Screening for Decision-Making Ability When Working with APS Clients

Instructor Led Training (in-person or virtual)

Trainer Manual

Academy for Professional Excellence

APSWI
Adult Protective Services Workforce Innovations

The Academy for Professional Excellence is a project of the San Diego State University School of Social Work

This training revision was developed by the Academy for Professional Excellence, with funding from the California Department of Social Services, Adult Programs Division.

Curriculum Developer for Revisions, 2021
Richard Albrecht, MS

Previous versions developed by The National Center on Elder Abuse, The Source for Information and Assistance on Elder Abuse

INTRODUCTION

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

We are pleased to welcome you to **Screening for Decision-Making Ability When Working with APS Clients Trainer Manual**, developed by Adult Protective Services Workforce Innovations (APSWI), a program of the Academy for Professional Excellence under a grant from the California Department of Social Services, Adult Programs Division.

The Academy for Professional Excellence, a project of San Diego State University School of Social Work, was established in 1996 to provide exceptional workforce development and organizational support to the health and human services community by providing training, technical assistance, organizational development, research, and evaluation. Serving over 20,000 people annually, the Academy continues to grow with new programs and a diversity of training focused on serving the health and human services community in Southern California and beyond.

The Academy is a project of San Diego State University School of Social Work (founded in 1963), which offers both a bachelor's and master's degree in Social Work. The School of Social Work at San Diego State University was founded in 1963 and has been continuously accredited by the Council of Social Work Education since 1966.

APSWI is a program of the Academy for Professional Excellence. APSWI is designed to provide competency-based, multidisciplinary training to Adult Protective Services professionals and their partners. APSWI's overarching goal is the professionalization of Adult Protective Services professionals to ensure that abused and vulnerable older adults and adults with disabilities receive high quality, effective interventions and services.

In partnership with state and national organizations, APSWI is developing a national APS Supervisor Core Competency Training Curriculum. This curriculum is developed, reviewed and approved by experts in the elder and dependent adult abuse fields.

APSWI's partners include:

- National Adult Protective Services Association (NAPSA) Education Committee
- California Department of Social Services (CDSS), Adult Programs Division
- County Welfare Directors Association of California (CWDA), Protective Services Operations Committee (PSOC)

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CASE PLANNING

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HOW TO USE THIS MANUAL

The training is designed as an Instructor Led Training (ILT) to be conducted either in person or virtually. For an in-person day, it is a six-hour event with two breaks and an hour lunch. For virtual training, plan for timing and spacing according to your agency's training needs. Trainers determine start and end times that work best for their communities and add additional breaks if needed.

If training virtually, the Participant Manual should also be sent ahead of time as a fillable PDF if using Adobe Acrobat or to allow participants to print a hard copy.

Trainer Notes are written entirely in bold text box and are provided as helpful hints.

Moderator Notes are written entirely in bold text box and are provided as helpful hints.

- Actions which the trainer takes during the training are written in **bold**.
- When there are both Trainer and Moderator notes on same page, Trainer and Moderator is **underlined**.

Use of language: Throughout the manual, APS Professional is used most often to describe APS line staff. The term client is used most often to describe the individual at the center of the APS investigation. However, if concept or material was directly quoted from copyrighted material, another term may be used.

He and she have been replaced with the gender-neutral they throughout this manual, unless quoted from copyrighted material. This should not be thought of as plural persons, but rather a gender-neutral term describing all humans.

Customizing the Power Point:

This manual is set up so that the trainer script/ background material is on the same page as the accompanying PowerPoint slide.

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 slide number will have a line through it to show you have hidden it.
NOTE: The slide remains in your file even though it is hidden when you run the presentation.

The course outline, provided in the next section of this manual, is the class schedule used for development of this curriculum. It can be used to help determine how much time is needed to present each section. However, times will vary based on the experience and engagement of the audience.

TRAINER GUIDELINES

It is recommended that someone with APS supervisory experience or experience with screening for decisional capacity facilitate this virtual workshop.

Suggestions for virtual training when possible:

- Have a moderator or co-host who can primarily focus on the virtual aspects of this training (e.g., monitoring chat box, launching polls, assigning breakout groups, monitoring participant reactions, etc.).
- Test out the use of the breakout room feature prior to conducting this training.
- Log in at least 30 minutes prior to the training to ensure the virtual classroom is fully functioning and that you are comfortable navigating it.
- Your equipment and platform may dictate how you do some activities or discussion. There are times you may not be able to see everyone's faces, names or reactions (thumbs up, mute/unmute, etc.). There is a need for both verbal discussion and chat discussion. At such times, the moderator will fill a critical role monitoring those features you cannot. Practice during a run through how you will use the various functions for each section.
- The optimal size for this virtual training is 20 participants.

Teaching Strategies	The following instructional strategies are used: o Lecture segments o Interactive exercises (e.g., breakout groups, chat box discussion, polling activities, role play) o Question/answer periods o PowerPoint Slides
Materials and Equipment	**The following materials are provided and/or recommended:** o Trainer Manual o Participant Manual (fillable PDF) o PowerPoint Slides o Headset with microphone o Computer

VIRTUAL TRAINING TIPS

Training and facilitation have always been an art. Virtual training is no exception. Below are some helpful tips to remember and implement when training in a virtual environment.

Assume nothing.

Do not assume everyone has the same knowledge/comfort level with technology or has access to equipment like printers, video camera, headsets or even reliable Wi-Fi.

Distractions are everywhere.

Participants have greater access to distractions (email, phone, others at home) which can take their focus away from the training. Therefore, explain everything and summarize before asking participants to complete an activity and check for clarification.

Over explain when possible.

The virtual room doesn't allow for participants to see everything you're doing as they can in-person. Share as you navigate the virtual environment. If you are silent while looking for something or finding a screen, they may think something is frozen.

Mute with purpose.

"Mute all" function can help ensure we don't hear conversations we're not supposed to. However, it can also send a message to the participants that they are a passive participant and may not make them feel comfortable taking themselves off mute when you want them to speak.

Two screens can be a lifesaver.

This allows you to move your chat box or participant gallery view away from your presentation so you can see more of what's going on.

Rely on practice, not luck.

Winging it during an in-person training or facilitation may work from time to time, but doesn't work in the virtual environment. In addition to covering the content, you have to manage all of the technology issues, learning styles in a virtual room, and it will show if you're not prepared.

Bring the energy.

As trainers, we are no strangers to being "on," standing and moving around. However, some of the body language, subtle nonverbal skills we relied on the in-person training room do not translate well in the virtual environment. While this may make you more tired, it's important to up your enthusiasm, voice, and presence in order to engage with attendees.

Be mindful of your space.

Training virtually brings an entirely new component of what we're willing to share with others. Learners can get distracted with what's in your background, whether what is physically there or if you set your video to use a virtual background. It's important to reflect on questions of privilege, diversity and equity when thinking of your training space. Are there objects in your background that can symbolize status, privilege and/or power? If so, consider removing them to dismantle any added power dynamics that already exist with you as the Trainer. Unknowingly, objects can come across as offensive or can activate unpleasant or traumatic memories, and can instantly discredit your rapport building. Think of neutral backgrounds that are not distracting and allow you to be the focus of what learners see.

EXECUTIVE SUMMARY

Screening for Decision-Making Ability When Working with APS Clients

This training is Module 17 of the NAPSA Core Competency Curriculum and designed for Instructor-Led facilitation for either in-person or virtually.

APS professionals are tasked with ensuring people's rights to self-determination are respected while also working to keep the person safe and healthy. Assessing and determining if clients have the ability to make informed decisions about their situations and care, is one of the greatest challenges faced by APS professionals. In this introductory training, participants will find opportunities to apply the fundamentals of screening for decision-making ability to their daily tasks in the field of APS work.

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

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

1. Define autonomy and decision-making incapacity
2. Distinguish between decision-making capacity and decision-making ability
3. Describe factors that may influence a client's decision-making ability
4. Identify key questions and approaches used to screen client decision-making ability, including working with special populations.
5. Identify implications for case planning as a result of a finding of limited decision-making capacity

Course Requirements: It is strongly recommended that participants have completed Modules 1 (APS Overview), 2 (Ethics, Values and Cultural Responsiveness) and 9 (Communication and Interviewing) of the NAPSA Core Competency Curriculum prior to attending this training. The Core Competency Curriculum can be found at https://theacademy.sdsu.edu/programs/apswi/core-competency-areas/

If training virtually, participants will need access to a computer with video conferencing capability and be able to connect to the virtual platform being used to deliver this training. A headset or earbuds with microphone and a video camera are highly encouraged.

Target Audience: This course is designed for new APS professionals as well as Vulnerable Adult Abuse partners (e.g. conservatorship investigators, workers in the aging and disability networks, law enforcement). This training is also appropriate for senior staff that require knowledge and/or skills review.

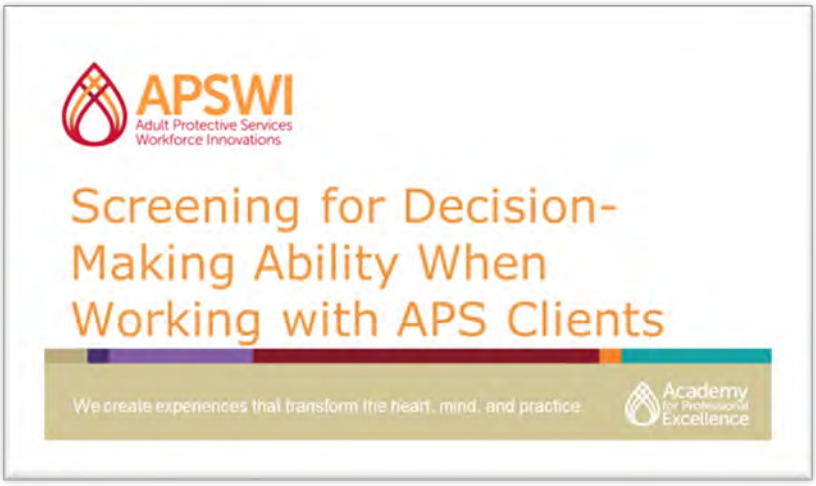
COURSE OUTLINE

CONTENT	MATERIALS	TIME
WELCOME, INTRODUCTIONS, & COURSE OVERVIEW		20-30 minutes
Activity #1: Agree, Disagree, Unsure	Agree, Disagree, Unsure signs, Tape, Handout #1-APS TARC Brief	*10-20 min*
OVERVIEW & KEY TERMS OF CAPACITY ASSESSMENT		25-30 minutes
Terminology	Handout #1- APS TARC Brief	
Executive Function		
FACTORS AFFECTING CAPACITY & ABILITY	Handout #2- Factors Affecting Decisional Impairment & Handout #1- APS TARC brief	45 minutes
Factors that Affect Decision-Making		
Activity #2: NCD, Delirium and Depression	Handout #3- NCD, Delirium and Depression Case Studies	*10-15 min*
Neurocognitive Disorders	Handout #4 Medical Conditions Affecting Capacity	
Delirium	Handout #5 - CAM	
Depression	Handout #6- Geriatric Depression and Columbia-Suicide Severity Rating Scales	
BREAK		**15 minutes**
ASSESSING DECISION-MAKING ABILITY		35-40 minutes
Activity #3: Case Study Activity-Assessing	Handout #7- Small Group Information Handout #8 – Group Leader Information	*25-30 min*
COGNITIVE DOMAINS		25 minutes
Six Domains		
LUNCH		**60 minutes**

METHODS FOR ASSESSING		80-90 minutes
Decision-Making Assessment Skills	Handout # 9- APS TARC Interview with Experts	
Framing the Questions	Handout #10- Framing the Questions	
Activity #4: Case Study Activity-Interviewing	Handout #11	*30 min*
Choosing the Right Tool	Handout #1- APS TARC Brief	
Clinical Professionals	Handout #12 Clinical Professionals	
BREAK		**15 minutes**
CASE PLANNING		45-50 minutes
Activity #5: Case Study Activity-Case Planning	Handout #13	
WRAP-UP AND EVALUATIONS		15 minutes
TOTAL TIME INCLUDING BREAKS AND LUNCH		**6.5-7 hours**

WELCOME, INTRODUCTIONS AND COURSE OVERVIEW
Time Allotted: 20-30 minutes

Slide #1: Welcome



Welcome participants to Module 17 of NAPSA Core Competency Curriculum: *Screening for Decision-Making Ability When Working with APS Clients*.

Introduce yourself by name, job title, organization and qualifications as the Trainer for this topic.

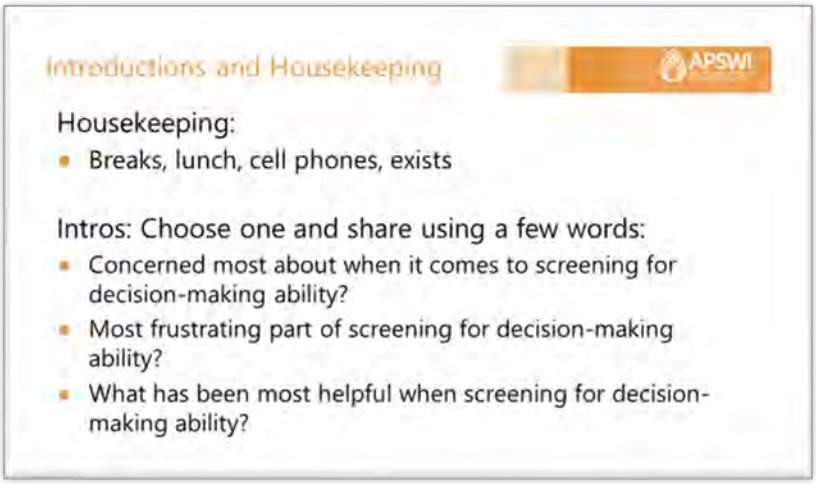
Slide #2: SDSU School of Social Work

Explain that the Academy for Professional Excellence is a project of San Diego State School of Social Work. Its mission is to provide exceptional workforce development and learning experiences for the transformation of individuals, organizations and communities.

Slide #3: About APSWI and the Academy

Explain that Adult Protective Services Workforce Innovations (APSWI) provides innovative workforce development to APS professionals and their partners. APSWI is a program of the Academy for Professional Excellence along with others listed on the slide.

Slide #4: Introductions and Housekeeping



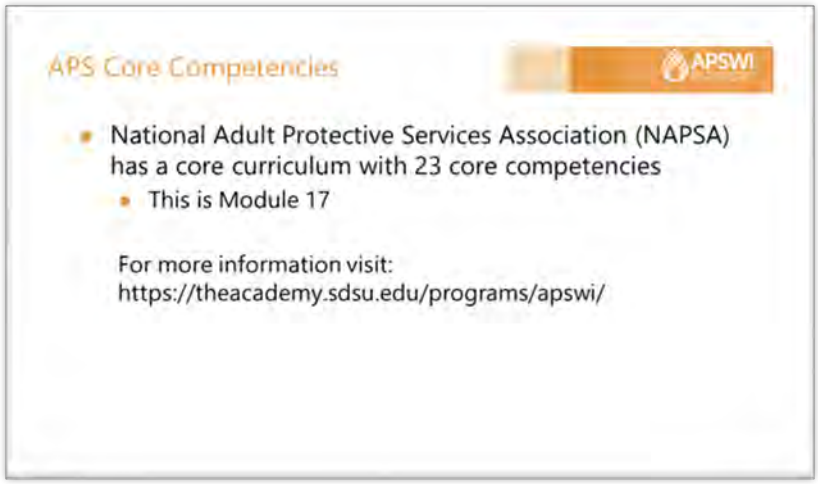
Review the following housekeeping:

- Breaks, including lunch (if applicable)
- Use the restrooms whenever you need to do so. **Share** location of restrooms
- Please turn off your cell phone 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 missed.

Ask participants to introduce themselves and in just a few words, share either of the following (they choose, answers will vary based on experience in the field):

- What they are most concerned about when it comes to screening a client's ability to make decisions?
- What has been the most frustrating part of screening someone's ability to make decisions?
- What have they seen be most helpful when screening someone's ability to make decisions?
- **Note**: If most choose the first two to answer, **redirect** to see if anyone can share about the third-most helpful.

Slide #5: APS Core Competencies



Briefly share the following:

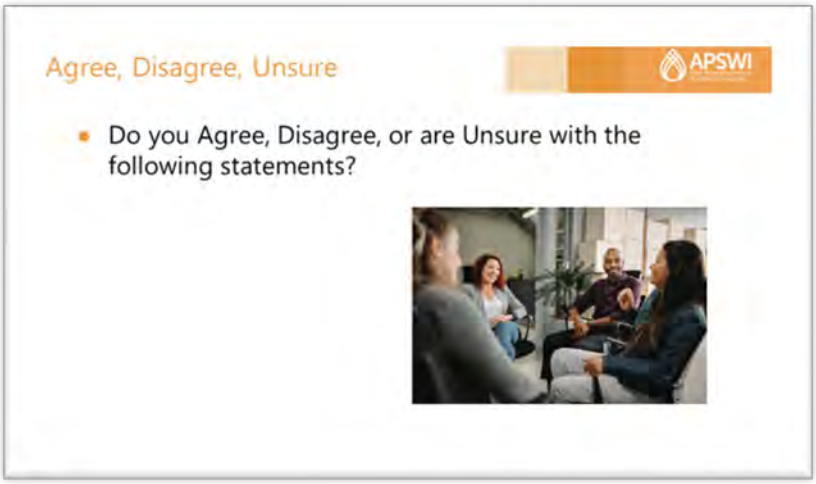
- This training is Module 17 of 23 practice-based modules that comprise a full set of core competencies for Adult Protective Services (APS) professionals developed by the National Adult Protective Services Association (NAPSA) in partnership with Adult Protective Services Workforce Innovations (APSWI).

