE 19



TOPIC: 3 D's

As the case study activity highlighted, differentiating between Dementia, Depression and Delirium can be difficult.

 **ASK:** participants about their experience in sorting out these three issues – what have their challenges been?


Have they ever discovered a client who had delirium? How did they know? What did they do?

Any experiences with suicidal clients?

SLIDE 20

Dementia Defined

- It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. It includes a memory deficit *plus* a deficit in at least one other cognitive domain.
- Final common behavioral pathway” for many diseases/ etiologies that affect the brain



HANDOUT #4:
Medical Conditions
Affecting Capacity
Participant manual pg 23

TOPIC: Dementia Defined

- Dementia is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. It includes a memory deficit *plus* a deficit in at least one other cognitive domain.
- Final common behavioral pathway” for many diseases/etiologies that affect the brain

Refer participants to **Handout #4**, a resource from the American Bar Association and American Psychological Association Commission on Law and Aging, for more specific information on types of dementia and other issues that affect capacity.

SOURCE: *Advanced Biopsychosocial Assessment: Navigating the Grey Areas*

HANDOUT #4 Appendix G. Medical Conditions Affecting Capacity³

Dementia is a general term for a medical condition characterized by a loss of memory and functioning. Primary degenerative dementias are those with disease processes that result in a deteriorating course, including Alzheimer’s disease, Lewy Body Dementia, and Frontal Dementia (each associated with a type of abnormal brain cell).

Condition	Etiology	Symptoms	Treatability
Alcoholic Dementia	A fairly common form of dementia, caused by long-term abuse of alcohol, usually for 20 years or more. Alcohol is a neurotoxin that passes the blood-brain barrier.	Memory loss, problem-solving difficulty, and impairments in visuospatial function are commonly found in patients with alcohol dementia.	Alcohol dementia is partially reversible, if there is long-term sobriety—cessation of use. There is evidence to suggest that some damaged brain tissue may regenerate following extended sobriety, leading to modest improvements in thinking and function.
Alzheimer’s disease (“AD”)	Most common type of dementia, caused by a progressive brain disease involving protein deposits in brain and disruption of neurotransmitter systems.	Initial short-term memory loss, followed by problems in language and communication, orientation to time and place, everyday problem solving, and eventually recognition of people and everyday objects. In the early stages, an individual may retain some decisional and functional abilities.	Progressive and irreversible, resulting ultimately in a terminal state. Medications may improve symptoms and cause a temporary brightening of function in the earlier stages.
Bipolar Disorder or Manic Depression	A psychiatric illness characterized by alternating periods of mania and depression.	May affect functional and decisional abilities in the manic stage or when the depressed stage is severe.	Can be treated with medications, but requires a strong commitment to treatment on the part of the individual. Varies over time; periodic re-evaluation is needed.

³ This list is meant to define terms **as used in this** book, and is not meant to define terms more universally. The glossary uses definitions from the *Diagnostic and Statistical Manual of Mental Disorders*, where available, and where not, definitions are based on the consensus of the working group.

ASSESSING CAPACITY – TRAINER’S MANUAL

Condition	Source	Symptoms	Treatability
Coma	A state of temporary or permanent unconsciousness.	Minimally responsive or unresponsive, unable to communicate decisions and needs a substitute decision maker.	Often temporary; regular re-evaluation required.
Delirium	A temporary confusional state with a wide variety of causes, such as dehydration, poor nutrition, multiple medication use, medication reaction, anesthesia, metabolic imbalances, and infections.	Substantially impaired attention and significant decisional and functional impairments across many domains. May be difficult to distinguish from the confusion and inattention characteristic of dementia.	Often temporary and reversible. If untreated may proceed to a dementia. It is important to rule out delirium before diagnosing dementia. To do so, a good understanding of the history and course of functional decline, as well as a full medical work-up, are necessary.
Frontal or Frontotemporal Dementia (Pick’s disease is one example)	Broad category of dementia caused by brain diseases or small strokes that affect the frontal lobes of the brain.	Problems with personality and behavior are often the first changes, followed by problems in organization, judgment, insight, motivation, and the ability to engage in goal-oriented behavior.	Early in their disease, patients may have areas of retained functional ability, but as disease progresses they can rapidly lose all decisional capacity.
Jacob-Creutzfeldt Disease	A rare type of progressive dementia affecting humans that is related to “mad cow” disease.	The disease usually has a rapid course, with death occurring within two years of initial symptoms. These include fatigue, mental slowing, depression, bizarre ideations, confusion, and motor disturbances, including muscular jerking, leading finally to a vegetative state and death.	There is no treatment currently and the disease is relentlessly progressive.

ASSESSING CAPACITY – TRAINER’S MANUAL

Condition	Source	Symptoms	Treatability
Diffuse Lewy Body Dementia (DLB)	A type of dementia on the Parkinson disease spectrum.	DLB involves mental changes that precede or co-occur with motor changes. Visual hallucinations are common, as are fluctuations in mental capacity.	This disease is progressive and there are no known treatments. Parkinson medications are often of limited use.
Major Depression	A very common psychiatric illness.	Sad or disinterested mood, poor appetite, energy, sleep, and concentration, feelings of hopelessness, helplessness, and suicidality. In severe cases, poor hygiene, hallucinations, delusions, and impaired decisional and functional abilities.	Treatable and reversible, although in some resistant cases electroconvulsive therapy (ECT) is needed.
Developmental Disorders (“DD”), including Mental Retardation (“MR”)	Brain-related conditions that begin at birth or childhood (before age 18) and continue throughout adult life. MR concerns low-level intellectual functioning with functional deficits that can be found across many kinds of DD, including autism, Down syndrome, and cerebral palsy.	Functioning tends to be stable over time but lower than normal peers. MR is most commonly mild. Some conditions such as Down syndrome may develop a supervening dementia later in life, causing decline in already limited decisional and functional abilities.	Not reversible, but everyday functioning can be improved with a wide range of supports, interventions, and less restrictive alternatives. Individuals with DD have a wide range of decisional and functional abilities and, thus, require careful assessment by skilled clinicians.
Parkinson’s Disease (PD)	Progressive brain disease that initially affects motor function, but in many cases proceeds to dementia.	PD presents initially with problems with tremors and physical movement, followed by problems with expression and thinking, and leading sometimes to dementia after a number of years.	PD is progressive, but motor symptoms can be treated for many years. Eventually, medications become ineffective and most physical and mental capacities are lost. Evaluation of capacity must avoid confusion of physical for cognitive impairment.

Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists
 ©American Bar Association Commission on Law and Aging – American Psychological Association


ASSESSING CAPACITY – TRAINER’S MANUAL

Condition	Source	Symptoms	Treatability
Persistent Vegetative State (PSV)	A state of minimal or no responsiveness following emergence from coma.	Patient is mute and immobile with an absence of all higher mental activity. Cannot communicate decisions and requires a substitute decision maker for all areas.	Cases of PSV usually lead to death within a year’s time.
Schizophrenia	A chronic brain-based psychiatric illness	Hallucinations and delusions; poor judgment, insight, planning, personal hygiene, interpersonal skills. May range from mild to severe. Impact on functional and decisional abilities is variable.	Many symptoms can be successfully treated with medication. Capacity loss may occur when patients go off their medications.
Stroke or Cerebral Vascular Accident (“CVA”)	A significant bleeding in the brain, or a blockage of oxygen to the brain.	May affect just one part of the brain, so individuals should be carefully assessed to determine their functional and decisional abilities.	Some level of recovery and improved function over the first year; thus a temporary guardianship might be considered if the stroke is recent.
Traumatic Brain Injury (“TBI”)	A blow to the head that usually involves loss of consciousness.	Individuals with mild and moderate TBI may appear superficially the same as before the accident, but have persisting problems with motivation, judgment, and organization. Those with severe TBI may have profound problems with everyday functioning.	Usually show recovery of thinking and functional abilities over the first year; thus a temporary guardianship should be considered if the injury is recent.
Vascular Cognitive Impairment	Multiple infarcts that cause cognitive impairment	Functional strengths and weaknesses may vary, depending on the extent and location of the strokes.	May remain stable over time if underlying cerebrovascular or heart disease is successfully managed.
Vascular Dementia (“VaD”)	Multiple strokes that accumulate and cause dementia.	Functional strengths and weaknesses may vary, depending on the extent and location of the strokes.	May worsen if cerebrovascular disease continues to cause progressive impairment.

SLIDE 21

Irreversible Dementias

- Alzheimer’s Disease
- Vascular Dementia
- Parkinson’s Disease
- Frontal-Temporal Dementia
- Dementia with Lewy Bodies
- Alcohol-related Dementia



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Irreversible dementias

- Alzheimer’s Disease
- Vascular Dementia
- Parkinson’s Disease
- Frontal-Temporal Dementia
- Dementia with Lewy Bodies
- Alcohol-related Dementia

SLIDE 22

Causes of Reversible Dementias

Drugs, dehydration, depression
Electrolyte imbalances, emotional disorders
Metabolic disorders
Endocrine disorders
Nutritional Deficiencies
Trauma, tumor
Infections (urinary tract)
Acute illness, arteriosclerosis complications
Seizures, strokes, sensory deprivation

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Causes of reversible dementias


- **Drugs, dehydration, depression**
- **Electrolyte imbalances** The most serious electrolyte disturbances involve abnormalities in the levels of sodium, potassium, and/or calcium. Other electrolyte imbalances are less common, and often occur in conjunction with major electrolyte changes. Chronic laxative abuse or severe diarrhea or vomiting can lead to electrolyte disturbances along with dehydration.
- **Emotional disorders:** e.g. Bipolar, Manic, Depression
- **Metabolic disorders:** Metabolism is the process your body uses to get or make energy from the food you eat. Your body can use this fuel right away, or it can store the energy in your body tissues, such as your liver, muscles and body fat. A metabolic disorder occurs when abnormal chemical reactions in your body disrupt this process. When this happens, you might have too much of some substances or too little of other ones that you need to stay healthy. You can develop a metabolic disorder when some organs, such as your liver or pancreas, become diseased or do not function normally. Diabetes is an example.
- **Endocrine disorders:** Includes Adrenal Disease, Diabetes, Hypoglycemia, and Osteoporosis
- **Nutritional Deficiencies**
- **Trauma, tumor**
- **Infections (urinary tract)**
- **Acute illness, arteriosclerosis complications**
- **Seizures, strokes, sensory deprivation**

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

SLIDE 23

Delirium

- Disturbance in alertness, consciousness, perception, and thinking
- Sudden onset
- Caused by infection, dehydration, changes in chemical balance, head trauma, post surgical recovery
- Medical emergency
- Treatable and reversible



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

HANDOUT #5:
Confusion Assessment Method (CAM)
Participant manual pg 28

TOPIC: Delirium

- Explain the characteristics of Delirium – acute confused state, disturbance in alertness, consciousness, perception and thinking.
- Emphasize the sudden onset characteristic
- Can be caused by infection, dehydration, chemical imbalance, head trauma, or anesthesia, etc.
- Explain that it can be a medical emergency/ a life and death situation.
- Delirium is treatable and reversible

Refer participants to **Handout #5 – Confusion Assessment Method (CAM)** which can be administered in less than 5 minutes and measure two areas:

- Part one is an assessment instrument that screens for overall cognitive impairment.
- Part two includes only those four features that were found to have the greatest ability to distinguish delirium or reversible confusion from other types of cognitive impairment. (Waszynski, C. 2004)

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT #5

Confusion Assessment Method (CAM)

(Adapted from Inouye et al., 1990)

Patient’s Name: _____ Date: _____

Instructions: Assess the following factors.

Acute Onset

1. Is there evidence of an acute change in mental status from the patient’s baseline?
____ YES ____ NO ____ UNCERTAIN ____ NOT APPLICABLE

Inattention

(The questions listed under this topic are repeated for each topic where applicable.)

- 2A. Did the patient have difficulty focusing attention (for example, being easily distractible or having difficulty keeping track of what was being said)?

_____ Not present at any time during interview
_____ Present at some time during interview, but in mild form
_____ Present at some time during interview, in marked form
_____ Uncertain

- 2B. (If present or abnormal) Did this behavior fluctuate during the interview (that is, tend to come and go or increase and decrease in severity)?

____ YES ____ NO ____ UNCERTAIN ____ NOT APPLICABLE

- 2C. (If present or abnormal) Please describe this behavior.

Disorganized Thinking

3. Was the patient’s thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable, switching from subject to subject?

____ YES ____ NO ____ UNCERTAIN ____ NOT APPLICABLE

Altered Level of Consciousness

4. Overall, how would you rate this patient’s level of consciousness?

_____ Alert (*normal*)
_____ Vigilant (*hyperalert, overly sensitive to environmental stimuli, startled very easily*)
_____ Lethargic (*drowsy, easily aroused*)
_____ Stupor (*difficult to arouse*)
_____ Coma (*unarousable*)
_____ Uncertain

ASSESSING CAPACITY – TRAINER’S MANUAL

Disorientation

5. Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?
- YES NO UNCERTAIN NOT APPLICABLE

Memory Impairment

6. Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?
- YES NO UNCERTAIN NOT APPLICABLE

Perceptual Disturbances

7. Did the patient have any evidence of perceptual disturbances, such as hallucinations, illusions, or misinterpretations (for example, thinking something was moving when it was not)?
- YES NO UNCERTAIN NOT APPLICABLE

Psychomotor Agitation

- 8A. At any time during the interview, did the patient have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers, or making frequent, sudden changes in position?
- YES NO UNCERTAIN NOT APPLICABLE

Psychomotor Retardation

- 8B. At any time during the interview, did the patient have an unusually decreased level of motor activity, such as sluggishness, staring into space, staying in one position for a long time, or moving very slowly?
- YES NO UNCERTAIN NOT APPLICABLE

Altered Sleep-Wake Cycle

9. Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?
- YES NO UNCERTAIN NOT APPLICABLE

Scoring:

For a diagnosis of delirium by CAM, the patient must display:

1. Presence of acute onset and fluctuating discourse
- AND
2. Inattention
- AND EITHER
3. Disorganized thinking
- OR
4. Altered level of consciousness

Source:

Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med.* 1990;113(12):941-948.

Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: Acute Onset and Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day; that is, did it tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention; for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganized Thinking

This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of Consciousness

This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

Source:


Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegel AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med.* 1990;113(12):941-948.

ASSESSING CAPACITY – TRAINER’S MANUAL

Slide 24 & 25

Symptoms of Depression
Yesavage & Brink, GDS, MOOD SCALE

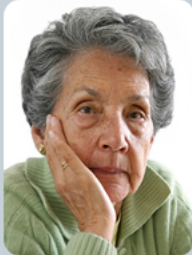
- Sleep Disturbance
- Loss of Energy/ Libido
- Change in Appetite/ Weight
- Psychomotor Retardation/ Agitation
- Poor Concentration/ Attention



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Symptoms of Depression
Yesavage & Brink, GDS, MOOD SCALE

- Anhedonia - Loss of Interest in Usual Activities
- Somatic Complaints
- Dysphoria - Flat Affect
- Sense of Hopelessness/ Worthlessness
- Suicidal Ideation



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

HANDOUT #6:
Geriatric Depression Scale
Participant manual pg 32

Topic: Depression

Depression in the elderly is often undiagnosed or under-diagnosed.

Many symptoms of depression can affect a client’s decision making capacity such as:

- Sleep disturbances which can affect concentration and attention
- Loss of energy and/or loss of interest in usual activities
- Sense of hopelessness, worthlessness or suicidal ideation.

Capacity issues caused by depression may fluctuate and be reversible with appropriate treatment.

Refer participants to Handout #6 on page 32 of the participant manual – it’s a the **Geriatric Depression Scale – Short Form** which they can use in their practice.

BREAK
15 minutes

HANDOUT #6

GERIATRIC DEPRESSION SCALE (Short Form)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things?
YES / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Answers in bold indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score >5 points is suggestive of depression and should warrant a follow-up interview. Scores >10 are almost always depression.