- This 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 https://theacademy.sdsu.edu/programs/apswi/core-competency-areas/

Slide #6: Agree, Disagree, Unsure

Trainer Note: This activity has the potential of running long if participants feel they have to plead their case or can't make a decision. Remind them that the material in today's training will help give context to the activity. <u>You may want to pick just 3-5 statements that you feel are most commonly misunderstood and read those only</u>.



Explain that APS programs vary nationwide in their use of terminology, roles and responsibilities, but the work around decision-making ability and capacity continues to be a common training need. Trying to determine if clients have the ability to make informed decisions about their situations and care is one of the greatest challenges faced by APS professionals.

<u>Activity #1: Agree, Disagree, Unsure (10-20 minutes)</u>
Individual

- *If training in-person, **create** and **tape** three signs around the room with "Agree", "Disagree" and "Unsure". It's best to have Agree and Disagree at opposite ends with Unsure in the middle. **Ensure** there is space for participants to move. **Create** a few extra sets of signs to provide to anyone who is unable to physically move. They can hold the signs up to participate.*
- *If training virtually, you can either **have** participants type in chat box "Agree, Disagree" or "Unsure" as you read each statement OR read each statement and **ask** participants to raise hands when you state Agree, Disagree, and then Unsure.*

Explain that you will read off statements highlighted in the APS TARC Brief, "Capacity Screening in Adult Protective Services: Guidance and Resources" to set the stage for this training and to see what experience or thoughts each participant is bringing to today's training so that we can come to some common ground.

Ask participants to decide whether they <u>agree</u> with the statement, <u>disagree</u> with it or are <u>unsure</u> and move to the corresponding sign (or make choice virtually). **Explain** that they

Continued

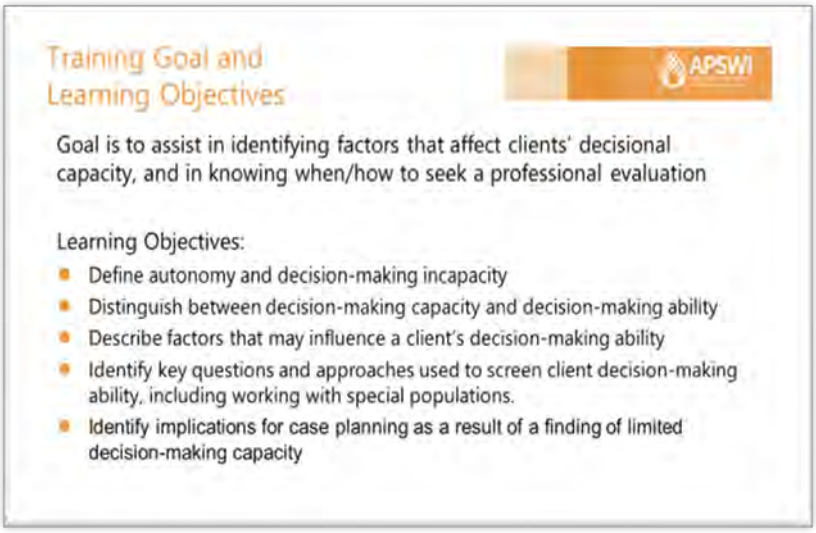
can move (or change their answer) if someone says something that makes them change their mind.

Read each statement and **allow** participants to make move or make their decision. **Ask** for a 1-2 participants from each group to share their reasoning. TIP: you may want to alternate starting with “Unsure”, “Agree” and “Disagree” for each statement read.

1. Decision-making capacity and competency are the same
2. Lack of decision-making capacity can be presumed when patients go against medical advice
3. There is no need to assess decision-making capacity unless patients go against medical advice
4. Decision-making capacity is an “all or nothing” phenomenon
5. Cognitive impairment equals lack of decision-making
6. Lack of decision-making capacity is a permeant condition
7. Patients who have not been given relevant and consistent information about their treatment lack decision-making capacity
8. All patients with certain psychiatric disorders lack decision-making capacity
9. Patients who are involuntarily committed lack decision-making capacity
10. Only mental health experts can assess decision-making capacity

Thank everyone and explain that the statements read are all common myths that many APS professionals have and often contribute to the complexity of screening for decision-making ability. The concepts and skill practice in today’s training will help clear up these common myths.

Slide #7: Training Goal and Learning Objectives



Share the goal of this training module:

- 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.
- APS professionals are able to assess client's situations and how they are functioning. They do this very well.
- **This training is NOT designed to enable APS professionals to conduct professional capacity evaluations.**
    - Only those licensed clinical social workers who have received specialized training, have gained specific experience or both, have the credentials to conduct professional capacity evaluations.
        - Many APS professionals are LCSW, but are not designated within their role as an APS professional to conduct a formal capacity evaluation and make a determination.
        - Even when designated to do so, it's helpful to bring in another to conduct the professional capacity evaluation to allow the APS professional to remain a neutral party.
    - Others who may be qualified are psychologists, geriatricians or psychiatrists.

Review the Learning Objectives:

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

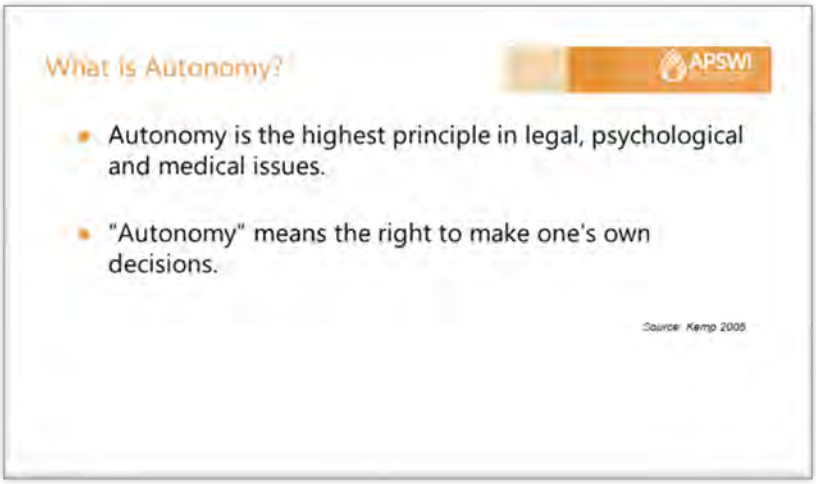
1. Define autonomy and decision-making incapacity
2. Distinguish between decision-making capacity and decision-making ability
3. Describe factors that may influence a client's decision-making ability

Continued

4. Identify key questions and approaches used to screen client decision-making ability, including working with special populations.
5. Identify implications for case planning as a result of a finding of limited decision-making capacity

OVERVIEW & KEY TERMS OF CAPACITY ASSESSMENT
Time Allotted: 25-30 minutes

Slide #8: What is Autonomy?



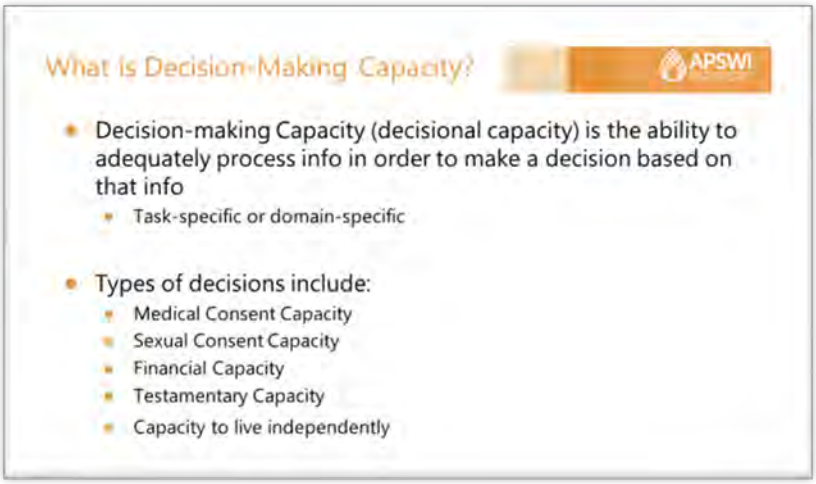
Explain that language is important and definitions and terminology vary between states and legal statutes as well as within APS programs. This training uses language that you may not be familiar with, yet, or which can easily be confusing. These next few slides will focus on clarify and defining terminology.

Share the following:

- "Autonomy" means the right to make one's own decisions (Kemp 2005).
- Understanding the concept of autonomy is essential for APS professionals, since one of your primary responsibilities is to honor and protect your client's autonomy, or right to self-determination 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 #9: What is Decision-Making Capacity?

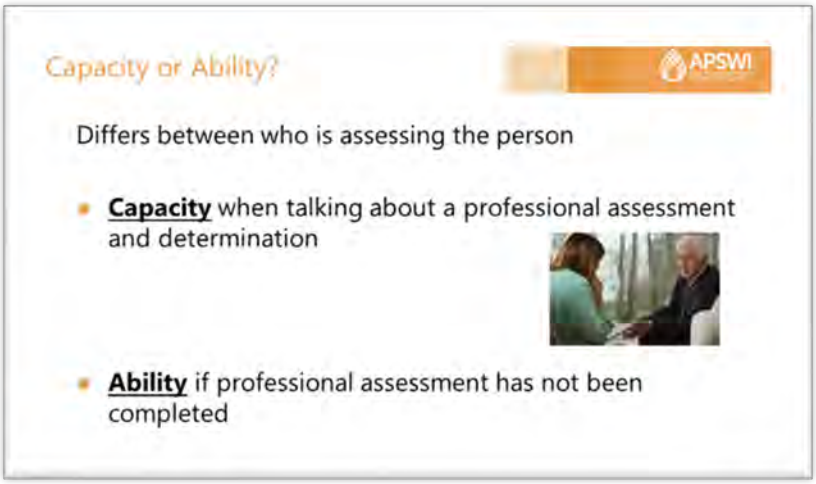


One of the biggest distinctions is the difference between decision-making capacity and decision-making ability, as they are often mistakenly used interchangeably.

- Decision-Making Capacity, also referred to as 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.
- It is important to remember that capacity is task-specific or domain-specific.
    - Someone can lack the capacity to manage their finances but can still have the capacity to make medical decisions, or vice versa.
    - This is why in-depth evaluations are necessary in making this determination.
- Types of decisions include:
    - Medical Consent Capacity;
    - Sexual Consent Capacity;
    - Financial Capacity;
    - Testamentary Capacity (e.g., creating a will);
    - Capacity to Live Independently
- **Refer** participants to **Handout #1- APS TARC Capacity Screening in Adult Protective Services**. **Share** that this guide discusses the different areas of decision-making that require capacity and would be a great reference to review after training to reinforce concepts learned from today.

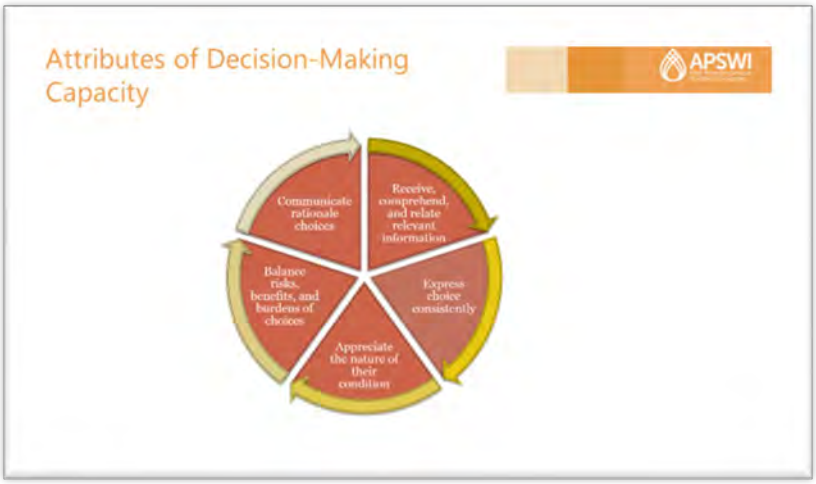
Slide #10: Capacity or ability?



Explain:

- Decision-making ability is similar to decision-making capacity, but differs between who is assessing the person's decision-making. It is important that we understand the difference between these two terms and how they should be used, so that there is not an indication of a professional determination being made when it's not appropriate to do so.
    - *Capacity* should be used when talking about a professional assessment and determination.
    - *Ability* should be used if a professional assessment has not been completed, e.g. APS professionals can use: "I have concerns with the client's ability to make informed decisions", "I have concerns with the client's ability to understand consequences of decisions".
- Unless a professional assessment has been completed on decision-making capacity, ability is the term that APS staff should use when speaking with clients, family and supervisors.

Slide #11: The Attributes of Decision-Making Capacity



Share that there are several attributes that encompass decision-making capacity.

- Receive, comprehend, and relate relevant information
  - Is the person able to receive and retain information that is necessary for the decision they are making?

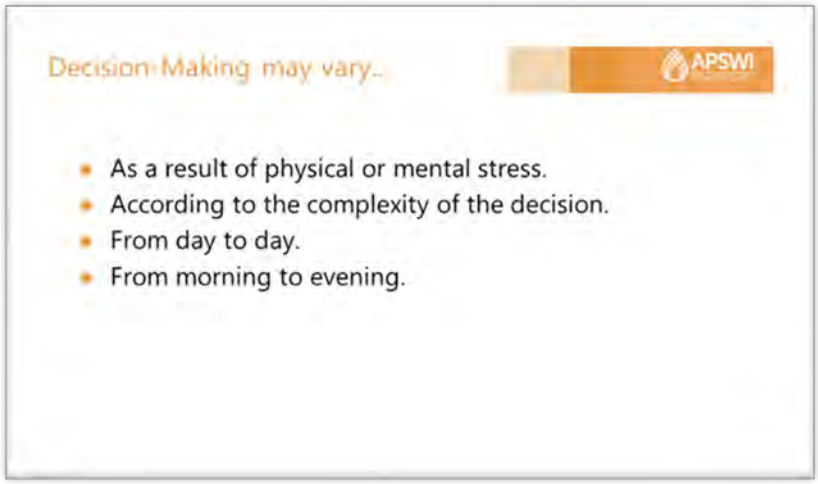
- Express choice consistently
  - Is their choice wavering due to circumstance, time, etc. or is the same?

- Appreciate the nature of their condition
  - Is the person able to explain the significance of the situation that is presented to them? For example, a client has a significant cut on their leg with clear indication of an infection, and when asked about it the client states “that’s just a scrap, it will heal on it’s own.”

- Balance risks, benefits and burdens of choices
  - This attribute can be influenced by personal bias and cultural aspects.

- Communicate rationale choices
  - This is the expression of “why”. Can the client articulate why they want to make this decision? This helps to bring together all the other attributes. “I am making this decision because in my culture, when this happens, and there are no other factors…”

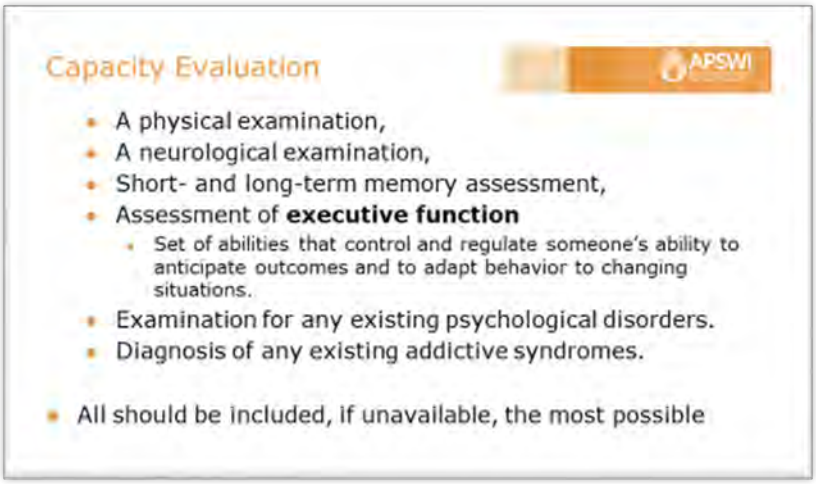
Slide #12: Decision-Making may vary…



- A person's decision-making abilities may vary for a number of reasons.
    - As a result of physical or mental stress.
        - Mental fatigue – we've all had those draining days where you are just ready for your brain to have a rest, not have to think about anything, and even avoid a decision such as "what's for dinner", because you don't want to put the energy into it.
    - According to the complexity of the decision.
        - This is where nuance comes in. We will use math as an example. A client may have the ability to complete simple arithmetic but can they understand calculus.
    - From day to day.
    - From morning to evening.
        - Sun downers, or a result of mental stress as indicated above.