(Sheikh & Yesavage, 1986)

CASE STUDY ACTIVITY #1: ASSESSING DECISIONAL CAPACITY



TIME ALLOTTED: 30 minutes

SLIDE 26

CASE STUDY ACTIVITY –
ASSESSING DECISIONAL CAPACITY

- ▶ Participants are divided into small groups. Each group will be provided with a case example.
- ▶ The task of group members is to find out as much information about their case as they can by questioning the group leader.



Small Group Information
Case Study 1: Anna Kovacs
Case Study 2: Juan Garcia
Case Study 3: Mark Hudson
Case Study 4: Rob and Wilma Benson
Case Study 5: Sharon Delay
In participant manual pgs. 34-38

TOPIC: Case study activity

- ◆ The **purpose** of this exercise is to find out as much information as possible about the factors affecting your group’s client’s decisional capacity.

INSTRUCTIONS

TIME ALLOTTED: 30 minutes

Small group discussion: Participants will be divided into 5 or fewer groups. One Leader will be identified for each group. Assign each groups one case study. The Leader will use the **Group Leader Information which the trainer needs to distribute** and the small group will use **Small Group Information located in the participant manual**. A recorder will be chosen by the group.

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL

TRAINER NOTE: There are 5 cases available for the Trainer to use. To be effective, each group should have a minimum of 6 participants. The number of groups/cases used will depend on the size of the class.

Each case study reflects the psychological, physical and environmental factors that affect the client(s) named in the case. Each case also has two parts:

- **Group Leader Information**, which provides key information about the case such as:
 - client’s name,
 - age,
 - marital status,
 - the reason for the referral to APS and
 - who made the referral.
 -
- **Small Group Information**, which provides some information and a place for the recorder to write down answers asked of the leader

After the groups are formed:

- ◆ Assume that the members of your group have just received an intake call and have a very limited amount of information about the client.
- ◆ The Leader of your group represents the people who have more information about the client. This information is essential in order for you to begin assessing whether the client has the capacity to make informed decisions.
- ◆ Think about the questions you should ask the **Leader** in order to get the information you need. Please refer to case study **Small Group Information** to guide your quest for information.
- ◆ Choose a **Recorder** who will write all the available information on case study **Small Group Information** as the Leader answers your questions.

Group Leader Instructions for small group discussion: (30 minutes)

- ◆ Help the group select a recorder.
- ◆ Remind the group members that they are to ask the Leader questions about the case study client using **Small Group Information** as a guide. The recorder will note the answers on the Handout.
 - Answer the questions using **Group Leader Information**.
 - Do not volunteer additional information about the client unless you are asked directly.

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL

- ◆ After 20 minutes, lead a discussion asking the questions:
 1. *Which factors did you miss?*
 2. *How might you have questioned me more specifically to get the missing information?*
- ◆ Group leaders share information not already identified by small group.

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #1: Anna Kovacs Group Leader Information

Reason for referral to APS: Possible self-neglect

Referral made by: Visiting Nurse

Psycho-social Factors Affecting Capacity

Anna is an 82 year old widow.

She and her husband Miklos emigrated from Hungary 40 years ago.

Anna’s English is limited.

Miklos died suddenly of a massive heart attack one year ago.

He had worked his entire life and managed the financial affairs of the home. They had one daughter who died 10 years ago of cancer at the age of 38.

Anna had cared for her daughter during her two-year illness. Anna seems confused about her medications.

She does not seem to understand the importance of maintaining her diabetic diet. She eats a lot of rye bread and processed meats which are high in sugar.

Physical Factors Affecting Capacity

Anna was recently hospitalized due to complications of diabetes.

Her sugar levels were out of control.

She had developed gangrene in her left foot.

Two of her toes had to be amputated.

She is beginning to have problems with her vision. After rehab, she was sent home in a wheelchair.

There is no one providing in- home care.

Environmental Factors Affecting Capacity

Anna lives alone.

Reportedly, Anna was an excellent cook and housekeeper when she was younger.

Now the home is very cluttered. It is difficult for her to maneuver around the home in her wheelchair.

Prognosis

If Anna does not follow her diabetic medication and dietary regimen, she will be at risk of a foot or full-leg amputation.

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #2: Juan Garcia Group Leader Information

Reason for referral to APS: Need for assessment to determine capacity to give informed consent for medical treatment.

Referral made by: Staff at residential health care facility

Psycho-social factors affecting capacity

- Juan is a twenty-eight year old single man who came to this country from El Salvador when he was 18 years old.
- His status in this country is as an undocumented immigrant.
- His parents were divorced and he has had no contact with his father.
- His mother and four younger siblings are still in El Salvador.
- For the past ten years, he has sent money home every week to support his family.
- When he was not working, he would go to the local bar and drink with his friends.
- Juan has a 6th grade education. His spoken English is limited and he is more comfortable speaking Spanish. He cannot read or write English. He seems to have a good relationship with one nurse’s aide from El Salvador who is familiar with his hometown. He often depends on her to communicate his needs.

Physical factors affecting capacity

- Recently Juan sustained multiple injuries, including brain trauma, in a car accident.
- He has slurred speech, unsteady ambulation, and a seizure disorder as well as mood swings and erratic behavior.
- He was moved from the hospital to a residential health care facility.
- Facility staff describe him as difficult to manage. He is becoming more and more agitated.
- He told staff that he does not want to go into the hospital again.
- A recent medical test showed that there is considerable pressure on his brain.

Prognosis:

If surgery to reduce the pressure on his brain is not done, his life will be in danger.

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #3: Mark Hudson Group Leader Information

Reason for referral to APS: Possible self-neglect

Referral made by: Mark’s daughter

Psycho-social Factors Affecting Capacity

- Mark is 85 years old.
- He lives alone in the home that he and his recently deceased wife built in the 1950’s.
- Following his wife’s death two years ago, he became very despondent.
- Since his wife’s death, he has become increasingly reclusive, refusing to answer the phone or the door.
- He has been in two “fender-benders” while driving his car on major thoroughfares.
- He refuses to go shopping with his daughter to buy him much-needed clothes.
- He seems confused and distracted. His speech is fairly animated, though slightly “off topic” from the current subject of conversation.
- He is unhappy and confused that he doesn’t hear from his daughter as often as he used to.
- Mark has established a friendly relationship with the young hearing impaired man who delivers the pizzas. He sits by the door to watch for him. They have brief chats using gesturing and basic sign language, but the “chats” don’t last long, because the young man is on the clock.

Physical Factors Affecting Capacity

- He has gained a lot of weight in the past year.

Environmental Factors Affecting Capacity

- He allows his daughter to oversee his financial affairs.
- There are piles of dirty clothes and dirty dishes throughout the house.
- There are pizza boxes and pop bottles lying around, but not much evidence of other food.
- The television is blaring.
- On the floor, there are crossword puzzle books and a book on sign language.
- There is a pile of garbage overflowing from the kitchen trashcan.

Prognosis: Mark’s daughter wants “the State” to take guardianship of her father and put him in a nursing home.

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #4: Rob and Wilma Benson Group Leader Information

Reason for referral to APS: Possible financial exploitation

Referral made by: a concerned neighbor

Psycho-social Factors Affecting Capacity:

- Wilma’s demeanor is meek and apprehensive. She avoids eye contact and shrivels when her husband enters the room.
- Rob is a large man who smells of beer and seems overly cordial.

Physical Factors affecting Capacity:

- Rob and Wilma Benson are in their seventies.
- Rob has heart and liver problems, as well as frequent urinary tract infections.
- He wanders away from the farm when intoxicated, and has been picked up by neighbors walking along the rural highway near his home.
- Wilma was recently hospitalized due to a head injury which she reported was due to a fall in her home.
- Her vision was impaired due to the injury.
- She appeared malnourished and significantly dehydrated upon admittance to the hospital.
- ER staff believed that the head injury and bruising on her body were not consistent with a fall.

Environmental Factors Affecting Capacity:

- Rob and Wilma live alone in a rural area on a potato farm.
- Ten years ago, the Bensons turned the potato farm business over to their son and his wife, who promised to care of them financially from the farm revenue.
- The farm business has failed and the son recently put his parents’ farm up for sale.
- The son and daughter-in-law are trying to get Mr. and Mrs. Benson to “sign over” the house and property rights to them.
- There are piles of newspapers in the home, and beer cans strewn about. Holes in the sheet rock at arms level, suggest someone punched holes in the walls.
- There is no evidence of fresh food in the home.
- The plumbing is not functioning.
- There are many cats and cat feces inside and outside of the home.

Prognosis: The Bensons may lose their home. Mr. Benson’s health will deteriorate. Mrs. Benson will suffer more injuries.

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #5: Sharon Delay Group Leader Information

Reason for referral to APS: Possible sexual abuse

Referral made by: Group home staff person

Psycho-social Factors Affecting Capacity:

- Sharon is a 22 year old developmentally disabled woman. She is moderately mentally retarded, reads with difficulty, but is verbal and cooperative.
- She lives in a group home with five other residents.
- Sharon’s parents are deceased.
- She has a boyfriend, Jake. She admits that she has been out with Jake and had sex with him.
- Sharon has a basic understanding of what it means to have sex.
- She knew that she was going to have sex with Jake, and wanted to do so.
- She also understands the consequences of sexual intercourse—that she could get pregnant or contract a sexually transmitted disease. She says that she is on the pill, and Jake used a condom.
- She likes Jake a lot, but does not want to have sex with him again if it means that he will go to jail.

Physical Factors Affecting Capacity:

- Sharon is slightly overweight.
- She is being treated for hypothyroidism, allergies and high blood pressure.
- She was recently taken to the hospital for a rape emergency examination after a group home staff person reported that she had had sex with Jake.
- The hospital examination showed no evidence of physical trauma.

Environmental Factors Affecting Capacity:

- Sharon’s sister, Jane, was appointed as Sharon’s conservator to manage her financial affairs, upon the advice of an attorney.
- Jane says that Sharon is unable to have consensual sex because she is “too stupid to know what she is doing,”
- Police arrested Jake for sexual assault.
- Jane wants Jake to be charged with rape of a vulnerable adult.

Prognosis: Jake will go to jail. Sharon will not be allowed to have another sexual relationship.

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #1: Anna Kovacs **Small Group Information**

Group Task: Your leader has information about Mrs. Anna Kovacs. Your task, during the first 20 minutes, is to obtain as much information as possible about Anna that will help you understand more about her and what factors may be affecting her decisional capacity in this situation.

In the last 5 minutes, your leader will provide you with any remaining relevant information about the client that has not been uncovered.

Using this sheet, ask one member of your group to fill in the information you know about this client based upon the leader’s answers to the group. Discuss how these factors might affect Anna’s decisional capacity.

Reason for referral to APS: Possible self-neglect of Anna Kovacs, an 82 year old widow who lives alone.

Referral made by: Visiting Nurse

Psycho-social Factors Affecting Capacity:

Physical Factors Affecting Capacity:

Environmental Factors Affecting Capacity:

Client’s Prognosis:

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #2: Juan Garcia **Small Group Information**

Group task: Your leader has information about Juan. Your task during the first 20 minutes, is to obtain as much information as possible about Juan that will help you understand more about him and what factors may be affecting his decisional capacity in this situation.

In the last 5 minutes, your leader will provide you with any remaining relevant information about the client that has not been uncovered.

Using this sheet, ask one member of your group to fill in the information you know about this client based upon the leader’s answers to the group. Discuss how these factors might affect Juan’s decisional capacity.

Reason for referral to APS: Need for assessment to determine capacity to give informed consent for medical treatment.

Referral made by: Staff at residential health care facility

Psycho-social factors affecting capacity:

Physical factors affecting capacity:

Environmental factors affecting capacity:

Client’s prognosis:

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #3: Mark Hudson **Small Group Information**

Group Task: Your leader has information about Mark Hudson. Your task, during the first 20 minutes, is to obtain as much information as possible about Mark that will help you understand more about him and what factors may be affecting his decisional capacity in this situation. In the last 5 minutes, your leader will provide you with any remaining relevant information about the client that has not been uncovered.

Using this sheet, ask one member of your group to fill in the information you know about this client based upon the leader’s answers to the group. Discuss how these factors might affect Mark’s decisional capacity.

Reason for referral to APS: Possible self-neglect

Referral made by: Mark Hudson’s daughter

Psycho-social Factors Affecting Capacity:

Physical Factors Affecting Capacity:

Environmental Factors Affecting Capacity:

Client’s Prognosis:

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #4: Rob and Wilma Benson **Small Group Information**

Group Task: Your leader has information about Mr. and Mrs. Benson. Your task, during the first 20 minutes, is to obtain as much information as possible about both of them that will help you understand what factors may be affecting their decisional capacity in this situation. In the last 5 minutes, your Leader will provide you with any relevant remaining information about the client that has not been uncovered.

Using this sheet, ask one member of your group to fill in the information you know about these clients based on the leader’s answers to the group. Discuss how these factors might affect Rob and Wilma’s decisional capacity.

Reason for referral to APS: Possible financial exploitation

Referral made by: A concerned neighbor

Psycho-social Factors Affecting Capacity:

Physical Factors Affecting Capacity:

Environmental Factors Affecting Capacity:

Client’s Prognosis:

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #5: Sharon Delay Small Group Information

Group Task: Your leader has information about Sharon. Your task, for the first 20 minutes, is to obtain as much information as possible about Sharon that will help you understand more about her and what factors may be affecting her decisional capacity in this situation. In the last 5 minutes, your leader will provide you with any relevant remaining information about the client that has not been uncovered.

Using this sheet, ask one member of your group to fill in the information you know about this client based upon the leader’s answers to the group. Discuss how these factors might affect Sharon’s decisional capacity.

Reason for referral to APS: Possible sexual abuse

Referral made by: Group home staff person

Psycho-social Factors Affecting Capacity:

Physical Factors Affecting Capacity:

Environmental Factors Affecting Capacity:

Client’s Prognosis:

CAPACITY ASSESSMENT: DOMAINS & TOOLS



TIME ALLOTTED: 75 min + 60 min Lunch

SLIDE 27

Components of Capacity Assessment

- The client understands relevant information.
 - Question: Do you know that you have a serious cut on your leg?
- The quality of the client’s thinking process.
 - Question: How can you get treatment for your wound?
- The client is able to demonstrate and communicate a choice.
 - Question: Do you want to get treatment for your wound?
- The client appreciates the nature of his/her own situation.
 - Question: What will happen if you don’t get your wound treated?

Source: Kemp 2005

TOPIC: Capacity assessment

Here are four basic questions to consider when assessing a client’s capacity to make informed decisions

1. Can the client understand relevant information?
 - *Do you know that you have a serious cut on your leg?*
2. What is the quality of the client’s thinking process?
 - *How can you get treatment for your wound?*
3. Is the client able to demonstrate and communicate a choice?
 - *Do you want to get treatment for your wound?*
4. Does the client appreciate the nature of his/her own situation?
 - *What will happen if you don’t get your wound treated?*

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL



ASK: For this last component what did you mean when you were trying to determine if the client “appreciates” the nature of his/her own situation?

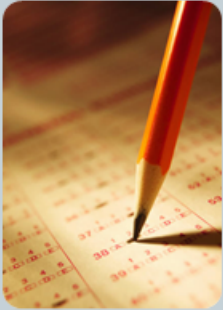
- ◆ The word “appreciate” is a legal term. These four components come from statutes developed across the country.
- ◆ The meaning of “appreciate” is therefore defined by the laws in your state. It can mean:
 - have understanding
 - an emotional response
 - generally understand risks and benefits
 - understand his/her own situation
- ◆ When “appreciate” is **not** defined in a statute, it generally means “understanding.”
- ◆ However, “appreciate” has had many, different definitions depending not only on statutes but also on the specific attorney’s and courtroom’s usage.
- ◆ Therefore it is important to get this clearly **defined** with your legal advisors.
- ◆ Then you need to make your **definition explicit** when working with others.