- These reasons must be considered in assessing how a person is functioning.
- More on this topic will be discussed shortly.

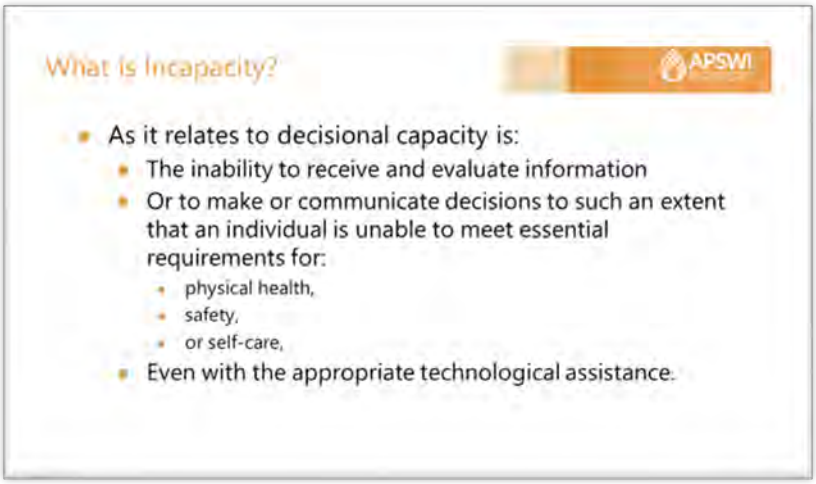
Slide #13: Capacity Evaluation



- To fully evaluate decision-making 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. We will discuss this in more depth later in the training.
    - 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.
- It is important that we consult with our supervisors when we have concerns about an individual's decision-making ability. The decision to have someone evaluated is based upon many different circumstances and usually includes the individual's level of risk.
- Later, we will identify which professionals are qualified to conduct capacity evaluations.

Slide #14: What is Incapacity?

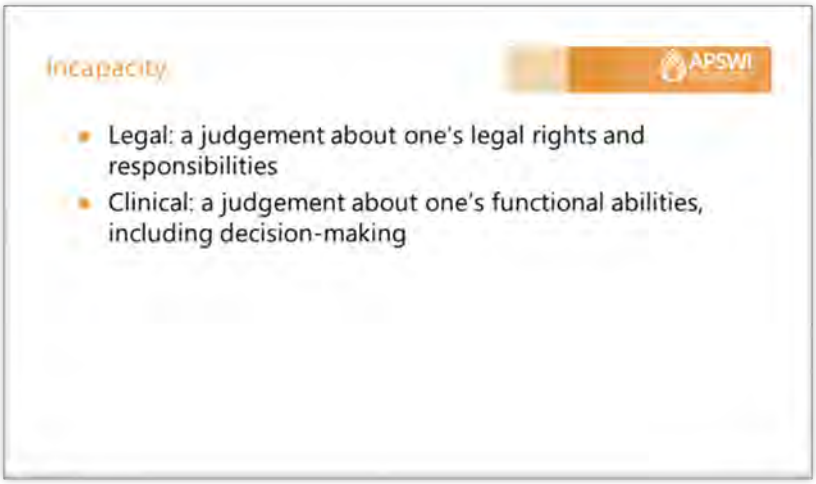


Incapacity, as it is related to decisional capacity, is:

- 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 #15: Incapacity



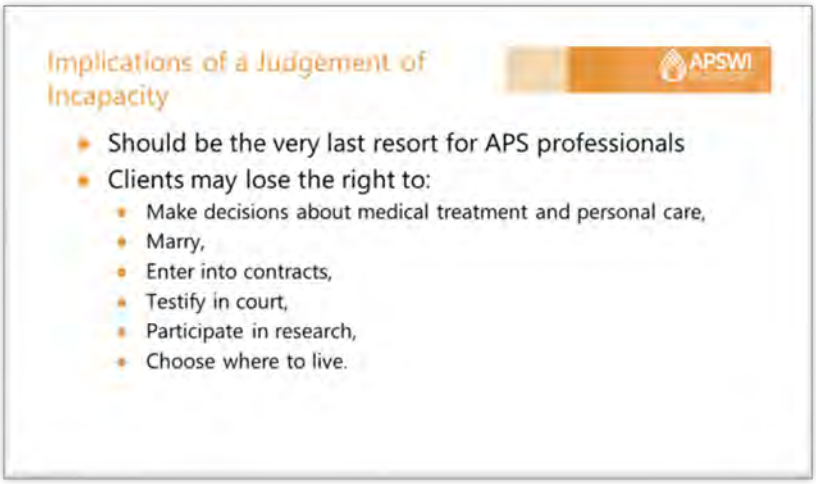
There are two basic types of incapacity judgments:

- Legal incapacity is the judgment about one's legal rights and responsibilities
- Clinical incapacity is a judgment about one's functional abilities, including decision-making

Trainer Note: Quinn, Mary Jo 2005. 114-116 and 275-277.

Mary Jo 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 #16: Implications of a Judgment of Incapacity



Share the following:

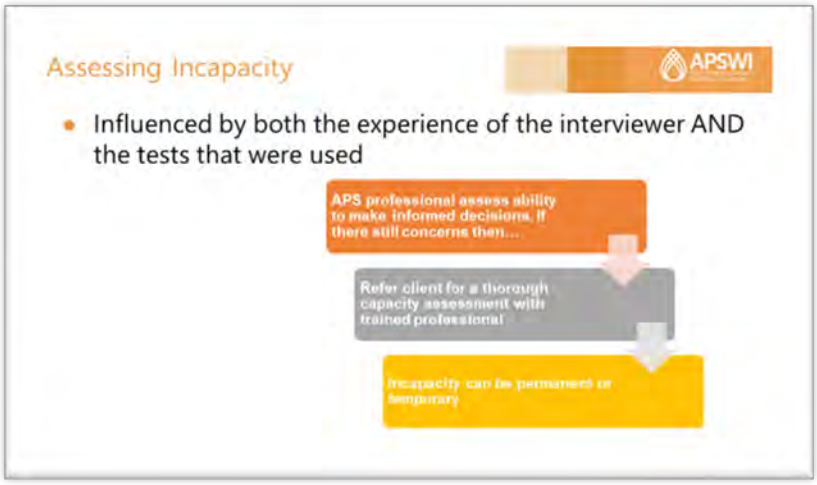
- The implications of a judgment of incapacity are life changing. Individuals may have many of their most basic rights curtailed.
- This is a very serious decision. Requesting a judgment of incapacity from a court should be the very last resort for APS professionals.
- Clients may lose the right to:
    - Make decisions about medical treatment and personal care,
    - Marry,
    - Enter into contracts,
    - Testify in court,
    - Participate in research,
    - Choose where to live.

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

Ask: What were the results for them?

Allow a few participants to share.

Slide #17: Assessing Incapacity



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

- As an APS professional, we assess a client's ability to make informed decisions.
- If, after our assessment, we have concerns with a client's ability to make informed decisions, we need to refer the client for a thorough capacity assessment from a trained professional.
- Incapacity can be permanent, or temporary, based upon the factors that are causing the inability to make informed decisions.
- **Age, eccentricity, poverty or medical diagnosis ALONE do not justify a finding of incapacity.**

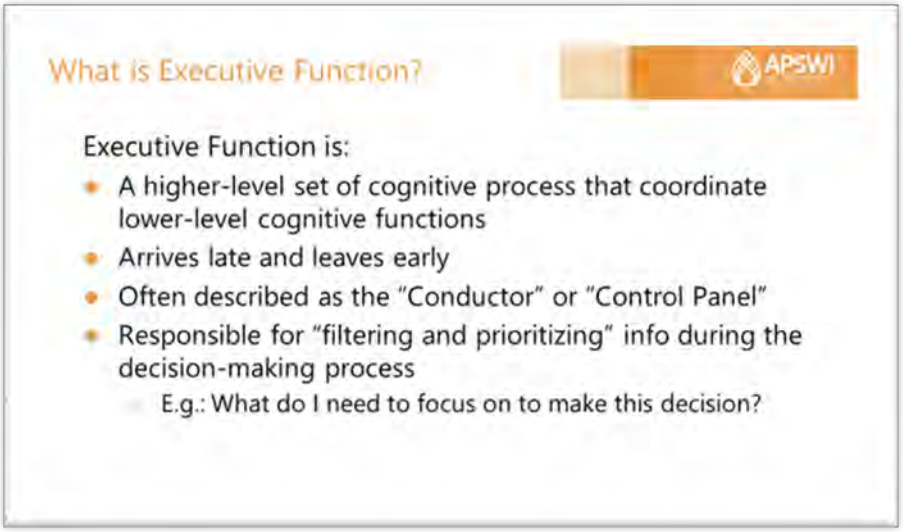
Measurement of decision-making ability happens only at a specific point in time and is based upon the type of decision being made.

- Decision-making ability is influenced by **medical conditions** such as:
  - Medication and medication interactions, which can include over or under medicating
  - Urinary Tract Infections
  - Sensory deficits that impact the ability to process information
  - Substance use
  - Mental illness
- Assessments are also influenced by **situational factors such as:**
  - Substance use that impacts a person's ability to think clearly and understand the consequences of decisions
  - Depression, grief, fear, or undue influences
  - Social setting
  - Nutrition

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

Slide #18: What is Executive Function?

Trainer Note: This slide is animated to allow you to talk through points.



Earlier we mentioned that a full capacity evaluation included assessing someone's executive functioning. This also is an important piece of the overall APS assessment when screening for decision-making ability.

Executive function is a higher-level set of cognitive process (i.e. Abstraction/critical thinking/emotional regulation) that coordinate lower-level cognitive functions (i.e. sensory inputs).

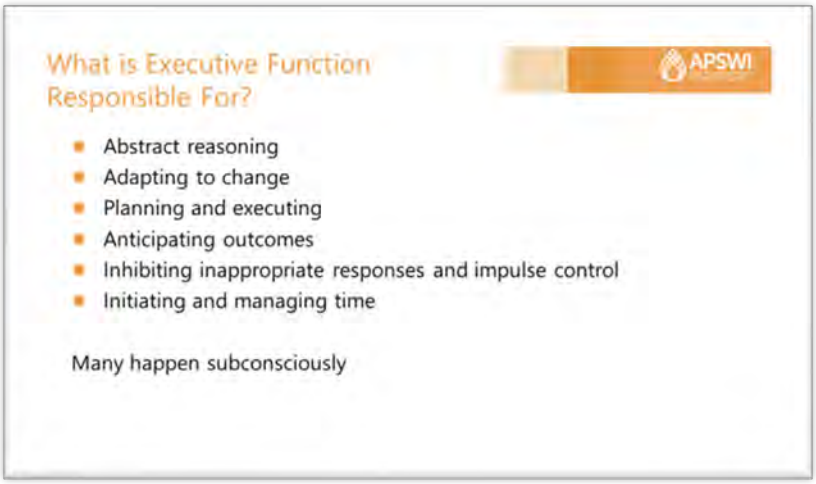
- Executive function arrives late and leaves early
    - Developmentally, executive function fully forms in the mid to late 20's and can start to decline, as early as, in someone's mid to late 30's.
    - Declines can be subtle and do not necessarily mean someone lacks decision-making ability.
    - Executive function is susceptible to decline due to deficits in the lower level cognitive functions, which include sensory inputs.
- Executive function can be described as the "Executive", "conductor", or "control panel"
- Executive function is responsible for "filtering and prioritizing" information during the decision-making process.
    - Executive function assists us with focusing on the information that impacts the decision to be made and reducing reliance on information that has little to no bearing on the decision's outcomes.
    - What this boils down to, executive function helps up remove the "noise" during the decision-making process and allows us to focus on outcomes and planning to implement any change from the decision. Removing the "noise" does not simply mean simplifying the information, it means

Continued

focusing on the important information and removing aspects that “cloud our judgement”.

- E.g.: Using a lottery scam as an example. “Mr. Smith, you have won the international lottery!! For you to collect your winnings all you have to do is send us payment for taxes and fees.”
    - Without executive function, we focus on the “I won” and “all I have to do is x”.
    - Executive function allows us to say “slow down, does this make sense”.

Slide #19: What is Executive Function Responsible For?



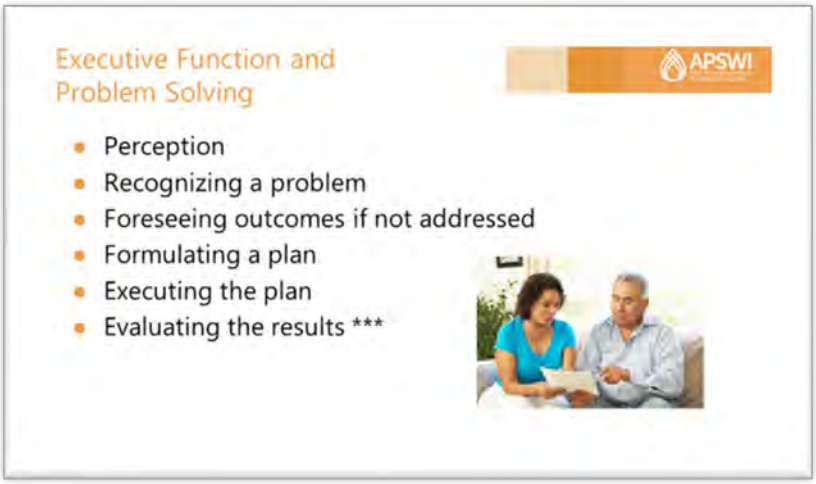
To help illustrate what "higher-level set of cognitive process that coordinate lower-level cognitive functions" means, consider that executive functioning is responsible for the following:

- Abstract reasoning
- Adapting to change
- Planning and executing
- Anticipating outcomes
- Inhibiting inappropriate responses and impulse control
- Initiating and managing time

Many aspects of executive functioning happen subconsciously and do not require us to "actively" think about.

Slide #20: Executive Function and Problem Solving

Trainer Note: Providing a scenario with examples of each step, may be helpful.



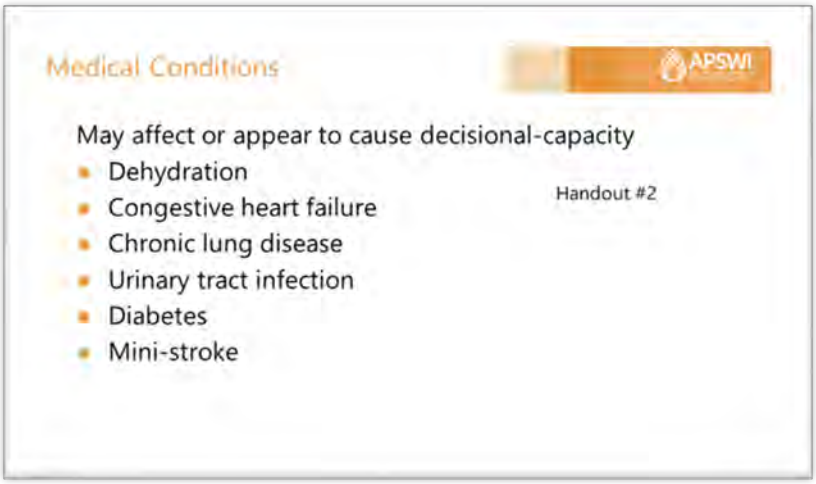
- As you can see, executive function plays an important role in our everyday life.
- Problem solving is an important aspect related to decision-making ability. We will spend a couple minutes discussing the process for solving problems.
    - Perception- being able to recognize stimuli and information
    - Recognizing a problem – something isn't working (money management, medication management, ADL/IADL completion, or medical care)
    - Foreseeing outcomes if not addressed – what will happen if this doesn't change
    - Formulating a plan – What are the steps necessary to accomplish my goal
    - Executing the plan – maintaining flexibility throughout the process
    - Evaluating the results – if we do not evaluate the results, how do we know that the plan worked?
        - This is one of the critical aspects of executive function and important for APS professionals to evaluate during the case planning process.
- As you can see, aspects of executive function are involved in every step of the process.

FACTORS AFFECTING CAPACITY & ABILITY
Time Allotted (45 minutes)

Slide #21: Medical conditions

HANDOUT #2

Factors Affecting Decisional Impairment



Share the following:

- There are many factors that affect a person's decision-making capacity and ability, including medical conditions, some of which are listed on the slide.
- In **Handout #2- Factors Affecting Decisional Impairment**, you will find a number of physical, psychological and situational factors which may cause a person to ***appear*** to lack decisional 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 factors diminished the client's decision-making ability and resulted in the adult's inability to make informed decisions?*

TRAINER NOTE: Joanne Otto, MSW, authored the original curriculum module: Assessing APS Clients' Decision-Making Capacity. She served as Executive Director of the NAPSA, 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

HANDOUT #2
FACTORS THAT AFFECT DECISION-MAKING

Factors Affecting Decision-Making in APS Clients | Screening for Decision-Making Ability

An individual's decision-making ability can be influenced by a number of factors, some of which can change day to day or hour to hour. When screening for decision-making ability, be mindful to identify any of the following factors which could influence a client's ability to make decisions.