TRAINER NOTE: Bennett Blum, MD provided the information about the nuances of the word “appreciate” in the legal model of capacity assessment. He is a consultant in forensic and geriatric psychiatry.

SLIDE 28

Assessment Scales and Tools

- Advantages and disadvantages
- When/how to use
- Types of assessment tools
 - Cognitive
 - × Folstein Mini-Mental State Exam
 - × St. Louis University Mental Status Exam (SLUMS)
 - × Montreal Cognitive Assessment (MoCA)
 - × Clock Drawing Test
 - × Paradise-2



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Assessment tools

Standardized tools give another dimension and help you decide when it is important to get further assistance – from a physician, psychiatrist, or attorney.

Scores may fluctuate depending on the time of day, emotional state of the client, and the comfort level of the worker administering the scale.

Assessment scales and tools cannot be used alone; they are always part of a package.

An effective way to use a tool is to weave questions in the interview.

Tools are just that, tools and each has strengths and limitations.

Most important tool is worker- skills and use of self.


For this reason, APS caseworkers should not rely solely on one assessment tool to determine whether a client needs a professional capacity evaluation.

Today we will be looking at some tools that are commonly used.

SLIDE 29

Cognitive Domains

- Orientation
- Attention
- Memory
- Language
- Visual-Spatial Organization
- Executive Functioning



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Cognitive domains

Before we review the tools themselves, let’s discuss the cognitive domains they assess. Generally there are six domains:

- ◆ Orientation
- ◆ Attention
- ◆ Memory
- ◆ Language
- ◆ Visual-Spatial Organization
- ◆ Executive Functioning

SLIDE 30

Cognitive Domains: Orientation

- Useful because standard.
- Mostly tests recent and longer-term memory
- Response is also influenced by level of alertness, attentiveness, and language capabilities.
- If there has been a precipitous change in orientation, this could signal a critical medical condition such as delirium.
- **Screens: MMSE, MoCA, SLUMS**

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Orientation

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- Mostly tests recent and longer-term memory
- Response is also influenced by level of alertness, attentiveness, and language capabilities.
- If there has been a precipitous change in orientation, this could signal a critical medical condition such as delirium.
- **Screens: MMSE, MoCA, SLUMS**

SLIDE 31

Cognitive Domains: Attention

- Nonspecific abnormalities that can occur in
 - Focal brain lesions,
 - Diffuse abnormalities such as dementia or encephalitis, and in behavioral or mood disorders.
 - Impaired attention is also one of the hallmarks of delirium.
- **Screens: MMSE-registration, serial 7s; digit repetition; MoCA-digits, letter vigilance; Trails A etc.**

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Attention

- Nonspecific abnormalities that can occur in
 - Focal brain lesions,
 - Diffuse abnormalities such as dementia or encephalitis, and in behavioral or mood disorders.
 - Impaired attention is also one of the hallmarks of delirium.
 -
- **Screens (e.g.): MMSE-registration, serial 7s; digit repetition; MoCA-digits, letter vigilance; Trails A etc.**

SLIDE 32

Cognitive Domains: Memory

- **Immediate memory:** recall of a memory trace after an interval of a few seconds, as in repetition of a series of digits.
- **Recent memory:** ability to learn new material and to retrieve that material after an interval of minutes, hours or days. (e.g. word lists)
- **Remote memory:** recall of events that occurred prior to the onset of the recent memory defect. Note: this cannot be reliably tested unless you have verifiable information.
- **Screens:** MMSE- registration, 3-item delayed recall; MoCA- registration, 3-item delayed recall etc.

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Memory

- ***Immediate memory: recall of a memory trace after an interval of a few seconds,*** as in repetition of a series of digits.
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- **Screens (e.g.): MMSE- registration, 3-item delayed recall; MoCA- registration, 3-item delayed recall etc.**

SLIDE 33

Cognitive Domains: Language

- **Verbal Fluency.** Refers to the ability to produce spontaneous speech fluently without undue word-finding pauses or failures in word searching. Normal speech requires verbal fluency in the production of responses and the formulation of spontaneous conversational speech.
- **Comprehension-** Commands (MMSE fold paper; SLUMS paragraph etc.), general ability to follow directions on exams
- **Naming-** MMSE watch, pen; MoCA camel etc.
- **Repetition-** MMSE sentences
- **Reading/Writing-** MMSE write a sentence

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Language

- Verbal Fluency. This refers to the ability to produce spontaneous speech fluently without undue word-finding pauses or failures in word searching. Normal speech requires verbal fluency in the production of responses and the formulation of spontaneous conversational speech.
- Comprehension- Commands (MMSE fold paper; SLUMS paragraph etc.), general ability to follow directions on exams
- Naming- (MMSE watch, pen; MoCA camel etc)
- Repetition- MMSE sentences
- Reading/Writing- MMSE write a sentence

SLIDE 34

Cognitive Domains: Visual-Spatial Organization

- Very sensitive to brain dysfunction- can pick up mild delirium and otherwise silent lesions.
- In a person’s history, listen for getting lost in previously familiar environments, difficulty estimating distance or difficulty orienting objects to complete a task.
- A sensitive indicator of delirium and can occur in any dementia syndrome; it often occurs early in the course of Alzheimer’s disease.
- **Screens: Clock drawing; Clox; overlapping pentagons, etc.**

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Visual-Spatial Organization

- Very sensitive to brain dysfunction- can pick up mild delirium and otherwise silent lesions.
- In a person’s history, listen for getting lost in previously familiar environments, difficulty estimating distance or difficulty orienting objects to complete a task.
- Visuospatial disturbance is a sensitive indicator of delirium and can occur in any dementia syndrome; it often occurs early in the course of Alzheimer’s disease
- **Screens (e.g.): Clock drawing; Clox; overlapping pentagons etc.**

SLIDE 35

Cognitive Domains: Executive Functioning

- Constellation of cognitive skills necessary for complex goal-directed behavior and adaptation to a range of environmental changes and demands.
- Includes planning strategies to accomplish tasks, implementing and adjusting strategies, monitoring performance, recognizing patterns, and appreciating time sequences.
- Deficits associated with disruptive behaviors and self-care limitations among patients with Alzheimer’s disease.
- **Screens: Clock drawing; Clox; verbal fluency tasks (category and letter); EXIT-25**

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: Executive Functioning

- Constellation of cognitive skills necessary for complex goal-directed behavior and adaptation to a range of environmental changes and demands.
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- Deficits associated with disruptive behaviors and self-care limitations among patients with Alzheimer’s disease.
- **Screens: Clock drawing; Clox; verbal fluency tasks (category and letter); EXIT-25**

SLIDE 36

MMSE (Mini Mental State Exam)


Advantages

- Well-known
- Huge normative data with age and education norms
- Translations for all languages we need
- Correct administration directions printed
- Quick, easy

Disadvantages

- Copyright issues
- Low ceiling, misses mild cognitive impairment
- Often incorrectly administered and interpreted

“Spell world Backwards”



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

TOPIC: The Folstein MMSE

Advantages:

- ◆ Well known and used by many APS programs as well as by psychiatrists and physicians as part of the court report for guardianship. In California the mini mental is not accepted by probate court, but it can still be helpful in worker’s assessment.
- ◆ Large normative data with age and education norms
- ◆ Translated into many languages
- ◆ Quick and easy to administer

Disadvantages:

- ◆ Does not address the client’s decision-making skills for specific tasks. Knowing the date or how to count backwards from 100 is not relevant when the client needs to make a decision regarding medical treatment.
- ◆ It also does not:
 - Elicit the person’s desires, wishes, or fears,
 - Detect mild dementia or degrees of far advanced cognitive disorders,
- ◆ The results are influenced by the client’s personal characteristics and experiences such as educational background, occupational status, cultural background, and other variables.
- ◆ Can be incorrectly administered and interpreted, particularly if cutoff scores are used and particularly if person has low literacy etc.

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- ◆ Copyrighted - if using official form and buying in bulk, each protocol would cost \$1.12. Copy right is owned by Psychological Assessment Resources (PAR)



ASK: if participants use the mini mental on a regular bases and their experience using it.

TRAINER NOTE: If you have access to the MMSE or similar tool, please share as an example. Due to copyright issues we were not able to provide a sample handout for this training

SLIDE 37

SLUMS
(St. Louis University Mental Status Examination)


Advantages

- Free
- Simple Directions/Administration
- Good coverage of domains
- Integrates clock drawing
- Has education corrected norms

Disadvantages

- Language translations in development
- Some stimuli very small,
- Would require staff-retraining
- Outside providers less familiar

"Draw a clock"



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

HANDOUT #7:
SLUMS Exam
Participant manual pg 43

TOPIC: SLUMS

Refer participants to **Handout #7** as you briefly review the tool.

Advantages:

- ◆ Free
- ◆ Simple Directions/Administration
- ◆ Good coverage of cognitive domains and integrates clock drawing
- ◆ Has education corrected norms

Disadvantages:

- ◆ No language translations as far as we know
- ◆ Some stimuli very small, would need to investigate if the single page is really used and/or if we need to develop other stimuli
- ◆ Would require staff-retraining
- ◆ Outside providers unfamiliar (except at VA where this was developed)

HANDOUT #7

Saint Louis University Mental Status (SLUMS) Examination

1. What day of the week is it? (1 point for the right answer)
2. What is the year? (1 point)
3. What state are we in? (1 point)
4. Please remember these five objects. I will ask you what they are later: apple, pen, tie, house, car. (No points yet)
5. You have \$100 and you go to the store and buy a dozen apples for \$3 and a tricycle for \$20.
 - How much did you spend? (1 point)
 - How much do you have left? (2 points)
6. Please name as many animals as you can in one minute. (No point for naming 0-4; 1 point for naming 5-9; 2 points for naming 10-14; and 3 points for naming 15 or more.)
7. What were the five objects I asked you to remember? (1 point for each object remembered.)
8. I am going to say a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
 - 87 (0 points)
 - 649 (1 point)
 - 8537 (1 point)
9. (Draw circle.) This circle represents a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
 - (2 points for hour markers labeled correctly)
 - (2 points for correct time)
10. (Show a triangle, a square and a rectangle.) Please place an X in the triangle. (1 point)
11. Which of those objects is the largest? (1 point)
12. I am going to tell you a story. Please listen carefully because afterward, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money in the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped working and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

- What was the female's name? (2 points)
- When did she go back to work? (2 points)
- What work did she do? (2 points)
- What state did she live in? (2 points)
-

SCORING: High school education: Normal: 27-30; Mild neurocognitive disorder: 21-26; Dementia: 1-20.
Less than high school education: Normal: 25-30; Mild neurocognitive disorder: 20-24; Dementia: 1-19.

Slide 38

MoCA (Montreal Cognitive Assessment)


Advantages

- Free
- Translations in many languages
- More sensitive than MMSE
- Interest in tool increasing

Disadvantages

- Takes longer than MMSE
- More complicated to administer than MMSE
- Some directions not printed on form
- No clear age and education norms
- Relatively small normative data
- Some stimuli very small
- Outside providers less familiar

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas



"Name the animals"

HANDOUT #8:
MoCA
Participant manual pg 45

TOPIC: MoCA

Refer participants to **Handout #8** as you briefly review the tool.

Advantages:

- ◆ Free
- ◆ Translations in many languages)
- ◆ More sensitive than MMSE to detect mild cognitive impairment- higher ceiling than MMSE- integrates clock
- ◆ Seems to be a lot of research interest in this tool, Kaiser has adopted it

Disadvantages:

- ◆ Takes longer than MMSE
- ◆ More complicated to administer than MMSE
- ◆ Some directions not printed on form- could lead to more administration errors-
- ◆ No clear age and education corrected norms immediately obvious
- ◆ Relatively small normative data
- ◆ Some stimuli very small, would need to investigate if the single page is really used and/or if we need to develop other stimuli
- ◆ Outside providers unfamiliar

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT #8

MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME :
Education :
Sex :

Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE							POINTS	
	<p>Copy cube</p>	Draw CLOCK (Ten past eleven) (3 points)						
[]	[]	[]	[]	[]	[]	___/5		
NAMING								
							___/3	
[]	[]	[]						
MEMORY	Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.	FACE	VELVET	CHURCH	DAISY	RED	No points	
	1st trial							
	2nd trial							
ATTENTION	Read list of digits (1 digit/ sec.).	Subject has to repeat them in the forward order [] 2 1 8 5 4						
		Subject has to repeat them in the backward order [] 7 4 2					___/2	
	Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors	[] FBACMNAAJKLBAFAKDEAAAJAMOF AAB					___/1	
	Serial 7 subtraction starting at 100	[] 93	[] 86	[] 79	[] 72	[] 65	___/3	
		4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt						
LANGUAGE	Repeat : I only know that John is the one to help today. [] The cat always hid under the couch when dogs were in the room. []						___/2	
	Fluency / Name maximum number of words in one minute that begin with the letter F	[] _____ (N ≥ 11 words)					___/1	
ABSTRACTION	Similarity between e.g. banana - orange = fruit	[]	train - bicycle	[]	watch - ruler			___/2
DELAYED RECALL	Has to recall words WITH NO CUE	FACE []	VELVET []	CHURCH []	DAISY []	RED []	Points for UNCUED recall only	___/5
Optional	Category cue							
	Multiple choice cue							
ORIENTATION	[] Date	[] Month	[] Year	[] Day	[] Place	[] City	___/6	
© Z.Nasreddine MD Version 7.1		www.mocatest.org		Normal ≥ 26 / 30		TOTAL ___/30		
Administered by: _____		Add 1 point if ≤ 12 yr edu						

ASSESSING CAPACITY – TRAINER’S MANUAL

Montreal Cognitive Assessment (MoCA)

Administration and Scoring Instructions

The Montreal Cognitive Assessment (MoCA) was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. Time to administer the MoCA is approximately 10 minutes. The total possible score is 30 points; a score of 26 or above is considered normal.

1. **Alternating Trail Making:**

Administration: The examiner instructs the subject: *"Please draw a line, going from a number to a letter in ascending order. Begin here [point to (1)] and draw a line from 1 then to A then to 2 and so on. End here [point to (E)]."*

Scoring: Allocate one point if the subject successfully draws the following pattern: 1 –A- 2- B- 3- C- 4- D- 5- E, without drawing any lines that cross. Any error that is not immediately self-corrected earns a score of 0.

2. **Visuoconstructional Skills (Cube):**

Administration: The examiner gives the following instructions, pointing to the cube: *"Copy this drawing as accurately as you can, in the space below".*

Scoring: One point is allocated for a correctly executed drawing.

- Drawing must be three-dimensional
- All lines are drawn
- No line is added
- Lines are relatively parallel and their length is similar (rectangular prisms are accepted)

A point is not assigned if any of the above-criteria are not met.

3. **Visuoconstructional Skills (Clock):**

Administration: Indicate the right third of the space and give the following instructions: *"Draw a clock. Put in all the numbers and set the time to 10 after 11".*

Scoring: One point is allocated for each of the following three criteria:

- Contour (1 pt.): the clock face must be a circle with only minor distortion acceptable (e.g., slight imperfection on closing the circle);
- Numbers (1 pt.): all clock numbers must be present with no additional numbers; numbers must be in the correct order and placed in the approximate quadrants on the clock face; Roman numerals are acceptable; numbers can be placed outside the circle contour;
- Hands (1 pt.): there must be two hands jointly indicating the correct time; the hour hand must be clearly shorter than the minute hand; hands must be centred within the clock face with their junction close to the clock centre.

A point is not assigned for a given element if any of the above-criteria are not met.

ASSESSING CAPACITY – TRAINER’S MANUAL

4. **Naming:**

Administration: Beginning on the left, point to each figure and say: “Tell me the name of this animal”.

Scoring: One point each is given for the following responses: (1) camel or dromedary, (2) lion, (3) rhinoceros or rhino.

5. **Memory:**

Administration: The examiner reads a list of 5 words at a rate of one per second, giving the following instructions: “This is a memory test. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn’t matter in what order you say them”. Mark a check in the allocated space for each word the subject produces on this first trial. When the subject indicates that (s)he has finished (has recalled all words), or can recall no more words, read the list a second time with the following instructions: “I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time.” Put a check in the allocated space for each word the subject recalls after the second trial.

At the end of the second trial, inform the subject that (s)he will be asked to recall these words again by saying, “I will ask you to recall those words again at the end of the test.”

Scoring: No points are given for Trials One and Two.

6. **Attention:**

Forward Digit Span: Administration: Give the following instruction: “I am going to say some numbers and when I am through, repeat them to me exactly as I said them”. Read the five number sequence at a rate of one digit per second.

Backward Digit Span: Administration: Give the following instruction: “Now I am going to say some more numbers, but when I am through you must repeat them to me in the backwards order.” Read the three number sequence at a rate of one digit per second.

Scoring: Allocate one point for each sequence correctly repeated, (N.B.: the correct response for the backwards trial is 2-4-7).

Vigilance: Administration: The examiner reads the list of letters at a rate of one per second, after giving the following instruction: “I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand”.

Scoring: Give one point if there is zero to one errors (an error is a tap on a wrong letter or a failure to tap on letter A).

ASSESSING CAPACITY – TRAINER’S MANUAL

Serial 7s: Administration: The examiner gives the following instruction: “Now, I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop.” Give this instruction twice if necessary.

Scoring: This item is scored out of 3 points. Give no (0) points for no correct subtractions, 1 point for one correction subtraction, 2 points for two-to-three correct subtractions, and 3 points if the participant successfully makes four or five correct subtractions. Count each correct subtraction of 7 beginning at 100. Each subtraction is evaluated independently; that is, if the participant responds with an incorrect number but continues to correctly subtract 7 from it, give a point for each correct subtraction. For example, a participant may respond “92 – 85 – 78 – 71 – 64” where the “92” is incorrect, but all subsequent numbers are subtracted correctly. This is one error and the item would be given a score of 3.

7. **Sentence repetition:**

Administration: The examiner gives the following instructions: “I am going to read you a sentence. Repeat it after me, exactly as I say it [pause]: *I only know that John is the one to help today.*” Following the response, say: “Now I am going to read you another sentence. Repeat it after me, exactly as I say it [pause]: *The cat always hid under the couch when dogs were in the room.*”

Scoring: Allocate 1 point for each sentence correctly repeated. Repetition must be exact. Be alert for errors that are omissions (e.g., omitting “only”, “always”) and substitutions/additions (e.g., “John is the one who helped today;” substituting “hides” for “hid”, altering plurals, etc.).

8. **Verbal fluency:**

Administration: The examiner gives the following instruction: “Tell me as many words as you can think of that begin with a certain letter of the alphabet that I will tell you in a moment. You can say any kind of word you want, except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix, for example, love, lover, loving. I will tell you to stop after one minute. Are you ready? [Pause] Now, tell me as many words as you can think of that begin with the letter F. [time for 60 sec]. Stop.”

Scoring: Allocate one point if the subject generates 11 words or more in 60 sec. Record the subject’s response in the bottom or side margins.

9. **Abstraction:**

Administration: The examiner asks the subject to explain what each pair of words has in common, starting with the example: “Tell me how an orange and a banana are alike”. If the subject answers in a concrete manner, then say only one additional time: “Tell me another way in which those items are alike”. If the subject does not give the appropriate response (fruit), say, “Yes, and they are also both fruit.” Do not give any additional instructions or clarification.

After the practice trial, say: “Now, tell me how a train and a bicycle are alike”. Following the response, administer the second trial, saying: “Now tell me how a ruler and a watch are alike”. Do not give any additional instructions or prompts.

ASSESSING CAPACITY – TRAINER’S MANUAL

Scoring: Only the last two item pairs are scored. Give 1 point to each item pair correctly answered. The following responses are acceptable:

Train-bicycle = means of transportation, means of travelling, you take trips in both;

Ruler-watch = measuring instruments, used to measure.

The following responses are **not** acceptable: Train-bicycle = they have wheels; Ruler-watch = they have numbers.

10. **Delayed recall:**

Administration: The examiner gives the following instruction: “I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember. Make a check mark (✓) for each of the words correctly recalled spontaneously without any cues, in the allocated space.

Scoring: Allocate 1 point for each word recalled freely without any cues.

Optional:

Following the delayed free recall trial, prompt the subject with the semantic category cue provided below for any word not recalled. Make a check mark (✓) in the allocated space if the subject remembered the word with the help of a category or multiple-choice cue. Prompt all non-recalled words in this manner. If the subject does not recall the word after the category cue, give him/her a multiple choice trial, using the following example instruction, “Which of the following words do you think it was, NOSE, FACE, or HAND?”

Use the following category and/or multiple-choice cues for each word, when appropriate:

FACE: category cue: part of the body multiple choice: nose, face, hand

VELVET: category cue: type of fabric multiple choice: denim, cotton, velvet

CHURCH: category cue: type of building multiple choice: church, school, hospital

DAISY: category cue: type of flower multiple choice: rose, daisy, tulip

RED: category cue: a colour multiple choice: red, blue, green

Scoring: No points are allocated for words recalled with a cue. A cue is used for clinical information purposes only and can give the test interpreter additional information about the type of memory disorder. For memory deficits due to retrieval failures, performance can be improved with a cue. For memory deficits due to encoding failures, performance does not improve with a cue.

11. **Orientation:**

Administration: The examiner gives the following instructions: “Tell me the date today”. If the subject does not give a complete answer, then prompt accordingly by saying: “Tell me the [year, month, exact date, and day of the week].” Then say: “Now, tell me the name of this place, and which city it is in.”

Scoring: Give one point for each item correctly answered. The subject must tell the exact date and the exact place (name of hospital, clinic, office). No points are allocated if subject makes an error of one day for the day and date.

TOTAL SCORE: Sum all subscores listed on the right-hand side. Add one point for an individual who has 12 years or fewer of formal education, for a possible maximum of 30 points. A final total score of 26 and above is considered normal.

ASSESSING CAPACITY – TRAINER’S MANUAL

Monday, October 5th, 2009

MoCA scores			
	Normal Controls (NC)	Mild Cognitive Impairment (MCI)	Alzheimer’s Disease (AD)
Number of subjects	90	94	93
MoCA average score	27.4	22.1	16.2
MoCA standard deviation	2.2	3.1	4.8
MoCA score range	25.2 - 29.6	19.0 – 25.2	21.0 – 11.4
Suggested cut-off score	≥26	<26	<26^ψ
<p>ψ Although the average MoCA score for the AD group is much lower than the MCI group, there is overlap between them. The suggested MoCA cut-off score is thus the same for both. The distinction between AD and MCI is mostly dependent on the presence of associated functional impairment and not on a specific score on the MoCA test.</p>			

Sensitivity and Specificity (%) MoCA and MMSE			
Cut-off	≥ 26	< 26	< 26
Group	Normal Controls	Mild Cognitive Impairment	Alzheimer Disease
(n)	(90)	(94)	(93)
MoCA	87	90	100
MMSE	100	18	78

MoCA Items Average scores

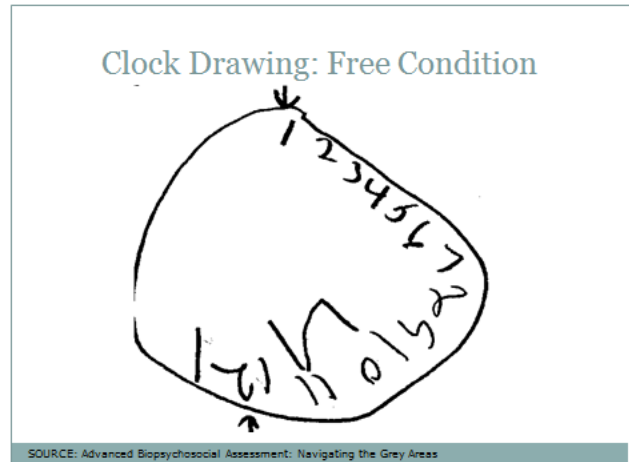
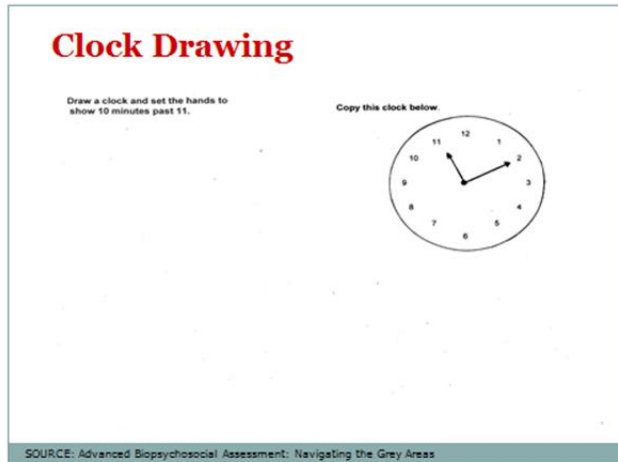
	NC		MCI		AD	
	AVG	SD	AVG	SD	AVG	SD
Trails	0.87	0.34	0.56	0.50	0.27	0.45
Cube	0.71	0.46	0.46	0.50	0.25	0.43
Clock	2.65	0.65	2.16	0.82	1.56	0.98
Naming	2.88	0.36	2.64	0.58	2.19	0.82
Memory	3.73	1.27	1.17	1.47	0.52	1.03
Digit span	1.82	0.44	1.83	0.43	1.49	0.62
Letter A	0.97	0.18	0.93	0.26	0.67	0.47
Serial 7	2.89	0.41	2.65	0.65	1.82	1.12
Sentence rep	1.83	0.37	1.49	0.71	1.37	0.80
Fluency F	0.87	0.34	0.71	0.45	0.32	0.47
Abstraction	1.83	0.43	1.43	0.68	0.99	0.80
Orientation	5.99	0.11	5.52	0.84	3.92	1.73
Total*	27.37	2.20	22.12	3.11	16.16	4.81

SD=Standard Deviation. AVG=Average

*Total is adjusted for education

Nasreddine et al. *J Am Geriatr Soc* 53:695–699, 2005.

SLIDE 39 & 40



HANDOUT #9:
Clock Drawing Test
Participant manual pg 53

TOPIC: Clock drawing test

- ◆ The clock has been proposed as a quick screening test for cognitive dysfunction secondary to dementia, delirium, or a range of neurological and psychiatric illnesses.
- ◆ Clock errors may be divided into categories including visuo-spatial, perseveration, grossly disorganized.
- ◆ Common errors in Alzheimer's disease include perseveration, counter-clockwise numbering, absence of numbers and irrelevant spatial arrangement.
- ◆ Test results can provide information on general cognitive functioning such as memory, information processing, and vision. It can also offer clues about the area of change or damage (i.e. brain change and/or damage).
- ◆ Scoring is relatively easy:
 - ◆ 1 point for the clock circle
 - ◆ 1 point for all the numbers being in the correct order
 - ◆ 1 point for the numbers being in the proper special order 1 point for the two hands of the clock
 - ◆ 1 point for the correct time.

A normal score is four or five points.

HANDOUT #9 - Clock Drawing Test

This is a simple test that can be used as a part of a neurological test or as a screening tool for Alzheimer's and other types of dementia.

The person undergoing testing is asked to:

1. Draw a clock
2. Put in all the numbers
3. Set the hands at ten past eleven.

Scoring system for Clock Drawing test (CDT)

There are a number of scoring systems for this test. The Alzheimer's disease cooperative scoring system is based on a score of five points:

- 1 point for the clock circle
- 1 point for all the numbers being in the correct order
- 1 point for the numbers being in the proper special order
- 1 point for the two hands of the clock
- 1 point for the correct time.

A normal score is four or five points.

Test results

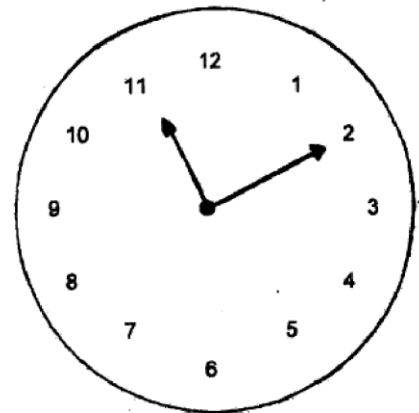
The test can provide information about general cognitive and adaptive functioning such as memory, how people are able to process information and vision. A normal clock drawing almost always predicts that a person's cognitive abilities are within normal limits.

The Clock Drawing Test does offer specific clues about the area of change or damage.

Research varies on the ability of the Clock Drawing test to differentiate between, for example, vascular dementia and Alzheimer's disease.

Draw a clock and set the hands to show 10 minutes past 11.

Copy this clock below.



SLIDE 41

PARADISE-2

- Questions on 16 behaviors and cognitive functions
- May be used by non-medical professionals
- Questions correspond to brain functions.
- Interpretation is subjective.

Source: Blum 2006

**HANDOUT #10:
Paradise – 2:
Model of Mental Capacity
Participant manual pg 55**

**HANDOUT #11:
Paradise - 2:
Summary of use
Participant manual
pg 56**

TOPIC: PARADISE- 2

Refer participants to **Handout #7** as you briefly review the tool.

- ◆ Paradise-2 test was developed by Bennett Blum. It asks questions about 16 behaviors and cognitive functions that correspond to certain brain functions.
- ◆ Non-medical professionals can get some indication of the person’s capacity because of the way behavior is connected to capacity.
- ◆ The tool is described in **Handouts #10 and #11**.

Here is an example of a very common behavior of seniors who may have capacity issues – wandering, The following example was offered by Bennett Blum.



Why is wandering important?

- ◆ Suppose you heard that Mrs. Jones regularly took random walks in the neighborhood and then came home? No worry.

“Wandering” means leaving point A and not knowing how to return.



Around what age does a child come up with strategies to find a way home?

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL

- ◆ Usually the child is 4-5 years old. Therefore the wandering older person no longer has the comparable strategic ability of a 4-5 year old.

That person has lost the ability to figure out what to do with the information...such as finances. That behavior tells you a lot about the potential capacity of the individual.

- ◆ As you see, however, the interpretation of the answers is still subjective,

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT #10: PARADISE-2 Model of Mental Capacity

Past behavior	Pertinent parties
Abstract concepts	Alertness
Remember information	Responsibilities
Alternatives – considered	Attention
Delusions	Decision making abilities
Illness	Impact
Strategic thinking	Significance
Emotional factors	Express desires

Questions to Consider

1. How does the current behavior compare with past behavior?
2. Did the person understand the abstract concepts (ex. what is a will, avoiding detection and capture)?
3. Are there concerns about memory?
4. Are/were alternatives known and considered?
5. Were the decisions free from delusions?
6. What were the effects of co-existing illness, medications, toxic substances, etc.?
7. Did the person engage in or display strategic thinking and analysis?
8. What were the relevant emotional factors affecting the decision, if any?
9. Did the person know the pertinent parties?
10. Were there concerns about the person's degree of alertness (i.e. consciousness) or attention when information was presented, or when executing the decision?
11. Did the person know his/her responsibilities and the responsibilities of the other involved parties?
12. Did the person have difficulty making or maintaining decisions?
13. Did the person understand the impact of the decision (i.e. the likely objective outcome) or behavior?
14. What is the significance of the decision (i.e. the subjective evaluation of the likely outcome)?
15. Did the person have difficulties expressing desires?

Source: Blum. 2002-2006.