Situational Factors

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.
Depression or Anxiety	Anxiety and depression can impact older adults in many ways and can make managing day-to-day issues more difficult. Depression can mimic cognitive impairment.
Grief	Intense grief reaction may result in temporary confusion, dependency, exhaustion and inability to make decisions. Grief can also leave a person susceptible to undue influence, which can impact a client's ability to make decisions.
Low IQ or Low Health Literacy	May affect patient's understanding of choices, risks and benefits. Health literacy is the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment.
Substance Use	As we age, we metabolize alcohol at faster rates, so consuming even small amounts of alcohol can impact older adults more quickly, and can ultimately lead to malnutrition and neurocognitive impairment due to substance use.

Medical Factors

Urinary Tract Infection	Most common infection in older adults. They can present as acute change in cognitive status and may result in confusion or delirium.
Chronic Pain	May inhibit the ability to receive and evaluate information due to lack of concentration or attention. Research suggests a relationship between untreated pain and increased depression among the older adults.
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.
Disease	Thyroid, diabetes, cancer, Parkinson's, heart disease and AIDS may cause diminished capacity as the diseases progress.
Low Blood Pressure	Can be due to medication error, causing dizziness, weakness and falling, which could result in head injury.
Physical Illness	May result in electrolyte imbalances that cause confusion and prevent rational decision-making.
Traumatic Brain Injury	May be the result of physical abuse or a fall. Falls are the most common injury in older adults due to difficulties with ambulation, environmental hazards, dizziness, alcohol, medications, or stroke. A patient with sudden changes in mental status after a fall may have subdural hematoma.
Sensory Deficits (e.g., hearing or vision loss)	Can mimic or exacerbate cognitive impairment. Communication difficulties due to sensory or physical impairments are often mistaken for confusion.
Substance Abuse	Illegal and prescription substance abuse in the APS population can be as much a factor as in the rest of the population.
Medication Mismanagement	Drug interactions and adverse reactions are common and can be serious. May be due to client'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.

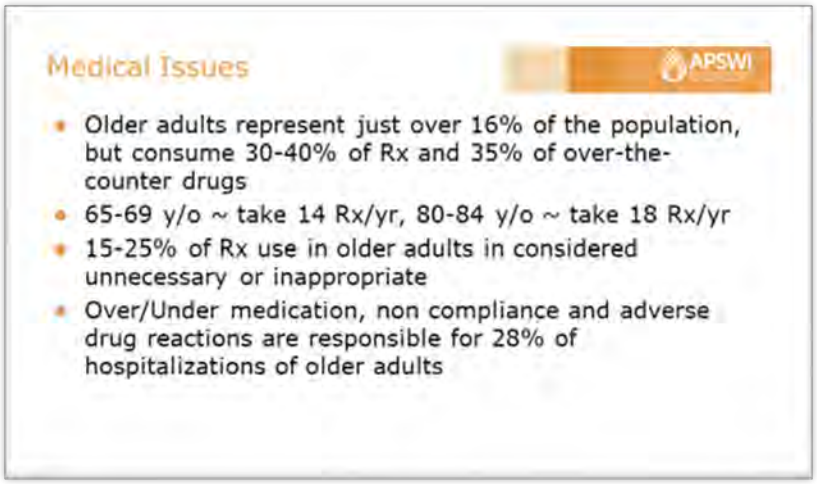
Medication-Related Problems

Adverse Reactions	Adverse prescription drug reactions and noncompliance are responsible for 28% of hospitalizations of older adults and 36% of all reported adverse drug reactions involve an older adult.
Medication Interactions	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 your client is taking four medications or more, it is likely that there could be serious interactions.
Medication Side-Effects	All medications have side effects—some are minor but some can be very serious.

Conditions Impacting Decision-Making

Neurocognitive Disorders (NCDs)	An umbrella term used to describe a group of conditions that involve a significant, persistent decline in functioning over a period of time. NCDs aren't a specific disease. There are reversible conditions which can mimic neurocognitive disorders, but many NCDs are associated with diseases or medical conditions which involve irreversible damage to the brain. It is important to note that a diagnosis of an NCD does not automatically equate to a loss of decision-making capacity or ability. The symptoms of neurocognitive disorders present on a continuum in terms of deficits and impact.
Delirium	An acute disorder that occurs suddenly and usually fluctuates during the day. 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." Delirium is often reversible with treatment. It may be caused by existing cognitive impairment, severe physical illness, stroke, Parkinson's disease, or dehydration, and can be aggravated by acute pain.
Depression	A biological mood disorder that persists for two weeks or more and can be marked by sadness, detachment, loss of interest, sleep disturbances, weight loss, fatigue, difficulty thinking or concentrating, feeling agitated or irritable, suicidal thoughts, and/or trouble doing normal day-to-day activities. Depression is highly treatable.

Slide #22: Medication Issues



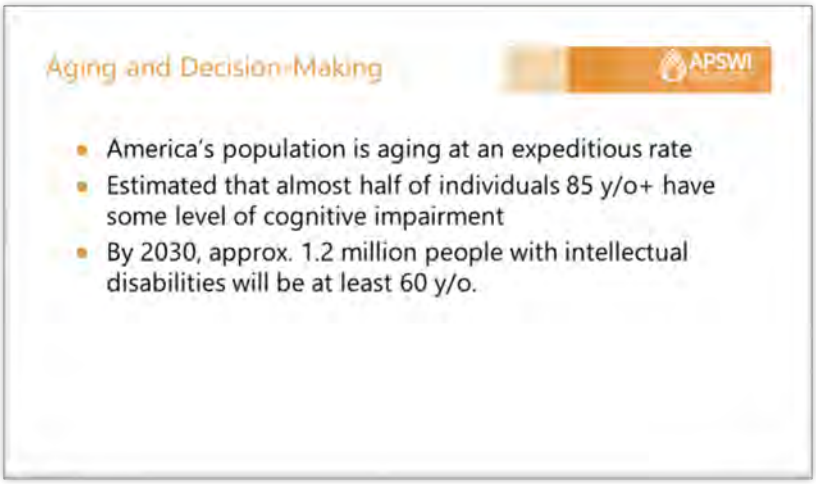
- Older adults represent just over 16% of the population, but consume 30-40% of prescription drugs and 35% of all over-the-counter drugs
- On average, individuals 65 to 69 years old take nearly 14 prescriptions per year, individuals aged 80 to 84 take an average of 18 prescriptions per year
- 15% to 25% of prescription drug use in older adults is considered unnecessary or otherwise inappropriate
- Over or under medication, non-compliance and adverse drug reactions are responsible for 28% of hospitalizations of older adults and 36% of all reported adverse drug reactions involve an older adult

Given these statics, 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, medical marijuana, herbal supplements, and other natural medicinal items and supplements). 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.

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 four 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*

Slide #23: Aging and Decision-Making



Review the following:

Handout #1-APS TARC Brief "Capacity Screening in Adult Protective Services: Guidance and Resources", highlights the fact that America's population is aging at an expeditious rate. According to U.S. Census Bureau, the number of Americans that will be aged 65 and older will double from 52 million to 95 million by 2060, accounting for almost one-quarter of the entire U.S. population. (2)

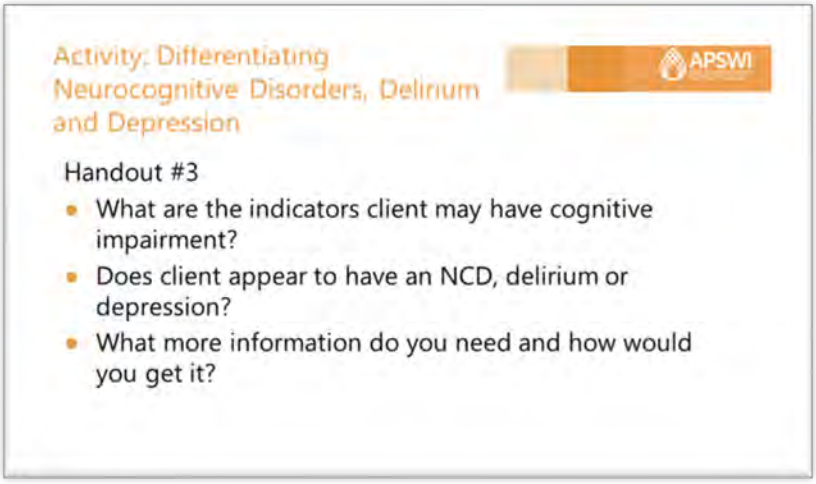
Because of the increase of persons who are 65 and older, you as and APS professional are likely to have an increase in the number of clients you interact with that have a cognitive impairment. It is estimated that almost half of individuals 85 years of age and above have some level of cognitive impairment. (3)

We should also consider the impact that advancements in medicine have had on life expectancy and its relationship with individuals with intellectual disabilities. By 2030, approximately 1.2 million people with intellectual disabilities will be at least 60 years old (4)

Let's take a look at 3 disorders that can commonly impact older adult's decision-making ability and how they can be distinguished.

Slide #24: Activity: Differentiating Neurocognitive Disorders (NCD), Delirium and Depression

HANDOUT #3: NCD, Delirium and Depression Case Studies



Neurocognitive Disorders, **Delirium**, and **Depression**, are three of the leading factors that can impact decision-making capacity and ability. In the past, these conditions were commonly referred to as *The 3 D's*. However, we have replaced *Dementia* with *Neurocognitive Disorders* in recognition of the stigma sometimes associated with the term dementia and to be consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5).

Activity #2: NCD, Delirium and Depression, 10-15 min
Large group

Refer participants to **Handout #3.**

Ask a volunteer to read the first case study #1 aloud and process the following questions, taking into account all client considerations (culture, education, language) when deciding how to conduct your assessment.

1. What are the indicators that client may have a cognitive impairment?
2. Does the client appear to have an NCD, delirium or depression?
3. What more information do you need and how would you get it?

Continue with case study #2 and #3.

If training virtually, it is encouraged to **have** participants to take themselves off mute, rather than using the chat box. You can **ask** each question and **have** a different volunteer unmute themselves to answer and get participation from a variety of learners.

TRAINER NOTE: Rosemary = Delirium, Proful = NCD and Mary Jo = Depression. Share reasons why these are most likely what each person is experiencing.

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

HANDOUT #3
NEUROCOGNITIVE DISORDERS, DELIRIUM AND DEPRESSION CASE STUDIES

Case Study #1 – Rosemary Cellini

Rosemary 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 Rosemary the week before when she returned from a brief hospitalization and she seemed fine at that time. When found wandering, Rosemary didn'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 learned 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.

1. What are the indicators that client may have a cognitive impairment?

2. Does the client appear to have a NCD, delirium or depression?

3. What more information do you need and how would you get it?

Case Study #2 – Proful Dixit

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

Proful has medication for arthritis, high cholesterol and Parkinson's.

1. What are the indicators that client may have a cognitive impairment?

2. Does the client appear to have a NCD, delirium or depression?

3. What more information do you need and how would you get it?

Case Study #3 – Mary Jo Jackson

Mary Jo Jackson, age 73, was referred to APS after the police did a welfare check requested by Mary Jo's neighbor, who reported they hadn't seen Mary Jo for a week and last time they saw each other, Mary Jo appeared to have suddenly lost weight.

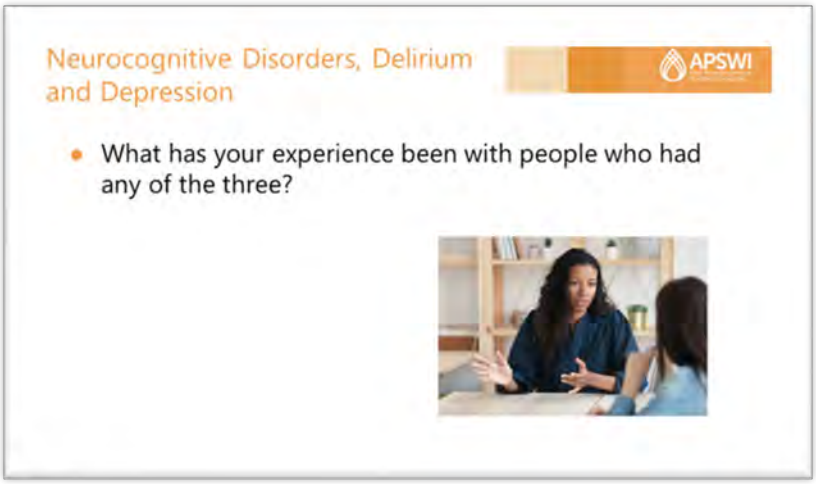
When you visit, Mary Jo asks, "Are you the police? They were just here the other day." During your visit, Mary Jo appears to have difficulty focusing on your conversation and states that she is tired about every five minutes. When you ask Mary Jo about her friendships and support system, she shrugs and seems uninterested in discussing her neighbor's concerns. She says she'll call her friends "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 Mary Jo appears unconcerned about getting more food in. She asks you to leave because she doesn't feel up to answering questions and just wants to sleep all day.

1. What are the indicators that client may have a cognitive impairment?

2. Does the client appear to have a NCD, delirium or depression?

3. What more information do you need and how would you get it?

Slide #25: Neurocognitive Disorders, Delirium and Depression



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

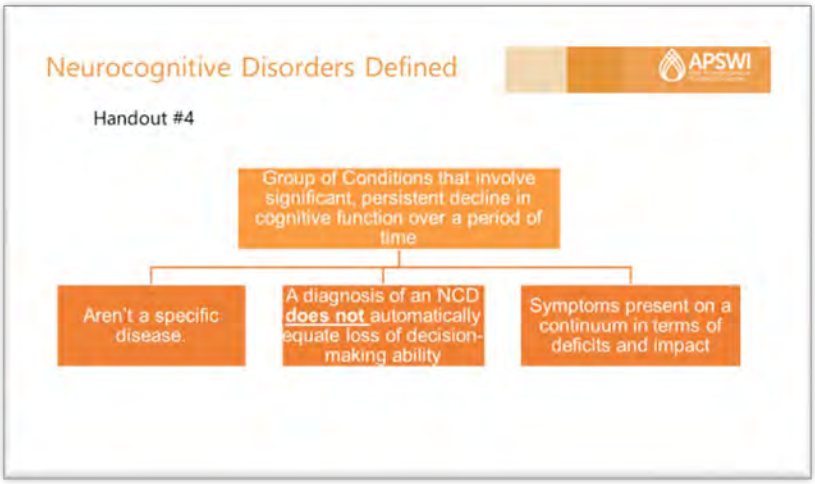
Ask: Participants about their experience in sorting out these three issues – what have their challenges been?

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

Slide #26: Neurocognitive Disorders Defined

HANDOUT #4:

Medical Conditions Affecting Capacity



Share the following and **acknowledge** that it may be difficult or take time shifting from the term "Dementia" to Neurocognitive Disorders.

Neurocognitive Disorders (NCDs) is an umbrella term used to describe a group of conditions that involve a significant, persistent decline in cognitive function over a period of time.

- NCDs aren't a specific disease. There are several reversible conditions which can mimic neurocognitive disorders, but many NCDs are associated with diseases or medical conditions which involve irreversible damage to the brain.
- It is important to note that a diagnosis of an NCD does not automatically equate to a loss of decision-making capacity or ability.
- The symptoms of neurocognitive disorders present on a continuum in terms of deficits and impact.

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 neurocognitive disorders and other issues that affect capacity.

HANDOUT #4
MEDICAL CONDITIONS THAT INFLUENCE DECISION-MAKING ABILITY AND CAPACITY

Adapted from APSWI Screening for Decision-Making Ability with APS Clients eLearning and Appendix G. Medical Conditions Affecting Capacity-Assessment of Older Adults with Diminished Capacity

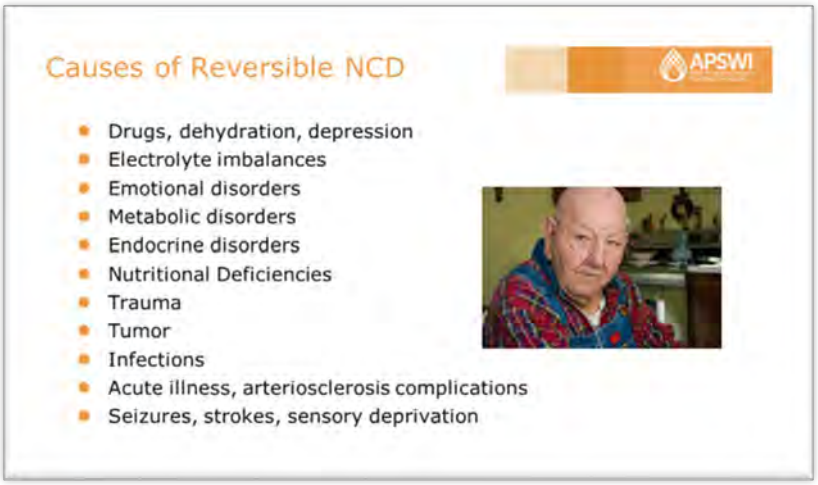
Condition	Symptoms/ Source
Urinary Tract Infection (UTI)	One of the most common infections in older adults. Can present as acute change in cognitive status and my result in confusion or delirium
Chronic Pain	May inhibit the ability to receive and evaluate information due to lack of concentration or attention. Research suggest a relationship between untreated pain and increased depression among older adults.
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 call cause dehydration.
Disease (e.g. Thyroid, diabetes, cancer, Parkinson's, heart disease, and AIDS)	Certain diseases may cause diminished capacity as the diseases progress.
Low Blood Pressure	Dizziness, weakness and falling, which could result in head injury. Can be due to medication error.
Physical Illness	Confusion and prevent rational decision-making. May result in electrolyte imbalances
Traumatic Brain Injury (TBI)	Falls are the most common injury in older adults due to difficulties with ambulation, environmental hazards, dizziness, alcohol, medications, or stroke. A patient with sudden changes in mental status after a fall may have subdural hematoma. Physical Abuse can also cause a TBI.
Sensory Deficits (e.g. hearing/vision loss)	Can mimic or exacerbate cognitive impairment. Communication difficulties due to sensory or physical impairments are often mistaken for confusion.
Substance Use Disorders	Illegal, prescription, or recreational substance use in the APS population can be as much a factor as in the rest of the population.
Neurocognitive Disorders (dementias)	Usually marked by cognitive impairment and loss of functioning from a baseline level of performance.
Serious Mental Illness	A mental health disorder that results in serious functional limitations that impact one or more major life activities.

Slide #27: Irreversible NCDs

Many of the Neurocognitive Disorders that you are probably familiar with are progressive diseases that are not able to be cured. Treatments for these types of diseases are usually rooted in slowing the progression of the disease. Medications and "cognitive" exercises are usually prescribed and suggested.

- Alzheimer's Disease
- Vascular Neurocognitive Impairment
- Parkinson's Disease
- Frontal-Temporal NCD
- NCD with Lewy Bodies
- Alcohol-related NCD

Slide #28: Causes of Reversible NCD



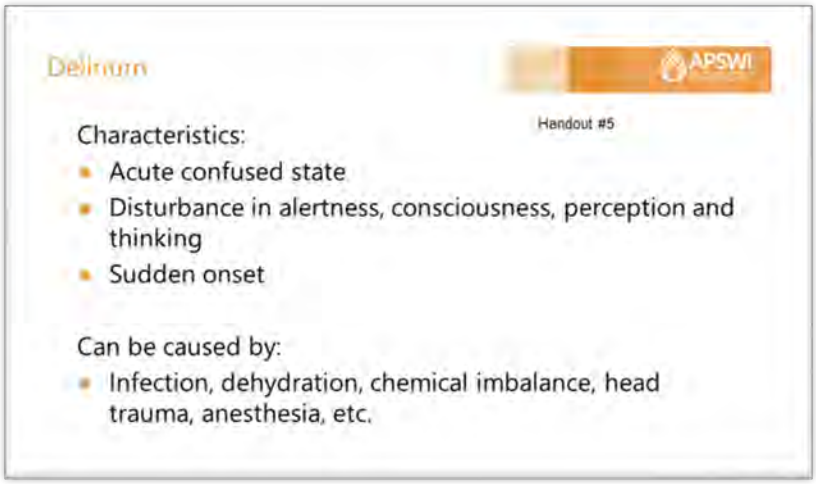
- **Drugs, dehydration, depression**
- **Electrolyte imbalances:** The most serious electrolyte disturbances involve abnormalities in the levels of sodium, potassium, and/or calcium. Other electrolyte imbalances are less common and often occur in conjunction with major electrolyte changes. Chronic laxative 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 #29: Delirium

HANDOUT #5:

Confusion Assessment Method (CAM)



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 five minutes and measure two areas:

- Part 1 is an assessment instrument that screens for overall cognitive impairment
- Part 2 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*

HANDOUT #5:
CONFUSION ASSESSMENT METHOD (CAM)

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

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])

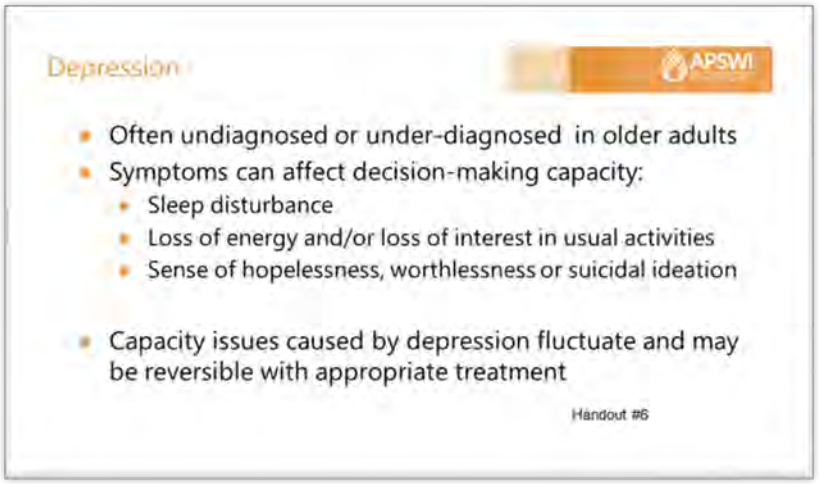
Source:

Inouye SK, van Dyck CH, Alessi CA, Balkin S, 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.

Slides #30: Depression

HANDOUT #6

Geriatric Depression Scale & Columbia-Suicide Severity Rating Scale.



Depression in older adults 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 in their Participant Manual. There are two scales they can use in their practice: **Geriatric Depression Scale – Short Form** and the **Columbia- Suicide Severity Rating Scale**.

Share that if there are any concerns for possible suicide ideations, APS professionals need to follow their agency's protocol and immediately connect with appropriate response people.

Encourage participants to follow up with their Supervisor about these Scales or others that are available and request training on working with people who express suicidal thoughts or ideations.

HANDOUT #6
GERIATRIC DEPRESSION SCALE
(SHORT FORM)

Choose the best answer for how you have felt over the last 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)

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *How long ago did you do any of these?*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

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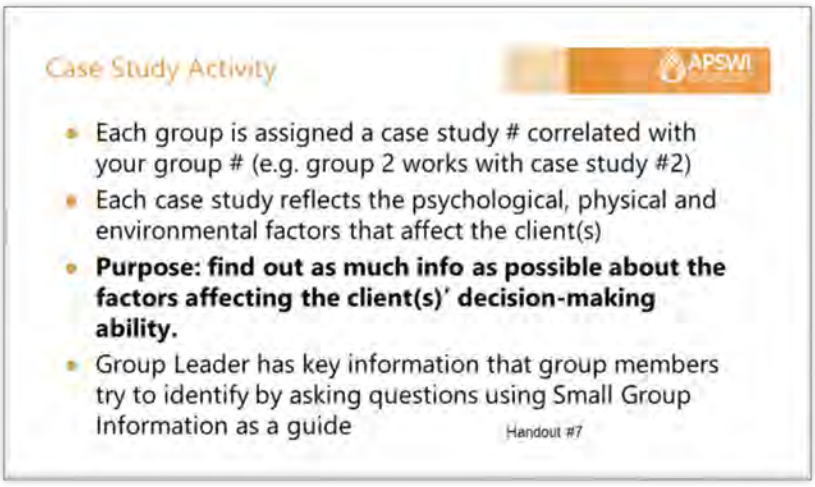
ASSESSING DECISION-MAKING ABILITY
Time Allotted: 35-40 minutes

Slide #31: Case Study Activity

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



Activity #3: Case Study- Assessing, 25 minutes
Small groups

Explain that this next activity will be completed in small groups of 4-5. If training virtually, **use** breakout room function if available. If not, **choose** 1-2 case studies and **do** as a large group.

Share that we'll use these case studies in a later activity where we will ask for volunteers to role-play. **Ask** that each participant keep this in mind when completing this activity as we hope someone from each group would be willing to play the role of the person with decision-making ability in question, but we will not force anyone to do so.

Inform participants of the following, **pausing** for time to process each step: (**note**, simplified instructions are in their participant manual)

- Each group will receive a case study involving a client whose decision-making ability is in question.
    - Each case study reflects the psychological, physical and environmental factors that affect the client(s) named in the case.
- The **purpose** of this exercise is to find out as much information as possible about the factors affecting your group's client's decision-making ability.

Explain that once they are in their groups, they should follow these instructions:

- Identify a Group Leader who will receive a handout which will contain key information about the case. This is for the Group Leader only.
- They need to choose a recorder to record group's thoughts and will be responsible for reporting out for the group.
- All non Group Leaders will receive a handout which provides some general information about their case and will help inform the questions they ask the Group Leader.

Continued

- Once in groups, everyone but the Group Leader should 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 Group Leader 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 ability to make informed decisions.
- Think about the questions you should ask the Group Leader in order to get the information you need. Please refer to case study **Small Group Information** to guide your quest for information.
    - You will ask questions for approx. 20 min.
- The Recorder will write all the available information on case study **Small Group Information** as the Leader answers your questions.
- The Group Leader should remind members to ask them questions about the case study client using **Small Group Information** as a guide. The recorder will note the answers on the Handout.
- The Group Leader will answer the questions using **Group Leader Information**.
    - Do not volunteer additional information about the client unless you are asked directly.
- After 20 minutes, the Group Leader will lead a 5 minutes discussion asking the questions:
    1. Which factors did you miss?
    2. How might you have questions me more specifically to get the missing information?
- Group leaders share information not already identified by small group.

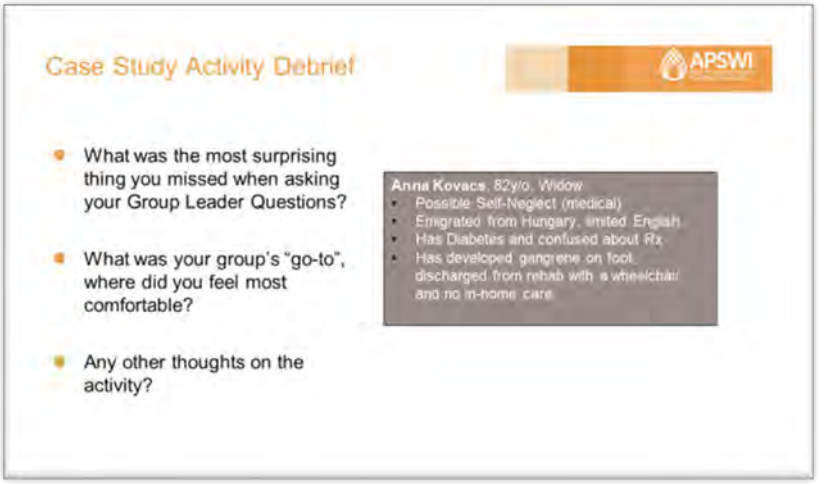
In-person delivery: Once participants are in groups, **assign** each group a Case Study (Case Study 1-5) and **provide** each Group Leader **Handout #8**. **Ask** the Group Leader to locate their case study on the handout. **Provide** the rest of the group **Handout #7 Ask** them to locate their case study on the handout.

Virtual delivery: If using breakout rooms, inform participants their breakout room number is also the number of their case study. Before launching breakout rooms, **inform** them **Handout #8** is for the Group Leader only and identify their case study, reflective of their breakout room number. The rest of the group will look at **Handout #7** and identify their case study which is reflective of their breakout room number.

- Once breakout rooms have been launched, **visit** each room and **ask** for the Recorder's name. You can call on this person directly in the report out of the activity to speed up the process.

Slide #32: Case Study Activity Debrief

Trainer Note: This slide is animated to allow summary points from each case appear and disappear for each group's report out.



Activity Debrief: 7-10 minutes

Gather everyone back and **ask** the following questions for a general debrief of the activity:

- What was the most surprising thing you missed when asking your Group Leader Questions?
- What was your group's "go-to", where did you feel most comfortable?
- Any other thoughts on the activity?

Trainer Note: After the activity, check in with the groups and ask if someone from each group is willing to play the role of the APS client in a later activity. If you get a volunteer from each group, then in Activity #4 you can do breakout/table groups. If you have less than that, do whichever scenarios you have volunteers for as a large group. If no one volunteers, see Activity #4 for suggestions. If you have no volunteers to play the role, it's suggested that you choose one or two that you are comfortable

HANDOUT #7
SMALL GROUP CASE STUDY INFORMATION

Case Study #1: Anna Kovacs
Small Group Information

Group Task: Your leader has information about 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 decision-making ability 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 decision-making ability.

Reason for referral to APS: Possible self-neglect (medical) 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:

Case Study #2: Juan Garcia
Small Group Information

Group Task: Your leader has information about Juan Garcia. 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 decision-making ability 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 decision-making ability.

Reason for referral to APS: Self neglect and refusing medical treatment

Referral made by: Staff at home health care agency

Psycho-social Factors Affecting Capacity:

Physical Factors Affecting Capacity:

Environmental Factors Affecting Capacity:

Client's Prognosis:

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 decision-making ability 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 decision-making ability.

Reason for referral to APS: Possible self-neglect

Referral made by: Mark's daughter

Psycho-social Factors Affecting Capacity:

Physical Factors Affecting Capacity:

Environmental Factors Affecting Capacity:

Client's Prognosis:

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 more about their and what factors may be affecting their 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 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:

Case Study #5: Sharon Delay ***Content Warning
Small Group Information

Group Task: Your leader has information about Sharon Delay. Your task, during 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 decision-making ability 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 Sharon's decision-making ability.

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:

HANDOUT #8
GROUP LEADER CASE STUDY INFORMATION

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 has diabetes and 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 dangerously high.
- 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 had been previously been an excellent cook and housekeeper.
- 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.

Case Study #2: Juan Garcia
Group Leader Information

Reason for referral to APS: Self-Neglect, Medical

Referral made by: Staff at home health agency

Psycho-social Factors Affecting Capacity

- Juan is a 28-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 10 years, he has sent money home every week to support his family.
- Juan has a sixth grade education. His can converse in English to some extent, but 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.
- Upon release from the hospital, Juan went back to living in the community with the support of a home health agency.
- Home health 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 but has been complaining of constant headaches.
- 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.

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, declining to answer the phone or the door.
- He has been in two "fender-benders" while driving his car on major thoroughfares.
- He refused 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 gestures 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 soda 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.

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 had 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 for them financially from the farm revenue.
- The farm business has failed and the son recently put it 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 arm's 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 the home.

Prognosis

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

Case Study #5: Sharon Delay ***Content Warning
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 woman with a developmental disability. She has a moderate intellectual disability, reads with difficulty, but is verbal and communicates with staff and peers.
- 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 infection. She says that she is on the pill, and Jake used a condom.

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 sexual assault forensic 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".

Prognosis

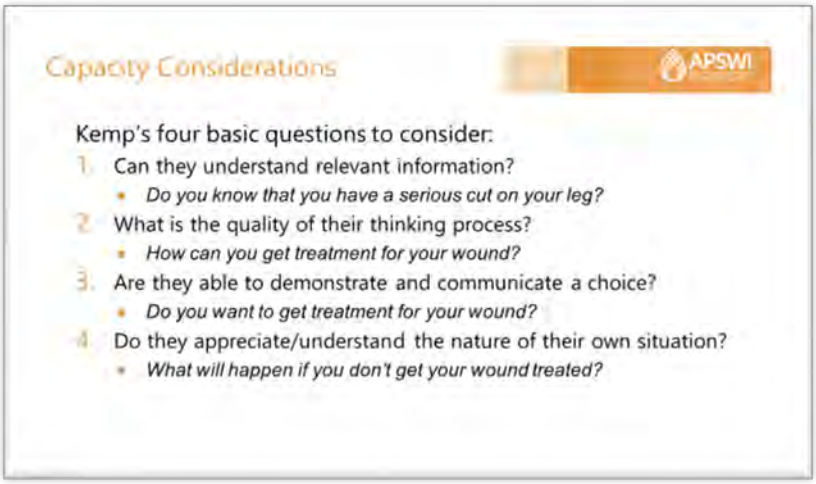
Sharon will not be allowed to have another sexual relationship.

Special Consideration for APS professionals:

Many jurisdictions require cross reporting to Law Enforcement (LE) in cases of alleged sexual abuse. You can be a resource for the client when working with LE. APS professionals can discuss with others they work with that a diagnosis alone, does not mean automatic loss of ability to consent to sexual activity.

COGNITIVE DOMAINS
Time Allotted: 25 minutes

Slide #33: Capacity Considerations



Here are four basic questions Dr. Bryan Kemp suggests APS professionals can use to consider when assessing a client's ability 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 their own situation?
   - *What will happen if you don't get your wound treated?*

Ask: *For this last component, what did you mean when you were trying to determine if the client "appreciates" the nature of their own situation?*

- The word "appreciate" is a legal term. These four components come from statues 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 their own situation
- When "appreciate" is **not** defined in a statute, it generally means "understanding".

Continued

- 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.

Trainer Note: if possible, research the statute applicable to the location where you are training and have participants review in depth.