Bennett Blum, MD gave permission for NAPSA to use this tool in Module #17 on 10/19/07

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT # 11: PARADISE-2: Summary of Use

PARADISE-2 is a review of 16 behaviors and cognitive functions. Each component is described in lay terms, and so may be assessed by non-medical professionals; however, each also corresponds to well-known brain functions. The 16 components are listed below:

PARADISE-2 Protocol of Functional Mental Capacity

P ast behavior	P ertinent parties
A bstract concepts	A lertness - problems
R emember information	R esponsibilities
A lternatives – considered	A ttention - problems
D elusions	D ecision making abilities
I llness	I mpact
S trategic thinking	S ignificance
E mootional factors	E xpress desires

Evaluation is performed for each decision, or period of time, in question. After obtaining information from sources (ideally, from multiple sources), list which of these abilities fall under the headings “clear impairment,” “no impairment,” “conflicting information,” or “insufficient information.” When completed, PARADISE-2 provides a detailed behavioral description that clarifies matters in legal settings, and may be used to guide further medical evaluation. This analysis requires significantly more information and time than is usually available in outpatient settings; however, US and international courts have found this method to be of greater assistance than traditional medical assessments.

PARADISE-2 is used internationally, and is the partial basis for new international legal precedent and standard for evaluating certain types of competency.

Source: Blum. 2002,2005,2006

Bennett Blum, MD gave permission for NAPSA to use this tool in Module #17 on 10/19/07

SLIDE 42

Clinical Professionals Qualified to Evaluate Capacity

- ▶ Geriatricians, geriatric psychiatrists
- ▶ Neurologists
- ▶ Neuropsychologists
- ▶ Nurses
- ▶ Occupational therapists
- ▶ Physicians
- ▶ Psychiatrists
- ▶ Psychologists
- ▶ Licensed social workers

Source: American Bar Association & American Psychological Association 2005

Slide 42

**HANDOUT #12:
Clinical Professionals
Participant manual pg 58**

TOPIC: Clinical professionals



Has anyone here used the MMSE, SLUMS, MoCA, PARADISE-2? Or other tests to screen their clients’ decisional capacity? What was your experience with these tests?

The key concept here is that NO tool works for all purposes in all situations!

There are limitations to every test of capacity. Unless you are a licensed physician or mental health specialist, you are not professionally qualified to conduct a professional evaluation.

- ◆ Handout #12 has is a list **of** clinical professionals who are qualified to conduct evaluations with descriptions of their training.
 - Geriatricians, geriatric psychiatrists, geropsychologists.
 - Neurologists
 - Neuropsychologists
 - Nurses
 - Occupational therapists
 - Physicians
 - Psychiatrists
 - Psychologists
 - Licensed social workers
- ◆ Find out who in your agency, community, or your area, is qualified to conduct evaluations.
- ◆ Work with your supervisor or administrator to work out a protocol for referrals.

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT #12: Clinical Professionals

A clinician is a general term for a healthcare professional who works with patients. A wide range of clinicians may bring expertise to the capacity evaluation process. *The information provided on this page is meant to highlight some of the strengths that varied professionals may bring to the capacity evaluation practice. It is not meant to define or limit the absolute, necessary, or full scope of practice for these professionals, but rather to highlight some potential strengths each discipline may bring to the capacity evaluation process.*

Geriatricians, Geriatric Psychiatrists, or Geropsychologists, practitioners with specialized training in aging, are experienced in considering the multiple medical, social, and psychological factors that may impact an older adult’s functioning. A geriatric assessment team is comprised of multiple disciplines, each with advanced training in syndromes of aging.

Neurologists, M.D.’s with specialized training in brain function, may address how specific neurological conditions (e.g., dementia) are affecting the individual and his/her capacity.

Neuropsychologists, psychologists with specialized training in cognitive testing, may address relationships between neurological conditions, cognitive tests results, and an individual’s functional abilities.

Nurses have medical expertise and some, such as visiting nurses in Area Agencies on Aging, may have in-depth information on how a person’s medical condition is impacting functioning in the home. Geriatric nurse practitioners are advanced practice nurses with additional credentials to assess and treat the medical problems of aging.

Occupational Therapists are professionals with advanced degrees specializing in the assessment of an individual’s functioning on everyday tasks, such as eating, meal preparation, bill paying, cleaning, and shopping.

Physicians, (primary care clinicians or internists) can provide a summary of the individual’s major medical conditions. In some cases, the physician may have provided care to the individual over many years and can provide a historical perspective on the individual’s functioning (although this cannot be assumed).

Psychiatrists, M.D.’s with specialized training in mental health, may address how specific psychiatric conditions (e.g., schizophrenia) and related emotional/mental systems may be affecting the individual and his/her capacity. Geropsychiatrists receive additional training in problems of aging; forensic psychiatrists receive additional training in mental health and the law.

Psychologists, clinicians with advanced training in behavioral health, may utilize standardized testing and in-depth assessment, useful when the judge wants detailed information about areas of cognitive or behavioral strengths or weaknesses. Geropsychologists receive additional training in problems of aging; forensic psychologists receive additional training in mental health and the law.

Licensed social workers, are trained to consider the multiple determinants on an individual’s social functioning, and are often knowledgeable about a wide range of social and community services that may assist the individual.

Source: American Bar Association Commission on Law and Aging and American Psychological Association. 2005.

CAPACITY SCREENING SKILLS




TIME ALLOTTED: 30 minutes

SLIDE 43

Capacity Assessment Skills

- Do your homework:
know your client
 - Educational level
 - Language issues
 - Cultural factors
- Set the stage
- Join with client
- Be prepared for responses



TOPIC: Capacity Assessment Skills



Ask what information it would be important to know about their clients in order to do an accurate assessment.

- ◆ Mention the importance of knowing client’s educational level as well as language ability – as these factors may influence the results of any tools they may use.
- ◆ Discuss how they deal with language barriers (including sign language)- how and if they use interpreters, what are the advantages and disadvantages.

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL



Ask about cultural/ethnic diversity in their caseloads and challenges they have had when interviewing diverse clients.

- ◆ Cultural diversity is a topic for a full day training. What is important is to be sensitive, to ask questions, not to jump to conclusions, not to impose your own cultural values on to the client.
- ◆ Cultural factors are difficult to describe. We may be told how certain cultures react under certain circumstances, but that may lead to stereotyping. We can learn generalities, but there are differences within cultures that have to do with level of acculturation, language, racism.
- ◆ Family values add another dimension. The challenge for intervention is when the client is at severe risk due to a cultural belief –how far do we address it and how far do we go- this will be covered in the coming modules.
- ◆ Try and learn the client’s value framework and usual standards of behavior. This will help determine if she/he is acting out of character or if the behavior is consistent with past history.



Ask how participants set the stage for an interview with a client or alleged perpetrator

- ◆ Setting the stage for the interview is important so that the client feels safe and comfortable. A quiet place with good lighting, avoiding glare, is recommended. It is important to be sensitive to any hearing or vision impairments.
- ◆ This process takes patience and perseverance as client may have difficulty concentrating or become anxious.
- ◆ More than one visit will probably be necessary. Starting with general topics and weaving questions into a conversation is less threatening. Breaking down questions or concepts, using large print, using simple language are all helpful in doing the assessment interview with disabled or cognitively impaired individuals.

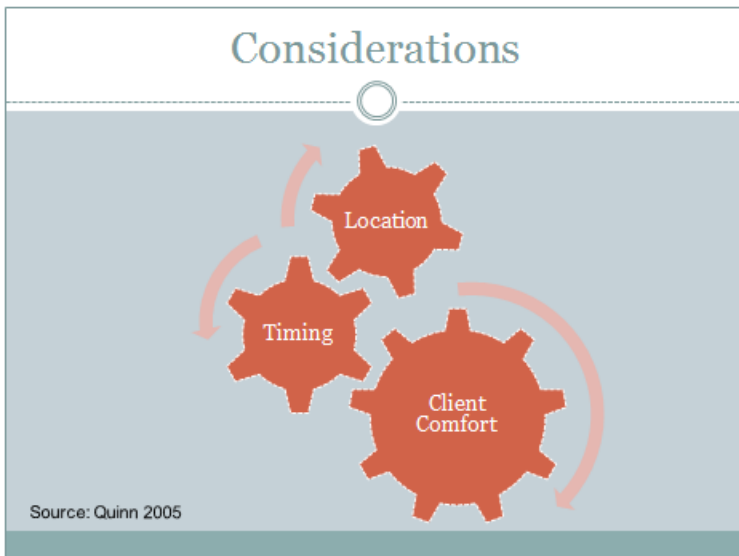
CONTINUE



Ask about their experience assessing cognitively impaired clients – what are some of the challenges.

- ◆ Sometimes cognitively impaired clients will respond by confabulating (making up stories to cover up memory deficits), changing the subject, using charm as a diversion, ignoring the question, telling the same story over and over, or even refusing to answer, becoming angry and terminating the interview.

SLIDE 44



TOPIC: Interview considerations

Before your initial interview with a client, take time to think about the significance of this first contact. Based on the information the client provides, you will be making decisions that may have a lasting impact on this person’s life.

- ◆ Think about the **location**.
 - If there will be other people present, including the possible perpetrator, how will you assure that you speak with the client privately?
- ◆ Think about when would be the best **time** to meet with the client.
 - From the intake information you received, do you know if the client thinks more clearly at a certain time of day?
 - How much time should you spend with the client on this first visit?
 - If possible, would you be able to schedule a series of short visits so that you have time to build rapport with the client, and to prevent him/her from getting tired?
- ◆ When you reach the interview site, take some time to make sure that the client is as **comfortable** as possible.
 - Is the room too warm or too cold?
 - Is there background noise that is making conversation difficult?

CONTINUE

ASSESSING CAPACITY – TRAINER’S MANUAL


- Is it too dark for the client to be able to see you, or is there too much light in the client’s face?
- Does the client need a drink of water, or perhaps some food, before the interview?
- Do you know if he/she has taken any medication, and if so, which ones?
- Is the client sitting in a comfortable chair?

Paying attention to details like these can make the difference between a successful interview and one that goes nowhere.

SLIDE 45

Framing the Questions

- ▶ Assessing the client’s ability to:
 - ▶ Understand and follow instructions;
 - ▶ Understand risks and benefits;
 - ▶ Make and execute a plan.
- ▶ Ask questions that focus on:
 - ▶ The client’s understanding of relevant information.
 - ▶ The quality of the client’s thinking process.
 - ▶ The client’s ability to demonstrate and communicate a choice.
 - ▶ The client’s understanding of his/her own situation.



**HANDOUT #13:
Framing the questions
Participant manual pg 61**

TOPIC: Framing the Questions

- ◆ Asking questions that provide information on the client’s ability to make informed decisions is a complex task. Each client in each situation needs to be approached differently.
- ◆ Remember that you will be assessing the client’s ability to:
 - Understand and follow instructions;
 - Understand risks and benefits;
 - Make and execute a plan.
- ◆ Remember that the purpose of your interview is to learn as much as you can about the client’s **decision-making process**. That means:
 - The client’s understanding of relevant information.
 - The quality of the client’s thinking process.
 - The client’s ability to demonstrate and communicate a choice.
 - The client’s understanding of his/her own situation.

CONTINUE

ASSESSING CAPACITY – TRAINER’S MANUAL

Notice that these are the same as the components of capacity assessment listed on slide #26. However, here we have replaced “appreciate” with “understanding of his/her personal situation.”

- ◆ The purpose of this interview is **not** to investigate the abuse, neglect or exploitation allegations, although information pertaining to possible mistreatment may come to light during the interview.
- ◆ For this interview, every question you ask must provide additional information about the client’s ability to make informed decisions. This is not an easy task.
- ◆ Stay focused and try to be as clear and specific as possible.
- ◆ Refer participants to Handout #13 and review



Can you give me some open-ended questions that might be asked to get more information about each component?

NOTE: As questions are suggested, ask the group to evaluate each response with the following questions:

1. *Does this response get at the information needed for one of the four components?*
2. *If so, could the question be framed more effectively?*

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT # 13: Framing the Questions

BEFORE YOU ASK:

- ◆ Collect as much collateral information as possible about the client.
- ◆ Make sure the client is in a comfortable, safe setting.
- ◆ Know the limits of your own expertise.
- ◆ Develop questions that encourage the client to talk about the specific (alleged) situation.
- ◆ During your time with the client, assess the client’s ability to:
 - Understand and follow instructions.
 - Understand risks and benefits.
 - Make and execute a plan.

SETTING THE SCENE FOR THE INTERVIEW:

- ◆ Conduct the interview in a quiet, private location.
- ◆ Make sure that the client is not facing towards a glaring light.
- ◆ Make sure that your (the interviewer’s) face is well lit.
- ◆ Take time at the beginning and end of the interview to make social conversation before asking difficult questions.
- ◆ Don’t rush the interview.
- ◆ Check frequently to make sure that the client is comfortable. Does he/she need a glass of water? Is the room warm/cool enough? Is he/she getting tired?

DO NOT:

- ◆ Assume that a person with physical disabilities, including one who is non-verbal, lacks mental capacity.
- ◆ Ask questions that can be answered “Yes” or “No” such as
 - “Are you OK”
 - “Do you understand?”
- ◆ Ask long, complicated questions. (Instead, start general and move to specifics, one step at a time, using short sentences).
- ◆ Put words in the client’s mouth. For example,
 - “I guess you were pretty scared”.
 - “So you would call ‘911’ if there was a problem?”.

ASSESSING CAPACITY – TRAINER’S MANUAL

USEFUL QUESTIONS TO FOCUS ON THE QUALITY OF THE CLIENT’S THINKING PROCESS:

- ◆ What would you do if your monthly check didn’t arrive?
- ◆ What would you do if you fell and could not get up?
- ◆ What would you do if you had a fire in your kitchen?
- ◆ What would you do if you had a serious medical emergency, such as severe chest pain?
- ◆ What would you do if someone wanted to have sex with you?

USEFUL QUESTIONS TO FOCUS ON THE CLIENT’S ABILITY TO DEMONSTRATE AND COMMUNICATE A CHOICE:

- ◆ If you were unable to live by yourself, where you would want to live?
- ◆ If you only had enough money to buy medicine for yourself or food for your cats, what would you do?
- ◆ How involved do you want your family to be in taking care of you?
- ◆ Do you have to have sex with someone if he/she asks you?

USEFUL QUESTIONS TO FOCUS ON THE CLIENT’S UNDERSTANDING OF HIS/HER OWN SITUATION:

- ◆ What do you think will happen if you do nothing to change your present situation?
- ◆ What are your choices right now?
- ◆ Why are you making this choice?
- ◆ What do you think will happen if you make a decision to.....?

CASE STUDY ACTIVITY #2: INTERVIEWING






TIME ALLOTTED: 30 minutes

SLIDE 46

**CASE STUDY ACTIVITY –
INTERVIEW QUESTIONS**

▶ Using the previous case examples, small groups will develop appropriate questions to evaluate the clients’ decisional capacity



Small Group Information
Case Study 1: Anna Kovacs
Case Study 2: Juan Garcia
Case Study 3: Mark Hudson
Case Study 4: Rob and Wilma Benson
Case Study 5: Sharon Delay
In participant manual pgs. 65-69

TOPIC: Case study activity

Goal: give you an opportunity to practice asking capacity-related questions in a simulated client/worker situation.

INSTRUCTIONS – Role Prep

TIME ALLOTTED: 10 minutes

- ◆ Reconvene small groups from case study activity #1. Refer participant to case study handouts on pages XX of the participant manual. They will be continuing on with the same case study.
- Acknowledge that there is sometimes resistance to role-playing and remind the groups that this training is a safe place for learning, with a lot of support from group members.
- In each group, have one person volunteer to play the “client” described in the scenario and one person to play the “APS worker”

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL

- Divide the remaining members of the groups into those who work with the person acting as the **client** and those working with the **APS worker**.
- If there are no volunteers to role play roles – assign the roles.