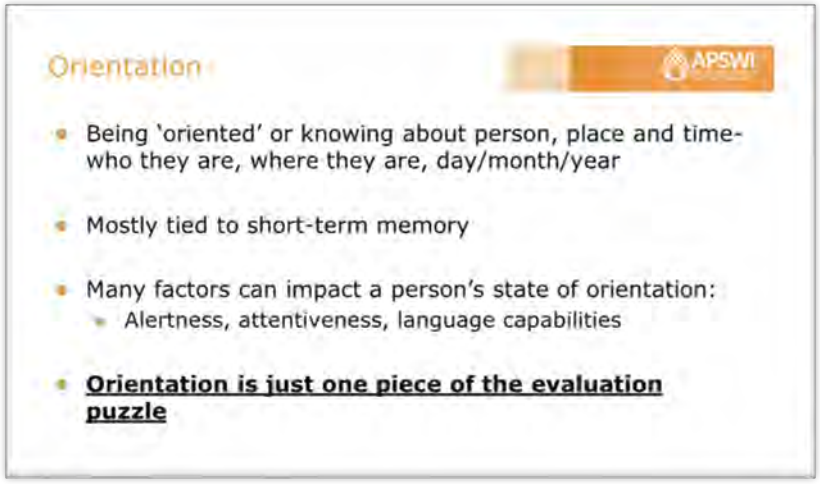
Slide #34: Cognitive Domains

As APS professionals use Kemp's questions to asses decision-making ability, it is important that you do so using the six cognitive domains as a reference. We will review the six domains and as we do, think about how Kemp's questions can apply to each domain and why the domains can impact decision-making ability.

Generally, there are six domains:

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

Slide #35: Orientation

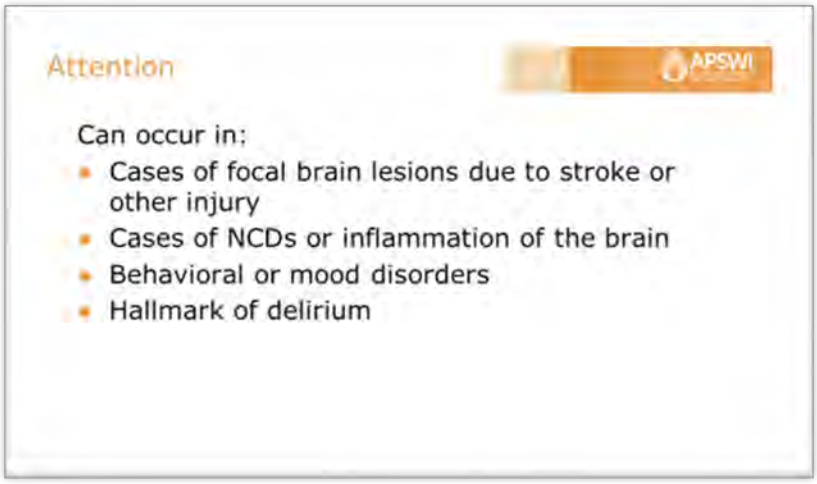


Orientation refers to the person being 'oriented' or knowledgeable about person, place and time, or who they are, where they are, and day, month, and year.

- These are mostly tied to short-term memory but in some cases can also be related to long-term memory and orientation.
- Many factors including level of alertness, attentiveness, and language capabilities can impact a person's current state of orientation, but if there has been a precipitous change in orientation, this could signal a critical medical condition such as delirium.

It is important to note, a finding of "alert and oriented" **does not equate** to an ability to make informed decisions. Conversely, someone who is not "alert and oriented" does not necessarily lack the ability to make informed decisions. This is just one piece of the evaluation puzzle.

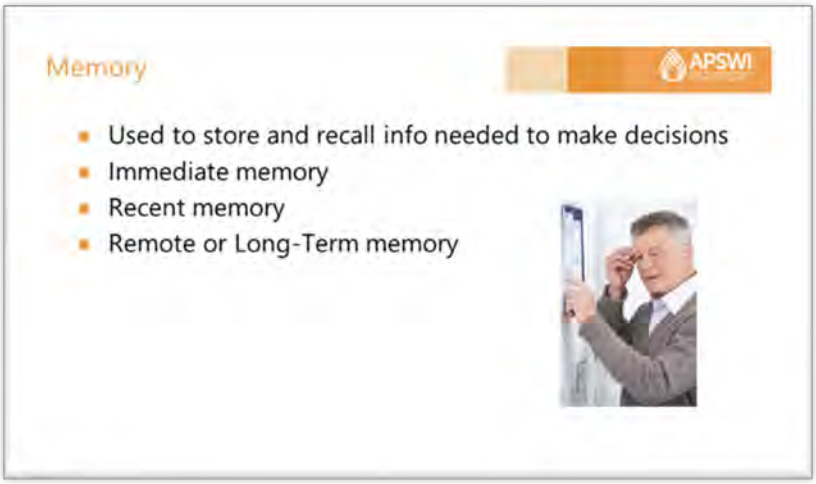
Slide #36: Attention



A lack of a person's ability to focus and maintain attention can be a key indicator in assessing a person's decision-making ability.

- Attention deficits can occur in cases of focal brain lesions due to stroke or other injury to the brain.
- They can also occur in cases of neurocognitive disorders or encephalitis (inflammation of the brain), and in behavioral or mood disorders like depression.
- Impaired attention is also one of the hallmarks of delirium.

Slide #37: Memory



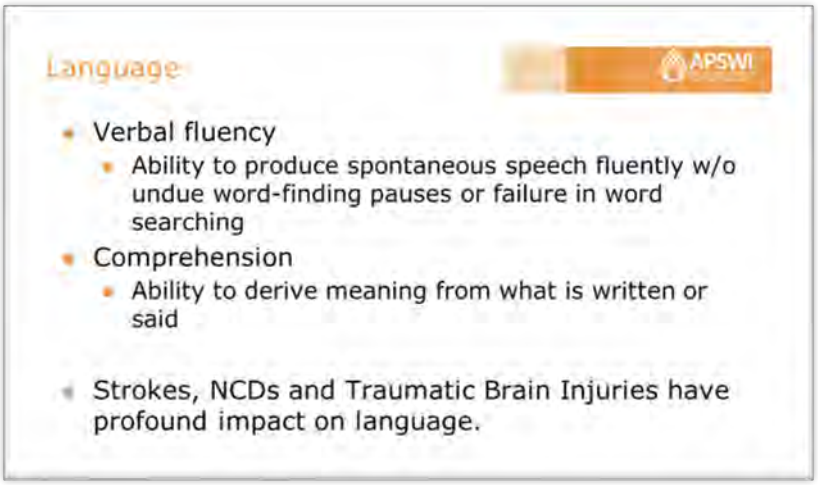
We use memory to store and recall information needed in the decision-making process. We will highlight three types of memory that can impact decision-making ability.

Immediate memory is the recall of a memory trace after an interval of a few seconds, as in repetition of a series of digits.

Recent memory is ability to learn new material and to retrieve that material after an interval of minutes, hours or days. Both Immediate and Recent memory are part of our short-term memory. Why is short-term memory important? It is required for tasks like taking medicine, adapting to taking a NEW medicine, keeping appointments, paying bills, fixing and eating meals.

Remote memory or Long-Term memory is the ability to recall and relate accurately events and pertinent facts from a more historical perspective. What is important about long term memory? Who do you call in case of emergency? What is your daughter or son's name and phone number? Show me how you would call them if something was wrong. Note that this can only be reliably tested if you verify the information given.

Slide #38: Language



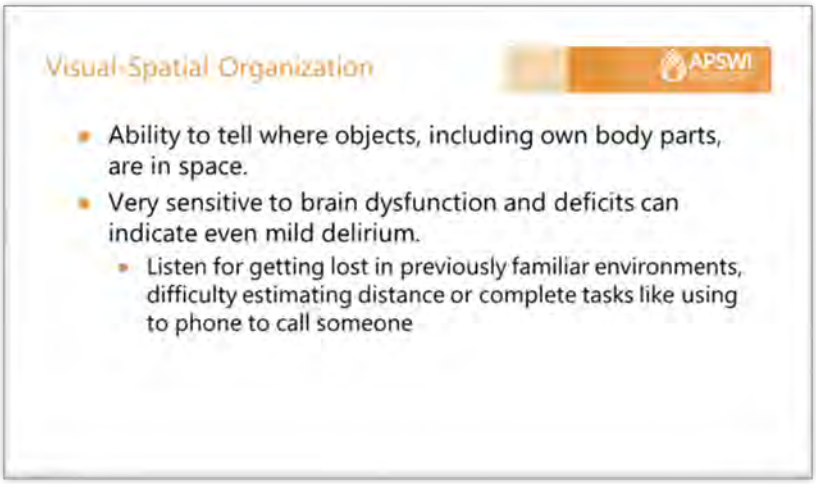
When we talk about language, we are really talking about Verbal Fluency and Comprehension.

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 is the ability to derive meaning from what is written or said**.** It can be measured by general ability to follow directions or commands on exams.

Strokes, Neurocognitive disorders and Traumatic Brain injuries can have profound impacts on language, from comprehension to expression.

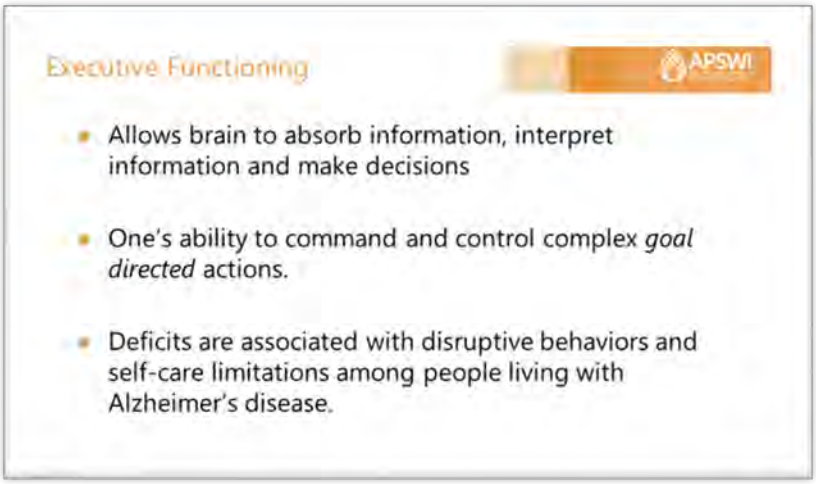
Slide #39: Visual-Spatial Organization



Visual-Spatial Organization is the ability to tell where objects, including your own body parts, are in space. It also involves being able tell how far objects are from you and from each other.

It is a very sensitive to brain dysfunction and deficits can indicate even 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 like the ability to use the phone to call someone.

Slide #40: Executive Functioning



Executive functioning is a group of functions that allow the brain to absorb information, interpret information and make decisions based upon this information.

Executive functioning is one's ability to command and control complex *goal directed* actions.

- Executive functioning can be viewed as the "executive" of a business, the "conductor" of an orchestra, or the "control panel" in an aircraft.
- It is responsible for organizing all the aspects of decision-making and allowing you to evaluate the results.
- Includes planning strategies to accomplish tasks, implementing and adjusting strategies, monitoring performance, recognizing patterns, and appreciating time sequences.
- Deficits are associated with disruptive behaviors and self-care limitations among people living with Alzheimer's disease.

METHODS FOR ASSESSING
Time Allotted: 80-90 minutes

Slide #41: APS Professional's Toolbox

In this section, we are going to discuss a variety of methods that can be used in assessing decision-making ability. These methods include APS interviews, formal screening tools, professional evaluations and other considerations. We will address ways to improve the utility of an APS interview, when a formal evaluation may be necessary, and how screening tools can be a help or hindrance during the assessment process.

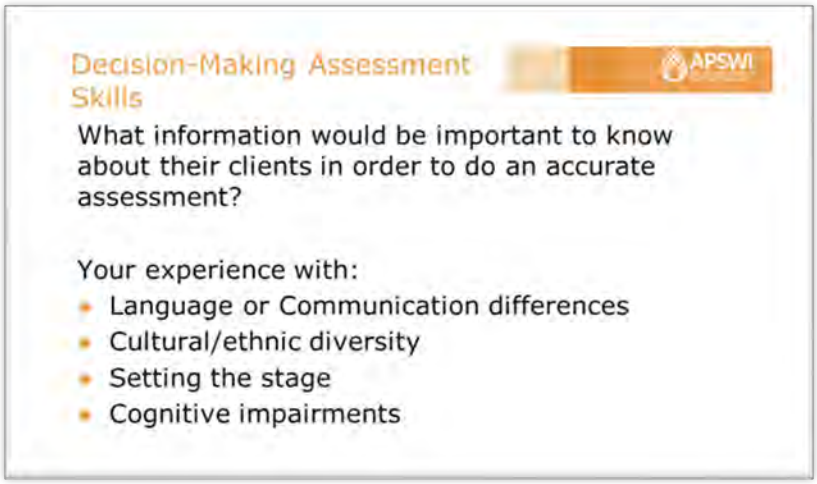
Because APS professionals are skilled in overall assessments and interviewing, we'll first spend some time on focusing on using your interviewing skills as a screening-tool.

Throughout this entire section, and in all trainings and interactions, APS professionals should interview while being culturally responsive. For the purpose of this training:

- "Cultural responsiveness, according to the National Center for Culturally Responsive Educational Systems (NCCREST), is "the ability to learn from and relate respectfully with people of your own culture as well as those from other cultures."
- The focus of this definition is that we each have our own journey, our own experiences, even when from similar cultures or identities and that relating respectfully with others allows us to be culturally responsive.
- Of course, no one knows all there is to know, even about their own cultures or identities. And it would be impossible to be an expert about every culture.
- What is important is to approach people of all 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 such as: attitudes, customs, faith/religious beliefs and family structure.

Slide #42: Decision-Making Assessment Skills

Trainer Note: This slide is animated.



Ask: What information would be important to know about their clients in order to do an accurate assessment?

- **Mention** the importance of knowing the client's educational level, as well as language ability and preferred language to be interviewed or assessed in – as these factors may influence the results of any tools they may use.
- **Discuss** how they deal with language differences (including sign language and people who do not speak) – how and if they use interpreters or assistive devises, what are the advantages and disadvantages.
    - Using interpreters should be a priority.
    - Never rely on the perpetrator or a family member to act as the interpreter
    - Direct all communication to the client and use non-verbal language skills as you address them
    - If interviewing someone who you have been told or you know from your own interaction with them does not speak, it is essential to find a professional who is familiar with their abilities and challenges and who is skilled in conducting capacity evaluations with people who do not speak.
        - Never assume that lack of speech means lack of decisional-capacity
        - Ask simple questions and allow for silence and time for processing the question.
        - Find out how they communicate- can they squeeze your hand, blink their eyes, or look left/right/up/down to answer questions.
    - **Refer** participants to **Handout #9- APS TARC Interview with Experts- Interviewing Persons with Disabilities**. **Explain** that this is a very brief overview that can be helpful. **Encourage** them to review on their own time.

Continued

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.
- 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 someone who has cognitive impairment or an intellectual disability.

HANDOUT #9

APS TARC INTERVIEW WITH EXPERTS- INTERVIEWING PERSONS WITH DISABILITIES

APS TARC
Adult Protective Services Technical Assistance Resource Center
enhancing effectiveness of APS programs

Interview with Experts – Interviewing Persons with Disabilities

Scott Modell on Improving your Interviews with Persons with Disabilities.

Scott J. Modell received his Ph.D. from the College of Education at Florida State University in 1997. From 2013 to 2016, he served as the Deputy Commissioner of the Tennessee Department of Children's Services. He has also served as the Deputy Commissioner of the Tennessee Department of Intellectual and Developmental Disabilities. Prior to moving to Tennessee, Dr. Modell spent fifteen years as a Professor at California State University, Sacramento. Over his last five years at the University, he additionally served as Director of the University's Autism Center for Excellence. He is an expert in child abuse, crime victims with disabilities, disability etiology, and interview techniques. He has authored nine books and has over 300 published articles and abstracts. Dr. Modell is frequently invited to lecture at national and international conferences regarding child abuse and crime victims with disabilities.

What are the biggest challenges APS workers face when interviewing persons with disabilities?

These interviews can be quite challenging in a number of ways. First, obtaining the necessary background information can be difficult depending on where the individual resides and who the caregivers are. This typically is easier when individuals are receiving services through a provider. Second, having the requisite skill set to conduct these interviews in the most reliable and most legally defensible manner is necessary. These skills go beyond basic interviewing and basic knowledge of disability.

What are the most common mistakes?

Common mistakes include making assumptions about intelligence based on the person's speech patterns or assumptions based on the person's disability label. Additionally, the goal of any interview is to gather reliable information. As such, asking leading questions and questions that are forced choice response (yes/no) type questions are less reliable.

"Common mistakes include making assumptions about intelligence based on the person's speech patterns or assumptions based on the person's disability label."

What recommendations do you have to improve the outcomes of interviews with persons with intellectual disabilities?

First, assume normal intelligence until you have multiple data points to tell you something different. Second, don't use or accept the label "non-verbal." This is problematic in several ways. It is not useful as there is no universally understood meaning of "non-verbal" and people's mental models of what that means are very different. Additionally, it more likely leads to not speaking to or trying to interview these individuals, and less

likely to go down a prosecutorial route if a crime has been committed. Third, get trained in forensic interviewing from one of the nationally recognized models. Even though all forensic interview protocols, with the exception of Project FIND (Forensic Interviewing Individuals with Disabilities), are geared toward children, it is still recommended to get trained. Fourth, conduct peer reviews of your interviews. It is the only way to improve. Lastly, if you don't have experiences working with individuals with disabilities, try to get that experience by volunteering.

You recommend interviewing individuals who don't speak. How do you conduct such an interview? What tips do you have?

I recommend at least trying to communicate with individuals who don't speak. While you won't be successful with all individuals, there are many who can report information reliably using gestures or AAC (Augmentative and Alternative Communication) devices. If an individual has a yes/no repertoire (gesture) then questions can be presented in that format in the most non-leading manner. Project FIND has a protocol for that. It would take too long to discuss here.

"I recommend at least trying to communicate with individuals who don't speak. While you won't be successful with all individuals, there are many who can report information reliably using gestures or AAC (Augmentative and Alternative Communication) devices."

Any advice for dealing with clients with multiple disabilities, such as clients who have an intellectual and a sensory disability?

These can be tricky. It also depends on the sensory disability. If they have a visual or auditory disability, then learning about adaptations and accommodations for those populations would be helpful. If the sensory disability is sensory processing disorder, then gathering background information on what sensory input the individual is sensitive to is important. That could be visual, auditory, tactile, olfactory and so on.

Are there tools/software/assistive devices and such that you recommending using to improve interviews?

I don't recommend introducing assistive devices or creating gestures for an interview. I would argue that it would not be reliable as it assumes that person has learned the device/gesture and that they are using it reliably in real time. The reality is, it can take people a significant amount of time to learn to use adapted/assistive devices and to ensure that they are using them reliably. That should be taught outside the interview context.

APS TARC
Adult Protective Services Technical Assistance Resource Center
enhancing effectiveness of APS programs

One final question, where do you recommend that APS workers go to get additional information and training on interviewing persons with disabilities?

There is a lot of information on the web, but it is difficult to sift through. I would suggest that National Children's Advocacy Center (I know it is child focused, but could be adapted for adults) has some resources on interviewing individuals with disabilities. Additionally, as mentioned before – Project FIND.

Follow Us on Social Media!

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Adult Protective Services Technical Assistance Resource Center | https://apstarc.acl.gov | apstarc-ta@acl.hhs.gov

Slide #43: Setting the Scene

HANDOUT #10:

Framing the Questions

Trainer Note: This slide is animated.

Refer participants to **Handout #10**- **Framing the Questions** and **provide** a few moments to look over. They can use the handout to emphasize content you will cover on the next slides.

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?
    - Be sensitive to hearing or vision impairments
        - Is the space quiet enough to hear each other?
        - How is the lighting?

- 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 them from getting tired?

- When you reach the interview site, take some time to make sure that the client is as **comfortable** as possible.

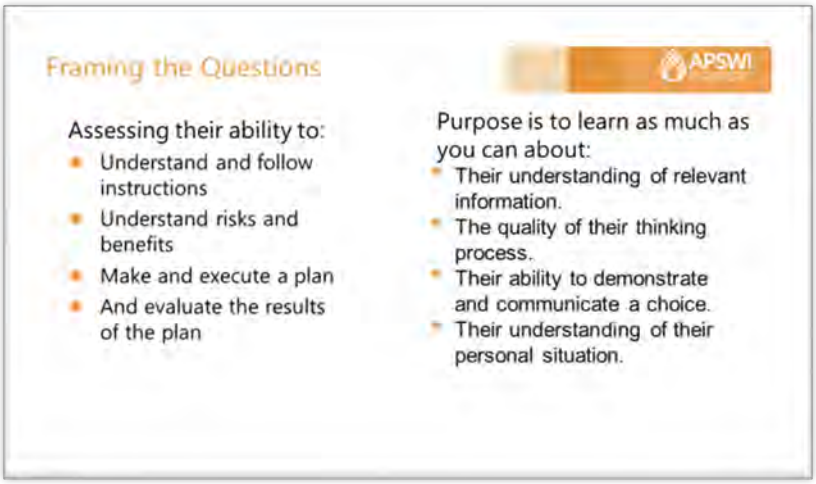
Continued

- Is the room too warm or too cold?
- Is there background noise that is making conversation difficult?
- 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 they have taken any medication, supplements or used any substances 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 #44: Framing the Questions

Trainer Note: This slide is animated.



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. More than one visit will probably be necessary.

- Remember that you will be assessing the client's ability to:
  - Understand and follow instructions
  - Understand risks and benefits
  - Make and execute a plan
  - And evaluate the results of the 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 their personal situation.

Notice that these are the same as the components of capacity assessment listed on Capacity Considerations using Kemp's 4 questions. However, here we have replaced "appreciate" with "understanding of their personal situation".

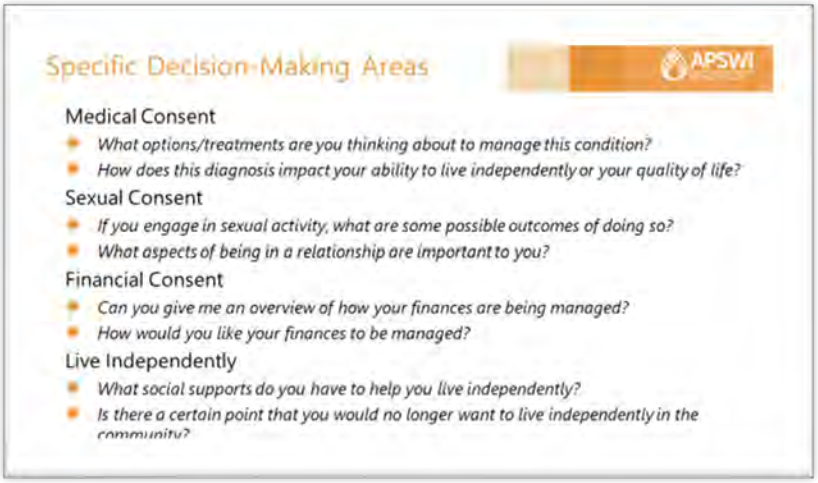
- The purpose of this part of the interview is **not** necessarily to investigate abuse, neglect or exploitation allegations, although information pertaining to possible mistreatment may come to light during the interview.
- For this interview, or portion of the interview, every question you ask must 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.

Continued

- Here are some examples of types of questions that help evaluate these areas
    - Do you know why I'm here today? (To be asked at some point after introductions and purpose of visit)
    - If there was a fire, what would you do?
        - "Call 911" is not a sufficient response, ask about all the steps that will be taken, (call 911, get to safety/out of the house)
        - If the client responds with "there won't be a fire", ask them to imagine if there would be a fire. If the client continues to insist that a fire can't happen, that is possibly indicative that they have difficulty with envisioning outcomes or consequences of decisions. If they can't understand that a fire is a possibility, they may not be able to comprehend other possible outcomes.
    - What will happen if you do not _____…(get treatment/change financial management/allow personal care, etc.) – can the client "see" consequences of not taking action.

Slide #45: Specific Decision-Making Areas

Trainer Note: This slide is animated.



As we discussed earlier, there are different areas that require decision-making capacity and we can use interview questions to evaluate any of these areas that may be of concern. We can use interview questions to help as assess the "why" a decision is being made as we discussed earlier. Why is this individual making this decision, why are these aspects important to them, and why are they accepting of any possible negative outcomes?

- Medical consent –
  - I understand you were recently diagnosed with (_____), how does this make you feel? What questions did you have for the doctor?
  - What options/treatments are you thinking about to manage this condition?
  - How does this diagnosis impact your ability to live independently or your quality of life?
  - What factors did you consider when you decided to not receive treatment? Why are these important to you?
- Sexual consent –
  - If you engage in sexual activity, what are some possible outcomes of doing so?
  - What precautions can you put in place to minimize these possible consequences?
  - What aspects of being in a relationship are important to you?
- Financial consent –
  - Can you give me an overview of how your finances are being managed?

Continued

        - How would you like your finances to be managed (if managed by another person), saving every penny, spending on things you enjoy, helping others, making sure you always have “enough”?
        - Why is this important to you?
    - Live independently –
        - Is there a certain point that you would no longer want to live independently in the community?
        - What factors are you considering in making this decision?
        - What social supports do you have to help you live independently?
        - Do you feel like you are a burden to family/friends with any help you need?

Again, these questions will help you identify concerns with a client’s decision-making ability. If concerns are present after you have completed the interview, you will need to consult with your supervisor to determine if a formal evaluation is necessary.

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

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

Does this response get at the information needed for one of our four components Dr. Kemp suggested (Understand the Information, Quality of Thinking Process, Demonstrate and Communicate Choice, Appreciate the nature of situation?)

If not, could the question be framed more effectively?

HANDOUT #10
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 situation and decision type.
- During your time with the client, assess the client's ability to:
    - Understand and follow instructions.
    - Understand the 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.
- Do not rush the interview.
- Check frequently to make sure the client is comfortable. Do they need a glass of water? Is the room warm/cool enough? Are they getting tired.
- Conduct multiple interviews at different times of the day and in different circumstances, if possible. Some clients function differently at certain times of the day.

DO NOT:

- Assume that a person with physical disabilities, including one who has no speech, lacks decision-making capacity
- Ask long, complicated questions.
- Put words in the client's mouth. For example:
    - "I guess you were pretty scared."
    - "So you would call 9-1-1 if there was a problem?"

WHEN ASKING QUESTIONS, *DO*:

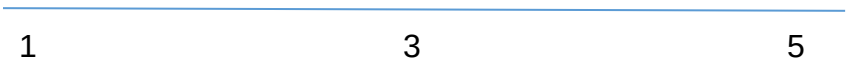
- Use communication aides - special equipment or adaptive devices, as necessary.
- For someone who has no speech, ask questions that can be answered "Yes" or "No" or with non-verbal cues like eye movement or raising right hand for yes and left hand for no. Questions can include:
    - Are you OK?
    - Do you understand?

  - It is ok to ask these types of questions when the individual has no speech and “yes” or “no” responses are the best way for them to respond.
- Start general and move to specifics, one step at a time, using short sentences.
- Speak slowly and clearly.
- Ask the client which language they would prefer to use (both the language they would prefer to be interviewed by and the language they will answer with) as well as the style of speaking that is understandable to the client.
- Ask only one question at a time, giving time for them to process and answer
- Ask open-ended questions.
- Consider using techniques to assist the client. For example, using hand gestures or drawings.
- Provide the client with examples of choices that others have made in similar situations.
- Ask for clarification and/or more information.
- Let the client know gently, but clearly, when you are about to ask a difficult question.
- Give the client plenty of time to answer. Don’t be afraid of periods of silence.
- Reassure the client if they appear anxious about answering.
- Keep your tone of voice steady. Try not to react emotionally, no matter what you hear.
- Reflect back what the client is telling you (Use “active listening”).

USEFUL QUESTIONS TO FOCUS ON THE CLIENT’S UNDERSTANDING OF RELEVANT INFORMATION:

- Can you tell me why I am here today?
- What are those pills for?
- How often do you take them?
- What kind of food did your doctor recommend to eat because of your diabetes?
- When did you eat your last meal?
- What did you have to eat?
- Who fixed your meal?
- What is your doctor’s name?
- Who pays your bills?

If #1 means no pain, #3 means some pain and #5 means that your pain is unbearable, tell me how much pain you are having right now.



- What does it mean when you have sex with someone?
  - Are there rules about having sex?
  - Please repeat the question I just asked you.

USEFUL QUESTIONS TO FOCUS ON 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:

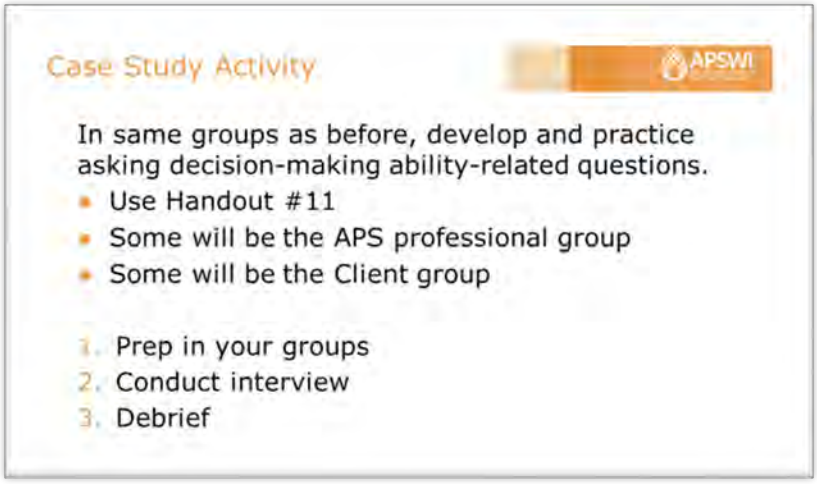
- If you were unable to live by yourself, where you would want to live?
- If you only had enough money to buy medicine for yourself or food for your cats, what would you do?
- How involved do you want your family to be in taking care of you?
- Do you have to have sex with someone if they ask you?

USEFUL QUESTIONS TO FOCUS ON THE CLIENT'S UNDERSTANDING OF THEIR 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 …..?

Slide #46: Case Study Activity

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



Trainer Note: If you get a volunteer from each group after Activity #3, you can do breakout/table groups. If you have less than that, do whichever scenarios you have volunteers for as a large group. If no one volunteers, it's suggested to choose one or two that you are comfortable playing the role of and do as a large group. Otherwise, groups can just develop questions and practice asking each other without role-playing the client.

Activity #4: Interviewing, 30 minutes including debrief
Small Group, Role Play

Goal: Give you the opportunity to practice asking decision-making ability-related questions in a simulated client/worker situation.

INSTRUCTIONS – Role Prep **Time Allotted: 10 minutes**

- **Explain** that participants will be in their small groups from Activity #3. **Refer** participants to the case studies on **Handout #10**. They will be continuing on with the same case study from Activity #3.
- **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 order to be effective and transfer the skill to the field, it's important that the role player is realistic, but not so challenging that the group cannot practice. Everyone should be able to practice the skills here and not get stuck.
- In each group, have the person who volunteered to play the "client" described in the scenario inform their group and ask for one person to play the "APS professional".

Continued

- Group leaders can divide the remaining members of the group into those who work with the person acting as the **client** and those working with the **APS professional**. For those who are working with the APS professional group, they can refer to **Handout #9** for help.
- Each sub group will have approx. 10 min to prepare questions or develop the client persona.

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 10 minutes, announce to the groups that it is time to move into the next phase of the exercise, which is the role play. If training virtually, you can cascade a message to all breakout rooms.

INSTRUCTIONS – The Interview (10 minutes)

- Now that each group has prepared their role players, you will be involved in a 10-minute interview.
    - The **APS professional** will ask the **client** questions pertaining to capacity-related issues, and the client will respond based on their understanding of the character being portrayed.
    - The **Observers**, everyone but the two role-players, will observe the interview carefully, but not interrupt the process.

If training in-person the two role players should sit facing each other. If training virtually, encourage observers to go off camera, leaving the two role-players on camera.

Trainer Note: **At the end of the 10 minutes, announce to the groups that it is time to move into the next phase of the exercise which the debriefing.**

INSTRUCTIONS – The debriefing (10 minutes)

Now that you have observed and/or role-played the interview, each group has **three tasks. The Group Leader can help stay on track by providing approx. three minutes for each task:**

1. Each of the role players gives feedback to the group members on their experience as a player first!

Continued

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 #11**. **Share** that in the real world, APS professionals cannot make a decision from a 10-minute interview. This activity is to practice skills that will be helpful in the field.

HANDOUT #11
CASE STUDY INFORMATION FOR FRAMING QUESTIONS

Case Study #1: Anna Kovacs –

Role Preparation (10 minutes)

After the volunteer for the client role and volunteer for APS professional role have been decided, the Group Leader will divide the small group into two sub-groups: the client's group and the APS professional's group. Each sub-group will help prepare the role players by discussing the questions listed below under "Guidelines" for each of the sub-groups.

- Guidelines for **APS professional** group:
  - Develop a strategy to establish rapport with Anna so she will feel comfortable with your questions.
  - Develop questions to elicit information on Anna's understand of relevant information
  - 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?
  - 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.
  - Develop questions you would ask to assess Anna's understanding of her situation.
- Guidelines for the **client** group:
  - Discuss your perceptions of what Anna might be experiencing emotionally, physically, cognitively.
  - Translate your thoughts into a likely "Anna" role; propose responses, questions and reactions that the role player will be able to use.

Conduct Interview (10 minutes)

Both sub-groups will observe the interview between Anna and the APS professional, silently.

Debrief (10 minutes)

Group leader take notes on the debriefing discussion

Following the interview, use the questions below for discussion within the 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 to 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 decision-making ability? 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?