GROUP LEADER INSTRUCTIONS – Role preparation

- ◆ Please help reconvene your small group
- ◆ Help your small group select someone to role play
 - A client
 - An APS worker

NOTE: If no one volunteers please assign the roles

- ◆ Half of the rest of the group works with the client and half with the APS worker:
 - For the **client** support group: Using the information you received in this morning’s session, help develop the client’s role and assist the role player to present the *persona* of a client who has some difficulty making and communicating informed decisions.
 - For the **APS worker** support group: Using the information you received in this morning’s session, help the APS worker develop questions that will elicit capacity-related information from the client. **Use Handout #13** as a guide.

TRAINER NOTE: Move from group to group, making sure that everyone understands the directions. After the role players are selected, the two sub groups engage in their preparation.

At the end of 15 minutes, the Trainer announces to the groups that it is time to move into the next phase of the exercise.

INSTRUCTIONS – The interview

TIME ALLOTTED: 10 Minutes

- ◆ Now that each group has prepared their role players, you will be involved in a 15-minute interview.
 - The **APS worker** will ask the **client** questions pertaining to capacity-related issues, and the client will respond based on his/her understanding of the character being portrayed.

CONTINUED

ASSESSING CAPACITY – TRAINER’S MANUAL

- The **Observers**, all of you who are not role players, will observe the interview carefully, but will NOT interrupt the process.

GROUP LEADER INSTRUCTIONS – The interview

- ◆ Position the two role players in chairs facing each other, and place the rest of the group—the Observers—in two rows facing the interview from each side.
- ◆ Remind the observers to watch and listen, but not to comment or ask questions during the interview.

NOTE: At the end of 15 minutes, the Trainer announces to the groups that it is time to move into the next phase of the exercise.

INSTRUCTIONS – The debriefing

TIME ALLOTTED: 10 Minutes

Now that you have observed and/or role-played the interview, each group has **three tasks**:

1. Each of the role players gives feedback to the group members on his/her experience as a player.
2. The Observers comment on the interview process and suggest questions that might have been more effective. Please comment on and support role players’ strengths.
3. Each group comes to consensus about the client’s decisional capacity, using questions 1 – 6 at the bottom of case studies **Handout # C**.

GROUP LEADER INSTRUCTIONS – The debriefing

NOTE: Keep the group members on track, allowing about 5 minutes for each of the 3 tasks. Use questions 1 – 6 on case studies **Handout # C**. Assist your group to reach a consensus regarding whether the client needs an additional professional evaluation.

- ◆ In the real world, an APS worker cannot make a decision from a 15-minute interview. But, you are doing this process as a learning activity and the skills you practice today will be helpful to you in the field.

NOTE: When your group is done, dismiss all to the BREAK time. If your group chooses to continue the discussion into the BREAK time, feel free to do so.

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #1: Anna Kovacs - Small Group Information for Framing the Questions

Role Preparation (10 minutes)

Divide the small group into two subgroups: the client’s group and the APS Worker’s group. Ask for a volunteer from the client’s group to play the role of Anna, and a volunteer from the APS Worker’s group to play the interviewer role. The remaining members of each subgroup will help prepare the role players by discussing the questions listed below under “Guidelines” for each of the subgroups.

◆ Guidelines for APS Worker group:

1. Develop a strategy to establish rapport with Anna so she will feel comfortable with your questions.
2. Develop questions to elicit information on Anna’s understanding of relevant information.
3. Develop questions that will help you assess the quality of Anna’s thinking process. How might you assess her ability to understand and follow instructions? To make and execute a plan?
4. Develop questions that will demonstrate Anna’s ability to identify and communicate a choice. Include questions to reveal her understanding of the risks and benefits of a choice.
5. Develop questions you would ask to assess Anna’s understanding of her situation.

◆ Guidelines for the client group:

1. Discuss your perceptions of what Anna might be experiencing emotionally, physically, cognitively.
2. Translate your thoughts into a likely “Anna” role; propose responses, questions and reactions that the role player will be able to use.

Interview (10 minutes)

Both subgroups will observe the interview between Anna and the APS worker, silently.

Debriefing (10 minutes)

Ask one member of the group to take notes on the debriefing discussion.

Following the interview, use the questions below for discussion within the reunited small group:

1. Based on her answers, do you believe that Anna understands relevant information?
2. Based on her answers, do you believe that Anna’s thinking process is clear enough to understand and follow instructions and to make and execute a plan?
3. Based on her answers, do you believe that Anna is able to demonstrate and communicate a choice? Can she identify the risks and benefits of her choice?
4. Based on her answers to these questions, do you have enough information to determine whether or not Anna should be referred for a professional capacity evaluation?
5. Would you use a standardized test to assess Anna’s capacity? If so, which test would you use? Why would you use this test? How would you use the test?
6. What additional information would you need?

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #2: Juan Garcia - Small Group Information for Framing the Questions

Role Preparation (10 minutes)

Divide the small group into two subgroups: the client’s group and the APS Worker’s group. Ask for a volunteer from the client’s group to play the role of Juan, and a volunteer from the evaluator’s group to play the interviewer role. The remaining members of each subgroup will help prepare the role players by discussing the questions listed below under “Guidelines” for each of the subgroups.

◆ Guidelines for APS Worker group to use:

1. Develop a strategy to establish rapport with Juan so he will feel comfortable with your questions?
2. Develop questions to elicit information on Juan’s understanding of relevant information.
3. Develop questions that will help you assess the quality of Juan’s thinking process. How might you assess his ability to understand and follow instructions? To make and execute a plan?
4. Develop questions that will demonstrate Juan’s ability to identify and communicate a choice. Include questions to reveal his understanding of the risks and benefits of a choice.
5. Develop questions you would ask to assess Juan’s understanding of his situation.

◆ Guidelines for the client group to use:

1. Discuss your perceptions of what Juan might be experiencing emotionally, physically, cognitively.
2. Translate your thoughts into a likely “Juan” role; propose responses, questions and reactions that the role player will be able to use.

Interview (10 minutes)

Both subgroups will observe the interview between Juan and the APS worker, silently.

Debriefing (10 minutes)

One member of the group takes notes on the debriefing discussion.

Use the following questions for discussion within the reunited small group; following the interview:

1. Based on his answers, do you believe that Juan understands relevant information?
2. Based on his answers, do you believe that Juan’s thinking process is clear enough to understand and follow instructions and to make and execute a plan?
3. Based on his answers, do you believe that Juan is able to demonstrate and communicate a choice? Can he identify the risks and benefits of his choice?
4. Based on his answers to these questions, do you have enough information to determine whether or not Juan should be referred for a professional capacity evaluation?
5. Would you use a standardized test to assess Juan’s capacity? If so, which test would you use? Why would you use this test? How would you use the test.
6. What additional information would you need?

ASSESSING CAPACITY – TRAINER’S MANUAL

Case Study #3: Mark Hudson - Small Group Information for Framing the Questions

Role Preparation (10 minutes)

Divide the small group into two subgroups: the client’s group and the APS Worker’s group. Ask for a volunteer from the client’s group to play the role of Mark and a volunteer from the evaluator’s group to play the interviewer role. The remaining members of each subgroup will help prepare the role players by discussing the questions listed below under “Guidelines” for each of the subgroups.

◆ Guidelines for APS Worker group to use:

1. How would you establish rapport with Mark so he will feel comfortable with your questions?
2. Develop questions to elicit information on Mark’s understanding of relevant information.
3. Develop questions that will help you assess the quality of Mark’s thinking process. How might you assess his ability to understand and follow instructions? To make and execute a plan?
4. Develop questions that will demonstrate Mark’s ability to identify and communicate a choice. Include questions to reveal his understanding of the risks and benefits of a choice.
5. Develop questions you would ask to assess Mark’s understanding of his situation.

◆ Guidelines for the client group to use:

1. Discuss your perceptions of what Mark might be experiencing emotionally, physically, cognitively.
2. Translate your thoughts into a likely “Mark” role; propose responses, questions and reactions that the role player will be able to use.

Interview (10 minutes)

Both subgroups will observe the interview between Mark and the APS worker, silently.

Debriefing (10 minutes)

Ask one member of the group to take notes on the debriefing discussion.

Use the following questions for discussion within the reunited small group; following the interview:

1. Based on his answers, do you believe that Mark understands relevant information?
2. Based on his answers, do you believe that Mark’s thinking process is clear enough to understand and follow instructions and to make and execute a plan?
3. Based on his answers, do you believe that Mark is able to demonstrate and communicate a choice? Can he identify the risks and benefits of his choice?
4. Based on his answers to these questions, do you have enough information to determine whether or not Mark should be referred for a professional capacity evaluation?
5. Would you use a standardized test to assess Mark’s capacity? If so, which test would you use? Why would you use this test? How would you use the test?
6. What additional information would you need?

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Case Study #4: Rob/Wilma Benson - Small Group Info for Framing the Questions

Interview and Role Preparation (10 minutes)

Divide the small group into two subgroups: the client’s group and the APS Worker’s group. Ask for two volunteers from the client’s group. One will play the role of Wilma, and the other will play the role of Rob. Ask for one or two volunteers from the APS Worker’s group to play the interviewer role(s). The remaining members of each subgroup will help prepare the role players by discussing the questions listed below under “Guidelines” for each of the subgroups.

◆ Guidelines for APS Worker group to use:

1. First, decide whether you would talk to them separately or jointly. If you decide to do it separately, you will need a second volunteer interviewer and you will need to conduct the interviews at the same time, with half of your sub-group observing each interview.
2. How would you establish rapport with Rob and Wilma so they will feel comfortable with your questions?
3. Develop questions to elicit information on their understanding of relevant information.
4. Develop questions that will help you assess the quality of both Rob’s and Wilma’s thinking processes. How might you assess each of their abilities to understand and follow instructions? To make and execute a plan?
5. Develop questions that will demonstrate their ability to identify and communicate a choice. Include questions that will reveal their understanding of the risks and benefits of a choice.
6. Develop questions you would ask to assess the Bensons’ understanding of their situation.

◆ Guidelines for the client group to use:

1. Discuss your perceptions of what Rob and Wilma each might be experiencing emotionally, physically, cognitively.
2. Translate your thoughts into likely roles for Rob and Wilma; propose responses, questions and reactions that the role players will be able to use.

Interview (10 minutes)

Both subgroups will observe the interview(s) between the clients and the APS Worker(s), silently.

Debriefing (10 minutes):

After the interview(s), use the following questions for discussion within the re-united small group:

1. Based on their answers, do you believe that Rob and Wilma understand relevant information?
2. Based on their answers, do you believe their thinking process is clear enough to understand and follow instructions and to make and execute a plan?
3. Based on their answers, do you believe the Bensons are able to demonstrate and communicate a choice? Can they identify the risks and benefits of their choices?
4. Based on Rob’s and Wilma’s answers to these questions, do you have enough information to determine whether either of them should be referred for a professional capacity evaluation?
5. Would you use a standardized test to assess Rob’s or Wilma’s capacity? If so, which test would you use? Why would you use this test? How would you use the test?
6. What additional information would you need?

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Case Study #5: Sharon Delay - Small Group Information for Framing the Questions

Group Leader’s Task: Use Handout #3: Group Leader Instructions.

Role Preparation (10 minutes)

Divide the small group into two subgroups: the client’s group and the APS Worker’s group. Ask for a volunteer from the client’s group to play the role of Sharon, and a volunteer from the evaluator’s group to play the interviewer role. The remaining members of each subgroup will help prepare the role players by discussing the questions listed below under “Guidelines” for each of the subgroups.

◆ Guidelines for APS Worker group to use:

1. How would you establish rapport with Sharon so she will feel comfortable with your questions?
2. Develop questions to elicit information on Sharon’s understanding of relevant information.
3. Develop questions that will help you assess the quality of Sharon’s thinking process. How might you assess her ability to understand and follow instructions? To make and execute a plan?
4. Develop questions that will demonstrate Sharon’s ability to identify and communicate a choice. Include questions that will reveal her understanding of the risks and benefits of a choice.
5. Develop questions you would ask to assess her understanding of her situation.

◆ Guidelines for the client group to use:

1. Discuss your perceptions of what Sharon might be experiencing emotionally, physically, cognitively.
2. Translate your thoughts into a likely “Sharon” role; propose responses, questions and reactions that the role player will be able to use.

Interview (10 minutes):

Both subgroups will observe the interview between Sharon and the APS Worker, silently.

Debriefing (10 minutes):

Ask one member of the group to take notes on the debriefing discussion.

After the interview, use the following questions for discussion within the whole small group:

1. Based on her answers, do you believe that Sharon understands relevant information?
2. Based on her answers, do you believe that Sharon’s thinking process is clear enough to understand and follow instructions and to make and execute a plan?
3. Based on her answers, do you believe that Sharon is able to demonstrate and communicate a choice? Can she identify the risks and benefits of her choice?
4. Based on her answers to these questions, do you have enough information to determine whether or not Sharon should be referred for a professional capacity evaluation?
5. Would you use a standardized test to assess Sharon’s capacity? If so, which test would you use? Why would you use this test? How would you use the test?

BREAK
15 minutes

CROSS CULTURAL INTERVIEWING & ASSISTED CAPACITY



TIME ALLOTTED: 15 minutes

SLIDE 47

CULTURAL AWARENESS

- Openness to learning about other persons’ beliefs, attitudes, values and customs.
- Awareness of cultures of physically and mentally challenged persons, of persons from other ethnic groups, and countries.



Source: Lodwick 2007

TOPIC: Cultural awareness

- ◆ Asking questions to determine the client’s ability to make informed decisions is a complex task even when you are working with adults who share your culture.
- ◆ The complexity increases tremendously when working with those who are from another culture. Then cultural awareness must become a more conscious part of the interview.

CONTINUED

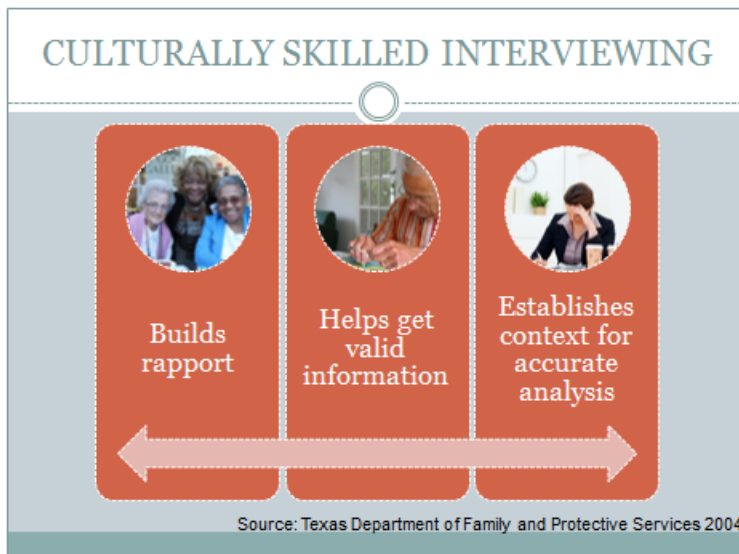
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- ◆ For the purpose of this training,

“Cultural awareness means openness to learning about other persons’ beliefs, attitudes, values and customs. It includes awareness about the cultures of physically and mentally challenged persons, as well as of persons from other ethnic groups, and countries.”

- ◆ The focus of this definition is on being open to other people’s ways of living in the world, whether the differences are related to disabilities, social class, religion, or gender issues.
- ◆ Of course, no one knows all there is to know, even about his or her own culture. And it would be impossible to be an expert about every culture.
- ◆ What is important is to approach people of other cultures with respect and with a willingness to learn what is most important to them. This means paying attention to subtle cues during the interview process.

SLIDE 48



TOPIC: Culturally skilled interviewing

- ◆ Culturally effective interviewing takes time and practice to develop. But the investment pays off by:
 - helping to develop rapport more quickly,
 - getting more accurate information, and
 - providing a context for accurate analysis.


Since accurately assessing decisional capacity is such an important issue, improved cultural awareness is essential.

SLIDE 49

Cross Cultural Interviewing Skills

▶ Learn as much as you can beforehand about cultural beliefs that affect:

- ▶ Values
- ▶ Attitudes
- ▶ Customs
- ▶ Faith/religious beliefs
- ▶ Family structure
 - ▶ Marriage
 - ▶ Roles



Source: Texas Department of Family and Protective Services 2004

TOPIC: Cross cultural interviewing skills

- ◆ When interviewing someone from another culture, learn as much as you can beforehand about cultural beliefs that affect:
 - Values
 - Attitudes
 - Customs
 - Faith/religious beliefs
 - Family structure
 - ./ Marriage
 - ./ Roles

SLIDE 50

Cross Cultural Interviewing Skills

- Be aware that strangers are perceived as “outsiders”.
- Take time to establish rapport.
- Speak clearly, avoid idioms and slang.
- Mirror the interviewee in tone of voice, eye contact, directness of speech.
- Be respectful.

Source: Texas Department of Family and Protective Services 2004

TOPIC: Cross-Cultural interviewing skills

- ◆ Cross-cultural skills include:
 - Being aware that strangers are perceived as “outsiders”.
 - Taking time to establish rapport.
 - Speaking clearly, avoiding idioms and slang.
 - Mirroring the interviewee in tone of voice, eye contact, directness of speech.
 - Being respectful.




What additional suggestions can you offer to facilitate successful cross-cultural interviews?

SLIDE 51

Using Interpreters

- ▶ Never rely on the perpetrator or a family member to act as the interpreter.
- ▶ Always use independent interpreters.
- ▶ When using an interpreter, direct all communication to the victim.



Source: Ramsey-Klawnsnik 2005

TOPIC: Using interpreters

Currently there is a much greater emphasis on using interpreters when providing services to people who are not native English speakers.

- ◆ It is important to remember to:
 - Never rely on the perpetrator or a family member to act as the interpreter even though this may seem like the easiest path to follow.
 - Always use independent interpreters.
 - No matter who is your interpreter, remember to direct all communication to the victim. Use your non-verbal language skills as you address your client.




Would someone be willing to share your experience using interpreters?

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SLIDE 52

Non-Verbal Clients

- Ask simple “yes” or “no” questions.
- Ask the client to:
 - squeeze your hand, or
 - blink his/her eyes.



HANDOUT #14:
Information on violence
against people with
disabilities
Participant manual
pg 73

TOPIC: Non-verbal clients

Another type of cross-cultural interviewing is with clients who are non-verbal.

- ◆ Conducting interviews with clients who are non-verbal, in order to assess their decisional capacity, is enormously challenging and could be the subject of a whole training module in itself.
- ◆ Basically, if you have a non-verbal client, it is essential to find a professional who is familiar with the client’s disabilities, and is skilled in conducting capacity evaluations of non-verbal clients.
- ◆ Here are a few tips when you are confronted with a person who is non-verbal:
 - Ask simple “yes” or “no” questions.
 - Ask the client to:
 - squeeze your hand, or
 - blink his/her eyes.



Please share some tips you’ve discovered for conducting interviews with clients who are non-verbal.

On **Handout #14** “Information on Violence Against People with Disabilities”, there is more information about critical considerations for working with people with disabilities.

ASSESSING CAPACITY – TRAINER’S MANUAL

HANDOUT #14: Violence Against People with Disabilities

Abuse against people with disabilities is a serious problem that we all must acknowledge, including health care providers, disability agencies, abuse investigators, domestic violence and sexual advocates, police, criminal justice personnel, crime victims’ advocates, and personal attendants.

- ◆ People with disabilities experience common forms of violence and abuse, including physical and sexual assault, financial exploitation and verbal abuse.
- ◆ People with disabilities also face unique forms of abuse, such as neglect, refusal to provide essential care, manipulation of medications, and withholding or destruction of equipment. These forms of abuse can be life threatening by causing health deterioration or leaving people with disabilities unable to get away or call for help.
- ◆ Compared to nondisabled people, people with disabilities are more vulnerable to abuse by health providers and personal assistants or caregivers, who may be family members, friends or formal providers.
- ◆ People with disabilities often face barriers to stopping or preventing abuse, including: lack of knowledge of abuse resources, social isolation; lack of emergency back-up support needed to get away from a caregiver who is the perpetrator; fear of being institutionalized or losing their children if they acknowledge being victimized, and cognitive or physical inaccessibility of domestic violence services.
- ◆ It is critical to screen people with disabilities. This requires asking questions about all of these forms of abuse and being sensitive to the unique risks and barriers individuals with disabilities may face in managing the problem.

For example, ask the person if anyone has refused or neglected to help them with an important personal need, such as using the bathroom, eating or drinking. If they say “yes”, ask if the abuser is someone the person with a disability depends on for care and if there is a back-up caregiver. Consider what are the potential risks involved in the situation? And how are these risks linked to the disabilities experienced by the person?

- ◆ Many people with disabilities are afraid that if they disclose abuse, they won’t be believed or that professionals will take control rather than supporting them to deal with the abuse.

It is very important to validate that the abuse is wrong and the victims / survivors shouldn’t have to live with it. Reassure the survivor that you will support them as they decide the best way to manage the problem. Help them identify their strengths and the resources they need.

- ◆ Creating a work / advocacy environment that is accessible and one that illustrates positive messages about disability may make people with disabilities more comfortable about disclosing abuse.

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Use appropriate language and structure the physical environment so people with disabilities can use it.

For example, use people-first language, such as “person with a physical or cognitive disability” rather than “handicapped, wheelchair bound or retarded”. Make sure your waiting room, restroom, exam tables and diagnostic equipment are accessible and your forms can be understood by people with learning or cognitive disabilities.

- ◆ Many states mandate reporting some forms of suspected abuse against people with developmental or mental health disabilities and/or dependent adults to protective services agencies. Find out your state’s mandatory reporting requirements and be sure to let people with disabilities know that you are a mandatory reporter.

For example, you might say, “I am required by law to report suspicion of abuse against women with disabilities to the [Adult Protective Services] agency. However, if you tell me about abuse, I’ll let you know if I have to report it and invite you to be involved in any way you want.”

- ◆ Find out what disability and domestic violence community resources are available for referral regarding abuse.

The Centers for Independent Living, ARCs, developmental disability, disability and aging agencies, or domestic violence / crisis lines in your area may be available to assist or to provide referral information.


Source: Arthur and Oswald. 2006

ASSESSING CAPACITY – TRAINER’S MANUAL

SLIDE 53

Assisted Capacity Interviewing Skills

- ▶ When a client appears to lack full decisional capacity, it may be possible to assist their decision-making by:
 - ▶ Treating medical problems
 - ▶ Providing information
 - ▶ Manipulating the environment
 - ▶ Providing encouragement and support



Source: Kapp 1990

TOPIC: Assisted capacity

Sometimes, providing the right intervention may improve a client’s decisional capacity. For instance, making sure that the client is taking the correct dosages of his/her medications, and that medication is taken at appropriate times, may produce a dramatic change in his or her decision-making ability.

- ◆ In other cases, giving the client more information may help him or her to decide.
- ◆ Changing the environment can also be useful at times. Someone who is very cold, hungry or tired may not be thinking clearly. Providing warmth, food and rest can make all the difference.
- ◆ And, of course, taking time to provide encouragement and support is always appropriate.



Can anyone share some examples of ways you have helped clients to enhance their decision-making skills, and what occurred as a result of this help?

CASE STUDY ACTIVITY #3: CASE PLANNING



TIME ALLOTTED: 45 minutes

SLIDE 54

CASE STUDY ACTIVITY –
CASE PLANNING

- Using the previous cases examples, the small groups will develop a next step for each case, based on the client capacity assessments.
- These next steps will be presented to the large group for discussion.



Small Group Information
Case Study 1: Anna Kovacs
Case Study 2: Juan Garcia
Case Study 3: Mark Hudson
Case Study 4: Rob and Wilma Benson
Case Study 5: Sharon Delay
In participant manual pgs. 76-80

Topic: Case Study Activity – Case Planning

INSTRUCTIONS – Small Group Discussion

TIME ALLOTTED: 20 minutes

- ◆ Reconvene small groups from case study activity #1. Refer participant to case study handouts on pages 76-80 of the participant manual. They will be continuing on with the same case study.
- ◆ Take a few minutes to review the group decision made about the client’s need for further professional evaluation at the end of the role play exercise.
- ◆ Have the group decide what is the most appropriate, immediate next step in the case planning process for this client. Don’t try to resolve all of the client’s issues, just focus on what needs to happen next, based on this client’s current situation and decisional capacity.
- ◆ Prepare for reporting to the large group.

CONTINUED

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TRAINER NOTE: At the end of fifteen minutes, reconvene into one large group.

LARGE GROUP REPORT AND DISCUSSION

TIME: 25 minutes

INSTRUCTIONS

- ◆ Each small group should provide a 5 minute description of:
 - The client,
 - their group’s assessment of the client’s need for further evaluation, and
 - the next step in the case planning process.

TRAINER NOTE: As each group completes its report, encourage the members of the large group to ask questions and comment on each small group’s assessment and case plan.

NOTE: If there is time, have the large group brainstorm about lessons learned from this activity. Otherwise, individuals can quickly call out, in a sentence or two, key things they learned.

CLOSING



TIME ALLOTTED: 15 Minutes

SLIDE 55

Closing

- Reflections
- Questions
- Evaluations
- Resources
 - NCEA: www.ncea.aoa.gov
 - NAPSA: www.napsa-now.org/

Thank you!

TOPIC: Closing

- ◆ Review slide and take time for reflections or questions.
- ◆ Share NCEA and NAPSA resource information
- ◆ Have participant complete evaluations

OPTIONAL – Post-test and Evaluation OPTIONAL-Handouts #15, #16, #17

NOTE: Distribute the post-test, its answers, and the training evaluation if you choose to use these tools.

- ◆ Before you leave, please take a few moments to complete the post-test and the evaluation. The post-test gives you self-assessment information. The evaluation will be helpful to us in planning future training sessions.

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HANDOUT #15: Post-test (optional)

Test # _____

1. What is the difference between an APS assessment of capacity and a professional capacity evaluation?
2. True or False (circle one) “Incapacity” is a medical term used to describe a person’s inability to make decisions.
3. Autonomy involves all of the following except one (please circle the incorrect option):
 - a) The person’s rights
 - b) The person’s choices
 - c) The person’s responsibilities
 - d) The person’s capacity
4. Once a person is judged incapacitated, he or she may lose the right to: (Circle the correct answer[s].)
 - a) Make decisions regarding medical care
 - b) Have a guardian appointed by the court
 - c) Have a conservator appointed by the court
 - d) Enter into contract agreements
 - e) Chose his/her place of residence
5. List 4 factors that may influence the decision-making capacity of an adult.
 - a)
 - b)
 - c)
 - d)
6. What are the four (4) standards used when assessing a person’s capacity?
 - a)
 - b)
 - c)
 - e)
7. List a strength and a limitation of a standardized capacity assessment tool, such as the Folstein Mini-mental Status Examination.
8. List 3 questions that could be asked of the client when assessing his or her capacity.
 - a)
 - b)
 - c)
9. List two special accommodations that are necessary when assessing the capacity of: a person with a disability (such as a hearing impairment), or who speaks no English, or who is non-verbal.

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HANDOUT #16: Pre and Post-test Answers (optional)

Test # _____

1. What is the difference between an APS assessment of capacity and a professional capacity evaluation?

APS caseworkers are able to assess clients’ situations and how they are functioning in their environment.

A professional capacity evaluation includes full physical and neurological examinations, short and long-term memory assessment, diagnosis of any existing psychological disorders and/or addictive syndromes.

2. True or False (circle one) “Incapacity” is a medical term used to describe a person’s inability to make decisions.

False. Incapacity is a legal term.

3. Autonomy involves all of the following except one (please circle the incorrect option):

- a) The person’s rights c) The person’s responsibilities
b) The person’s choices d) The person’s capacity

d) The person’s capacity

4. Once a person is judged incapacitated, he or she may lose the right to: (Circle the correct answer[s].)

- a) Have an operation
b) Sign a lease
c) Make a will
d) Marry

All of the above

5. List 4 factors that may influence the decision-making capacity of an adult.

- a)
b)
c)
d)

Select any 4 from Handout #2 Factors Affecting Capacity

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6. What are the four (4) components used when assessing a person’s capacity?
 - a) **Can the client understand relevant information?**
 - b) **What is the quality of the client’s thinking process?**
 - c) **Is the client able to demonstrate and communicate a choice?**
 - e) **Does the client appreciate the nature of his/her own situation?**
7. List strength and a limitation of a standardized capacity assessment tool, such as the Folstein Mini-mental Status Examination.

The Folstein MMSE is easy to administer, but does not address the client’s decision making skills for specific tasks.

8. List 3 questions that could be asked of the client when assessing his or her capacity.
 - a)
 - b)
 - c)

Use questions from Handout #13 Framing the Questions, or others that elicit similar information.

9. List two special accommodations that are necessary when assessing the capacity of: a person with a disability (such as a hearing impairment), or who speaks no English, or who is non-verbal.

Chose a comfortable quiet place where you will not be interrupted.

Use a professional interpreter.

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HANDOUT #17: Module 17 Evaluation (optional)

1=Unacceptable 2=Poor 3=Average 4=Above Average 5=Outstanding

(Please circle the number that reflects your evaluation of this workshop)

1. To what extent were your professional objectives for this workshop satisfied?

1. 2. 3. 4. 5.

2. To what extent did the written materials contribute to your learning experience?

1. 2. 3. 4. 5.

3. To what extent did the Power Point materials contribute to your learning experience?

1. 2. 3. 4. 5.

4. To what extent was the presenter effective in conveying the information?

1. 2. 3. 4. 5.

5. To what extent did the interactive exercises contribute to your learning experience?

1. 2. 3. 4. 5.

6. To what extent did the training contain significant intellectual or practical content?

1. 2. 3. 4. 5.

7. To what extent did the environment contribute to your learning experience?

1. 2. 3. 4. 5.

8. I would recommend this instructor for future training events?

Yes:

No:

9. Additional comments:

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APPENDIX

CORE COMPETENCIES FOR APS WORKERS November 2005

MODULE 1: APS OVERVIEW

Background Information

- Y History of APS
- Y National issues in APS
- Y Federal legislation
- Y Federal and state funding
- Y Grants
- Y Training opportunities
- Y History and role of NAPSA APS

Worker Satisfaction

- Y Care and support for APS workers
- Y Professional development APS

Clients

- Y APS client target populations
- Y Essential needs of dependent adults
- Y APS eligibility criteria
- Y Client benefits and entitlements APS

Legal Framework

- Y Federal Statutes
- Y State statutes and legal definitions
- Y State policies and standards
- Y Roles and responsibilities of APS workers

MODULE 2: APS VALUES AND ETHICS

Guiding APS Principles and Values

- Y Balance safety concerns and right to self-determination
- Y Treat people with honesty, care and respect
- Y Retention of civil and constitutional rights
- Y Assumed decision-making capacity unless a court adjudicates otherwise
- Y The right to be safe
- Y The right to accept or refuse services

APS Promising Practices Guidelines

- Y Practice self awareness and professional use of self
- Y Understand importance and support appropriate casework relationship
- Y Act as client advocate
- Y Avoid imposing personal values
- Y Seek informed consent
- Y Respect confidentiality
- Y Recognize individual differences
- Y Focus on client strengths and empowerment
- Y Involve the vulnerable adult in the service plan

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- Y Maximizes the vulnerable adult’s independence and self-determination
- Y Use the least restrictive services first
- Y Use family and informal support systems as possible
- Y Maintain clear and appropriate professional boundaries
- Y Avoid inadequate or inappropriate intervention
- Y Practice conflict resolution vs. confrontation Y
- Seek supervision and expert collaboration Y
- Provide integrated care management
- Y Don’t abandon clients who are difficult or unlikable
- Y Prevent further abuse, exploitation and neglect

Understanding Diversity

- Y Cultural competence
- Y Communicating cultural values
- Y Ageism awareness
- Y Disabilities awareness

MODULE 3: AGENCY STANDARDS and PROCEDURES

Agency Organizational and Administrative Structure

- Y Organizational/institutional environment or culture
- Y APS services/duties
- Y Specialized APS units, e.g. for homeless, after-hours, hospital liaison Regulations

and Policies

- Y Protocols for client emergency needs
- Y Protocols and procedures for facility investigations
- Y Protocols for translation, signing for the hearing impaired, communication services
- Y Arrangements for culturally appropriate services
- Y What to do when the client can’t be located

Managing APS Caseloads

- Y Workload standards
- Y Timeframes for response
- Y Caseload size
- Y Time management
- Y Effects of secondary trauma
- Y Burnout and stress management
- Y Coping strategies and staying resilient

Financial Management

- Y Fiduciary responsibility
- Y Agency forms and instructions

MODULE 4: THE AGING PROCESS

Facts on Aging

- Y Demographics Y
- Healthy aging Y
- Life expectancy

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- Y Social issues and aging
- Y Health care (AIDS and other communicable/infectious diseases)
- Y Role of family support for the elderly Stages

of Adult Development

- Y Impact of loss of independence
- Y Impact of poor health, illness, mental illness on client’s well-being
- Y Social/psychological/behavioral changes
- Y Effects of aging process on client’s ability to care for self
- Y Public perception of the elderly and ageism

MODULE 5: PHYSICAL AND DEVELOPMENTAL DISABILITIES

Overview of Disabilities

- Y Types of disabilities
- Y Definitions – federal/state
- Y Common misconceptions

Effects of Disabilities

- Y Effects of disabilities on client’s functioning
- Y Impacts of disability on caregiver and/or family

MODULE 6: MENTAL HEALTH ISSUES

Common Emotional Difficulties

- Y Coping with one’s own aging process
- Y Issues of separation/loss/grieving Types of

Mental Illness

- Y Depression/manic depression (bipolar disorder)
- Y Delirium/dementia
- Y Schizophrenia, hallucinations and delusions
- Y Personality disorder
- Y Obsessive compulsive disorder
- Y Suicidal ideations/suicide

MODULE 7: SUBSTANCE ABUSE

Types of Substance Abuse Issues

- Y Alcoholism
- Y Drugs
- Y Pharmacology
- Y Injuries and illness resulting from substance abuse

Medications

- Y Misuse of medications
- Y Medication side effects
- Y Medication drugdependency

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MODULE 8: DYNAMICS OF ABUSIVE RELATIONSHIPS

Predominant Types of Abuse/Neglect/Exploitation (ANE)

- Y Self-neglect
- Y Neglect by caregiver Y
- Financial exploitation Y
- Physical abuse
- Y Sexual abuse

Theories of Abuse

- Y Power and control
- Y Cycle of violence
- Y Victim/perpetrator dependency
- Y Exchange theory
- Y Caregiver stress
- Y Neglect due to pathologies of aging
- Y Emotional and verbal abuse dynamics

Characteristics of Victims and Perpetrators

- Y Victim/perpetrator dependency
- Y Victim/perpetrator mental health issues
- Y Abusive, neglectful, or exploitive caregivers
- Y Undue influence
- Y Psychology of perpetrators
- Y Dysfunctional families
- Y Abuse of elders living in domestic situations
- Y Abuse of elders living in institutions Domestic

Violence

- Y Domestic violence and elder/adult abuse
- Y Dynamics of power and control
- Y Why victims don't leave their abusers

MODULE 9: PROFESSIONAL COMMUNICATION SKILLS

Types of Interviews

- Y With victims
- Y With perpetrators
- Y With collateral contacts
- Y With family/groups Interviewing

Skills

- Y Trust and relationship building
- Y Engagement techniques
- Y Open-ended questioning
- Y Listening/reflection of content and feeling
- Y Responding to disclosures
- Y Showing empathy/compassion
- Y Acknowledging religious/cultural beliefs

Handling Special Situations

- Y Dealing with resistance and hostility

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Y Mediation, negotiation, conflict management

Working with Special Populations

- Y Cultural dynamics
- Y People with mental illness
- Y People with physical disabilities
- Y People with developmental disabilities

Communicating with Special Populations

- Y Cognitively, hearing, or visually impaired people
- Y Non-verbal clients
- Y Limited-English speaking clients
- Y Use of interpreters Communicating

with Other Professionals

- Y Health care professionals
- Y Law enforcement Y
- Legal professionals Y
- Victim advocates

MODULE 10: SELF-NEGLECT

Overview of Self-Neglect

- Y Types of self-neglect
- Y Statistics on self-neglect Y
- Indicators of self neglect Y
- Assessing level of risk
- Y Environmental safety assessment Theories of

Self-Neglect

- Y Cultural/social aspects of self-neglect
- Y Capacity evaluation
- Y Hoarding behavior
- Y Community attitudes towards self-neglect

Causes of Self-Neglect

- Y Societal causes for self-neglect
- Y Individual causes for self-neglect Preventing

Self-Neglect

MODULE 11: CAREGIVER OR PERPETRATOR NEGLECT

Overview of Caregiver or Perpetrator Neglect

- Y Types of caregiver neglect (unintended, intended, criminal)
- Y Statistics on caregiver neglect Y
- Indicators of caregiver neglect Y
- Assessing level of victim risk

Theories of Caregiver Neglect

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- Y Caregiver role: voluntary or involuntary
- Y Exchangetheory
- Y Personality/behavior of the caregiver
- Y Personality/behavior of the patient Causes

of Caregiver Neglect

- Y Cultural/social aspects of caregiver neglect
- Y Individual causes of caregiver neglect (burden of care, co-dependency, caregivers with mental illness, physical impairments or substance abuse)

Preventing Caregiver Neglect

MODULE 12: FINANCIAL EXPLOITATION

Overview of Financial Exploitation

- Y Types of financial exploitation
- Y Statistics on financial exploitation
- Y Indicators of financial exploitation
- Y Assessing client’s financial situation
- Y Assessing level of risk
- Y Assessing undue influence Theories

of Financial Exploitation

- Y Cultural/social aspects of financial exploitation Causes of

Financial Exploitation

- Y Societal causes of financial exploitation
- Y Individual causes of financial exploitation

Preventing Financial Exploitation

MODULE 13: PHYSICAL ABUSE

Overview of Physical Abuse

- Y Types of physical abuse
- Y Statistics on physical abuse
- Y Domestic violence indicators
- Y Medical indicators of abuse and neglect
- Y Assessing level of risk
- Y Lethality indicators

Theories of Physical Abuse

- Y Dynamics of physical abuse
- Y Cultural/social aspects of physical abuse
- Y Homicide/suicide

Causes of Physical Abuse

- Y Societal causes of physical abuse
- Y Individual causes of physical abuse

Preventing Physical Abuse

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MODULE 14: SEXUAL ABUSE

Overview of Sexual Abuse

- Y Types of sexual abuse
- Y Statistics on sexual abuse Y
- Indicators of sexual abuse Y
- Assessing level of risk

Causes of Sexual Abuse

- Y Societal causes of sexual abuse
- Y Individual causes of sexual abuse Preventing

Sexual Abuse

MODULE 15: APS CASE DOCUMENTATION/REPORT WRITING

Importance of Case Documentation

- Y Proper case documentation for substantiation of ANE
- Y Identifying data to include in case records

Documentation Overview

- Y Gathering of facts/chains of evidence
- Y Clear, concise and objective documentation
- Y Updating chronological records to monitor client progress
- Y Required forms and instructions
- Y Tracking/recording guidelines
- Y Monitoring services by other agencies
- Y Best practice tips

Documentation Equipment Skills

- Y Cameras
- Y Videos
- Y Tape recorders
- Y Computers
- Y Body maps

Confidentiality of Records

- Y Client permission to share information
- Y Legal issues (e.g. subpoena of records)

Report Writing Skills

MODULE 16: INTAKE PROCESS

Preparing for the Initial Client Visit

- Y Does report meet statutory requirements?
- Y Being inclusive--screen in, not out
- Y Reporter’s expectations
- Y Reviewing prior client records
- Y Identifying collateral contacts

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APS Worker Safety

- Y Safety planning for worker
- Y Assessing for violent or psychotic behavior
- Y Assessing for hazardous materials (drugs, communicable diseases, firearms)
- Y Neighborhood safety concerns
- Y Dangerous animals
- Y Location of interview
- Y Working with difficult people
- Y Non-violent crisis intervention
- Y De-escalating potentially dangerous situations
- Y When to contact law enforcement and how to request assistance
- Y Emergency communications—cell phones
- Y Communicable and Infectious Diseases

Investigation: Initial Client Contact

- Y Gaining access
- Y “Who sent you” issues
- Y Establishing rapport at the door
- Y Strategies for dealing with refusal of access by client or to client
- Y Interviewing the suspected abuser
- Y Assessing validity of reports of ANE
- Y Developing safety plans with/for clients Intake

Documentation

MODULE 17: INVESTIGATION: CLIENT CAPACITY

Initial Capacity Assessment

- Y Interviewing the suspected abuser
- Y Assessing validity of reports of ANE
- Y Developing safety plans with/for clients
- Y Intake documentation Capacity

Assessment

- Y When and how to refer client for professional capacity evaluation
- Y Interpreting and using assessment information
- Y Client’s strengths and social supports
- Y Ability to conduct activities of daily living
- Y Level and type of care needed Client’s

Ability to Make Informed Decisions

- Y Cultural influences on client’s decision-making
- Y Community standards
- Y Past history of making decisions
- Y Concept of “negotiated consent”

MODULE 18: INVESTIGATION: RISK ASSESSMENT

Overview of Risk Assessment

- Y Indicators of immediate risk of ANE
- Y Lethality indicators
- Y Emergency medical or psychiatric situations

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- Y Impact of illness/disability on client’s ability to protect him/her self
- Y Environmental hazards
- Y What to do when client refuses services Risk

Assessment of Caregiver

- Y Mental Illness
- Y Substance Abuse
- Y Emotional/financial dependence on victim
- Y Suicidal ideation

MODULE 19: VOLUNTARY CASE PLANNING and INTERVENTION PROCESS

Overview of Voluntary Case Planning and Intervention

- Y Mutual assessment of needs/goal setting
- Y Supportive counseling
- Y Policies and procedures for response

Types of APS Service Provision

- Y Accessing benefits and entitlements
- Y Safety planning for client
- Y Assuring basic needs are met (e.g. food, heat, transportation)
- Y Arranging for shelter and transition housing as necessary
- Y Providing information/referrals
- Y Linking clients and families with respite services and support groups
- Y Assisting clients discharged from hospitals, psychiatric wards and disability centers
- Y Providing emergency services or finding/developing emergency resources
- Y Managing client finances as necessary
- Y Providing respite care
- Y Mediation
- Y Caregiver training

Case Planning and Intervention

- Y Goal setting with clients
- Y Defining intervention strategies/response timeframes
- Y Finding and procuring resources
- Y Promoting coordinated/joint case planning and service delivery
- Y Arranging for culturally appropriate services
- Y Case documentation
- Y Reassessment/follow-up Preventing

ANE

- Y Consumer education

MODULE 20: INVOLUNTARY CASE PLANNING and INTERVENTION PROCESS

Overview of Involuntary Case Planning and Intervention

- Y Policies and procedures for response
- Y Legal standards for involuntary intervention
- Y Promoting coordinated/joint case planning and service delivery Case

Planning for Involuntary Services

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- Y Arranging for culturally appropriate services
- Y Goal setting with family/care provider
- Y Defining intervention strategies/response timeframes
- Y Finding and procuring resources

APS Interventions

- Y Providing services for caregiver
- Y Respite care
- Y Caregiver training
- Y Providing information/referrals
- Y Assuring basic client needs are met Y
- Accessing benefits and entitlements Y
- Safety planning for client
- Y Coordinating involuntary medical care
- Y Arranging for shelter and transition housing
- Y Coordinating involuntary mental health/substance abuse treatment Y
- Linking clients and families with respite services and support groups Y
- Providing emergency services
- Y Assisting clients discharged from hospitals, psychiatric and development centers
- Y Managing client finances as necessary
- Y Documentation
- Y Reassessment/follow-up Guardianships

and Conservatorships

- Y Statutory definitions
- Y Guardianship process
- Y Competency/incompetency criteria Y
- Probate conservatorship process Y
- Private conservatorship process

MODULE 21: COLLABORATION and RESOURCES

Overview of Collaboration and Resources

- Y Benefits of working as a team
- Y Roles of various professionals in resolution of ANE Local and

Regional Networks and Community-Based Services

- Y Roles and responsibilities of community resources
- Y Interagency protocols for referrals and service delivery
- Y Local resources contact information Inter-

Agency Relationships and Collaboration

- Y Multidisciplinary review teams
- Y Fatality review teams
- Y Community advisory groups
- Y State and local coalitions
- Y Public awareness campaigns
- Y Documentation of services and outcomes
- Y Abuse prevention activities

Community Outreach

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- Y Public education
- Y Working with the media
- Y Abuse prevention activities

Service Integration with Related Agencies

- Y State Units on Aging
- Y Department of Children and Family Services/Social Services
- Y Domestic violence resources
- Y Victim advocates
- Y Regulatory agencies

Health and Mental Health

- Y Medical Clinics/Hospitals
- Y Department of Mental Health
- Y Mental Health/ Counseling Agencies
- Y Medicaid/Medicare
- Y Agency in charge of Developmental Disabilities Law

Enforcement

- Y Police/Sheriff’s Department
- Y State Patrol
- Y FBI
- Y Medicaid Fraud
- Y Office of Attorney General
- Y Probation/parole

Legal Resources

- Y Office of District Attorney
- Y Department of Consumer Affairs
- Y OAA legal service providers
- Y Private attorneys

Emergency Resources

- Y Homeless shelters
- Y Domestic Violence Shelters
- Y Group homes
- Y Residential Health Care Facilities
- Y Boarding Homes
- Y Food pantries
- Y Church organizations
- Y Developing emergency resources when none exist

Financial

- Y Social Security
- Y Banking institutions
- Y Securities firms
- Y Food stamps Other

Resources

- Y Long-term care ombudsmen
- Y Immigration Services
- Y Clergy
- Y Universities and community colleges

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Y National organizations

MODULE 22: LEGAL ISSUES and LAW ENFORCEMENT

Overview of Legal Issues and Law Enforcement

- Y Role of criminal justice system
- Y State criminal codes
- Y Regulations and policies Legal

Tools

- Y Legal rights of adult clients Y
- Court ordered mediation Y
- Restorative justice
- Y Writing affidavits and petitions
- Y Mandatory reporting
- Y Filing emergency protective/restraining orders
- Y Legal resources for dependent adults
- Y Victims/witness programs
- Y Substitute decision-making on behalf of client
- Y Living wills, health care proxies, do not resuscitate (DNR) orders
- Y Collecting, preserving and analyzing evidence Working

with Law Enforcement and the Judicial System

- Y Differences in APS, law enforcement, and legal institutional cultures
- Y Caseworkers’ role in the legal process
- Y Requesting law enforcement assistance
- Y Conducting joint investigations/interviews with law enforcement
- Y Subpoena of case records

Preparing for Court

- Y Case documentation
- Y Initiating court procedures
- Y Assisting victims with court procedures Y
- Legal representation for APS workers Y
- Guidelines for presenting testimony
- Y Responding to cross-examination
- Y Writing court reports

MODULE 23: CASE CLOSURE

Overview of Case Closure

- Y Reasons for case closure
- Y Issues of grief and loss for client and worker
- Y Client’s end of life decision-making process
- Y Carrying out client’s end of life wishes (funeral arrangements, client’s estate disposition)

Case Termination

- Y Closure for client and worker
- Y Service delivery evaluation
- Y Summary case recording and case documentation
- Y How could abuse, exploitation and neglect have been prevented?