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

Role Preparation (10 minutes)

After the volunteer for the client role and volunteer for APS professional role have been decided, the Group Leader will divide the small group into two sub-groups: the client's group and the APS professional's group. Each sub-group will help prepare the role players by discussing the questions listed below under "Guidelines" for each of the sub-groups.

- Guidelines for **APS professional** group:
  - Develop a strategy to establish rapport with Juan so he will feel comfortable with your questions.
  - Develop questions to elicit information on Juan's understand of relevant information.
  - 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?
  - 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.
  - Develop questions you would ask to assess Juan's understanding of his situation.
- Guidelines for the **client** group:
  - Discuss your perceptions of what Juan might be experiencing emotionally, physically, cognitively.
  - Translate your thoughts into a likely "Juan" role; propose responses, questions and reactions that the role player will be able to use.

Conduct Interview (10 minutes)

Both sub-groups will observe the interview between Juan and the APS professional, silently.

Debrief (10 minutes)

Group Leader take notes on the debriefing discussion.

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

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 to 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 decision-making ability? 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?

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

Role Preparation (10 minutes)

After the volunteer for the client role and volunteer for APS professional role have been decided, the Group Leader will divide the small group into two sub-groups: the client's group and the APS professional's group. Each sub-group will help prepare the role players by discussing the questions listed below under "Guidelines" for each of the sub-groups.

- Guidelines for **APS professional** group:
  - Develop a strategy to establish rapport with Mark so he will feel comfortable with your questions.
  - Develop questions to elicit information on Mark's understand of relevant information
  - 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?
  - 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.
  - Develop questions you would ask to assess Mark's understanding of his situation.
- Guidelines for the **client** group:
  - Discuss your perceptions of what Mark might be experiencing emotionally, physically, cognitively.
  - Translate your thoughts into a likely "Mark" role; propose responses, questions and reactions that the role player will be able to use.

Conduct Interview (10 minutes)

Both sub-groups will observe the interview between Mark and the APS professional, silently.

Debrief (10 minutes)

Group Leader to take notes on the debriefing discussion.

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

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 to 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 decision-making ability? 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?

Case Study #4: Rob/Wilma Benson – Small Group Information for Framing Questions

Role Preparation (10 minutes)

After the volunteer for the client role and volunteer for APS professional role have been decided, the Group Leader will divide the small group into two sub-groups: the client's group and the APS professional's group. Each sub-group will help prepare the role players by discussing the questions listed below under "Guidelines" for each of the sub-groups.

- Guidelines for **APS professional** group:
    - First, decide whether you would talk to them separately or jointly. If you decide to 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.
    - How would you establish rapport with Rob and Wilma so they will feel comfortable with your questions?
    - Develop questions to elicit information on their understand of relevant information
    - Develop questions that will help you assess the quality of both Rob and Wilma's thinking process. How might you assess each of their abilities to understand and follow instructions? To make and execute a plan?
    - Develop questions that will demonstrate their ability to identify and communicate a choice. Include questions to reveal their understanding of the risks and benefits of a choice.
    - Develop questions you would ask to assess the Benson's understanding of their situation.
- Guidelines for the **client** group:
    - Discuss your perceptions of what Rob and Wilma might be experiencing emotionally, physically, cognitively.
    - Translate your thoughts into likely roles for Rob and Wilma; propose responses, questions and reactions that the role players will be able to use.

Conduct Interview (10 minutes)

Both sub-groups will observe the interview(s) between the clients and the APS professional, silently.

Debrief (10 minutes)

Group Leader take notes on the debriefing discussion.

After the interview(s), use the following questions for discussion within the group:

1. Based on their answers, do you believe that Rob and Wilma understand relevant information?

2. Based on their answers, do you believe that Rob and Wilma's 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 that Rob and Wilma are able to demonstrate and communicate a choice? Can they identify the risks and benefits to their choices?

4. Based on their answers to these questions, do you have enough information to determine whether or not either of them should be referred for a professional capacity evaluation?

5. Would you use a standardized test to assess Rob and Wilma's decision-making ability? 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?

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

Role Preparation (10 minutes)

After the volunteer for the client role and volunteer for APS professional role have been decided, the Group Leader will divide the small group into two sub-groups: the client's group and the APS professional's group. Each sub-group will help prepare the role players by discussing the questions listed below under "Guidelines" for each of the sub-groups.

- Guidelines for **APS professional** group:
  - Develop a strategy to establish rapport with Sharon so she will feel comfortable with your questions.
  - Develop questions to elicit information on Sharon's understand of relevant information
  - 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?
  - Develop questions that will demonstrate Sharon's ability to identify and communicate a choice. Include questions to reveal her understanding of the risks and benefits of a choice.
  - Develop questions you would ask to assess Sharon's understanding of her situation.
- Guidelines for the **client** group:
  - Discuss your perceptions of what Sharon might be experiencing emotionally, physically, cognitively.
  - Translate your thoughts into a likely "Sharon" role; propose responses, questions and reactions that the role player will be able to use.

Conduct Interview (10 minutes)

Both sub-groups will observe the interview between Sharon and the APS professional, silently.

Debrief (10 minutes)

Group Leader take notes on the debriefing discussion.

Following the interview, use the questions below for discussion within the 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?

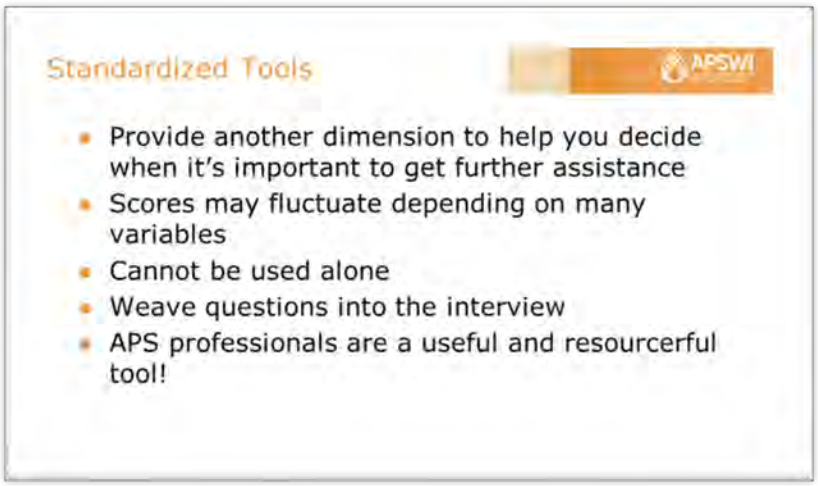
3. Based on her answers, do you believe that Sharon is able to demonstrate and communicate a choice? Can she identify the risks and benefits to her choice?

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 decision-making ability? 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?

Slide #47: Standardized Tools



Share the following:

- 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.

Emphasize that the most important tool is the worker – skills and use of self.

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

Slide #48: Benefits and Limitations of Commonly Used Tools

Refer participants to **Handout #1- APS TARC Brief, "Capacity Screening in Adult Protective Services: Guidance and Resources**".

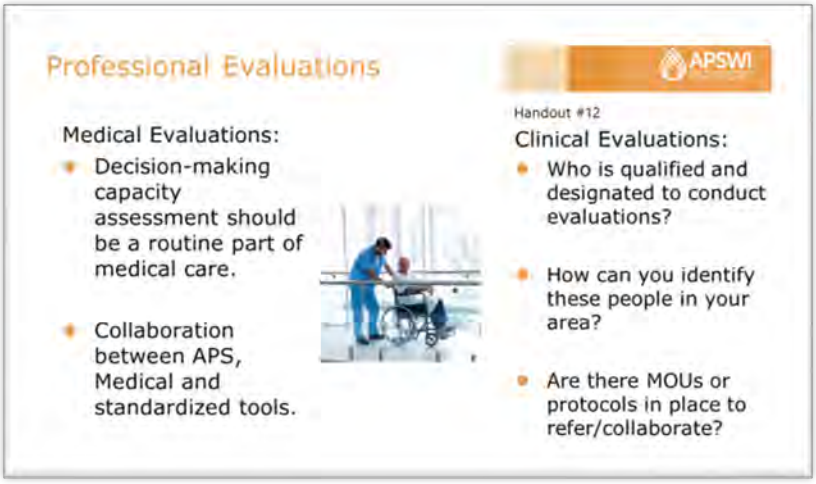
Ask them to individually review pages 9-12 which highlights benefits and limitations of 11 commonly used tools used in APS.

Provide 7-10 min for this review.

Ask if participants have any experience with any of the 11 tools and if so, to share in their own words any additional benefits of limitations not described in the brief.

Share that because no one screening tool assess for each cognitive domain, it may be helpful to take a few questions from various screening tools and weave them in to your interview for a more well-rounded assessment.

Slide #49: Professional Evaluations



Explain that when there are still concerns about someone's decisional capacity, Medical and Clinical professionals can assist.

- Medical Evaluations:
  - Assessment of decision-making capacity should be a routine part of medical care. It can indicate the need, or lack of need, for a physical/neurological evaluation… and physicians and nurses have the required specialized skills for this.
  - Everyone who struggles with assessing capacity issues wishes that there was a single, simple tool that could be used to accurately determine a person's decision-making ability. So far, however, no such tool has been developed.
  - This is because there is so much variability in both the person being examined and the person conducting the examination.
  - There is no single tool that has been scientifically proven to be an accurate measure of decision-making capacity in all situations and as we saw in Handout #1-there are limitations in each screening tool. For this reason, APS professionals should not rely solely on one assessment tool to determine whether a client needs a professional capacity evaluation.

- Clinical Evaluations:
  - Unless you are a licensed physician or mental health specialist and designated within your role to do so, you are not professionally qualified to conduct a professional evaluation.
  - **Handout #12** has a list of clinical professionals who are qualified to conduct evaluations with descriptions of their training.
    - Geriatricians, geriatric psychiatrists, geropsychologists
    - Neurologists
    - Neuropshychologists
    - Nurses

Continued

        - Occupational therapists
        - Physicians
        - Psychiatrists
        - Psychologists
        - Licensed Social Workers
    - Find out who in your agency, community or somewhere in your area, is qualified to conduct evaluations.
    - Work with your supervisor or administrator to meet with these professionals to emphasize the importance of their evaluations and to work out a protocol for referrals and payment.

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, MD'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 professions 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).

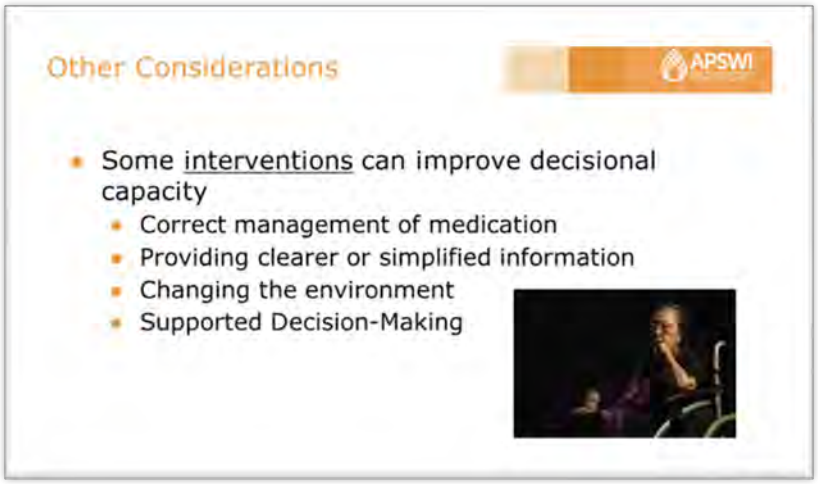
Psychiatrists, M.D.'s with specialized training in mental health, may address how specific psychiatric conditions (e.g., schizophrenia) and related emotional/mental systems may be affecting the individual and his/her capacity. Geropsychiatrists receive additional training in problems of aging; forensic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

Slide #50: Other Considerations



Sometimes, providing the right intervention may improve the 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.

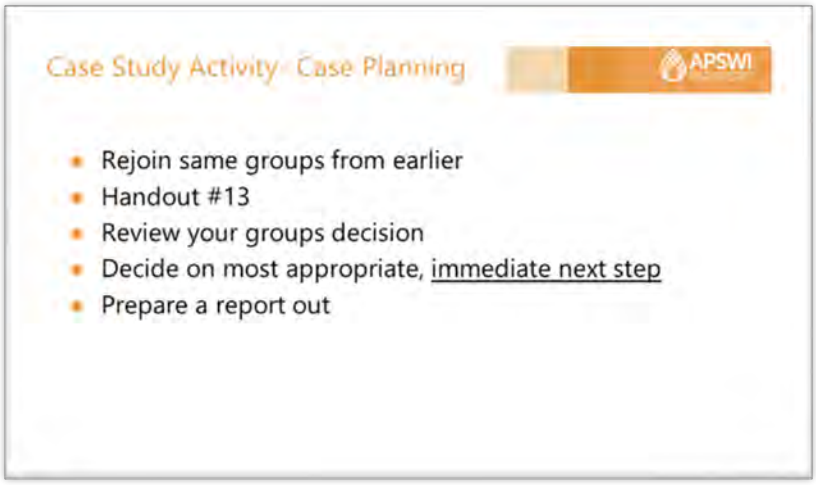
- In other cases, giving the client more information may help him or her to decide.
- Changing the environment can also be useful at times. Someone who is very cold, hungry or tired may not be thinking clearly. Providing warmth, food and rest can make a difference.
- And, of course, taking time to provide encouragement and support is always appropriate.
- There is a practice called "Supported Decision Making" that you can learn more about.

ASK: *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 PLANNING
Time Allotted: 45-50 minutes

Slide #51: Case Study Activity – Case Planning

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 Pages 65-69



Activity #5- Case Study- Case Planning, 45 min with debrief
Small groups

Share the following instructions:

- Everyone will join their small groups from Activities #3 and #4. **Refer** participants to **Handout #13- Case Studies: Next Step in Case Planning**, in their manuals. They will be continuing on with the same study.

- **Ask** that each group take a few minutes to review their group decision made about the client's need for further professional evaluation at the end of the role play exercise.

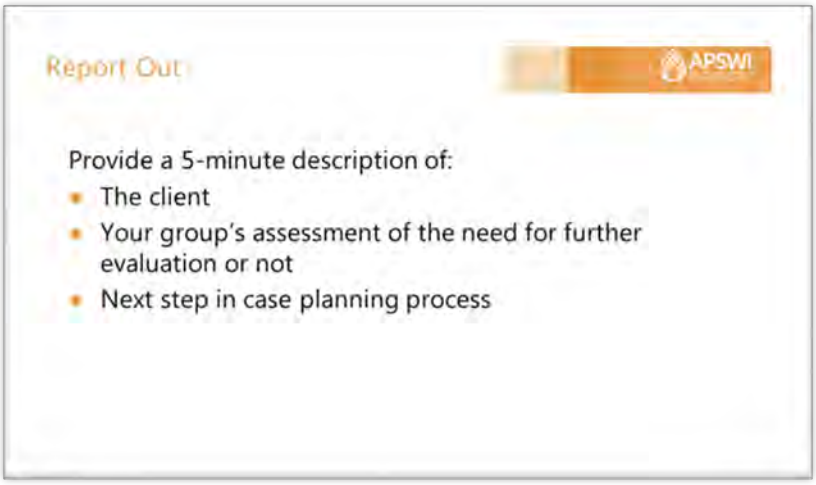
- Groups will decide what is the most appropriate, immediate next step in the case planning process for this client. Don't try to resolve all the client's issues, just focus on what needs to happen next, based on this client's current situation and decisional capacity.

- Prepare for reporting to the large group which should consist of a 5-minute description of:
  - The client,
  - Their small group's assessment of the client's need for further evaluation
  - The next step in the case planning process

- They have 15-20 minutes for this and will come back to report out.

Trainer Note: At the end of 15 minutes, reconvene into one large group.

Slide #52: Report Out



Report out and Discussion, 25 minutes

Ask for each group to share the following:

- A 5-minute description of:
  - The client,
  - Their small group's assessment of the client's need for further evaluation
  - 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.**

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.

HANDOUT #13:
CASE STUDIES- NEXT STEP IN CASE PLANNING

Case Study #1: Anna Kovacs

Task 1: Small Groups review – 20 minutes

Review the results of your assessment of Anna that was developed in small group discussion in Activity #4. Based on that assessment, discuss what should be the next step in the case planning process:

Task 2: Large Group Sharing – 25 minutes

Give a brief report to the large group, including:

- Basic background information on Anna

- The result of your assessment of Anna's ability to make decisions regarding her health care,

- The next step in the case planning process.

Case Study #2: Juan Garcia

Task 1: Small Groups review – 20 minutes

Review the results of your assessment of Juan that was developed in small group discussion in Activity #4. Based on that assessment, discuss what should be the next step in the case planning process:

Task 2: Large Group Sharing – 25 minutes

Each small group gives a brief report to the large group, including:

- Basic background information on Juan

- The result of your assessment of Juan's ability to make decisions regarding his health care,

- The next step in the case planning process.

Case Study #3: Mark Hudson

Task 1: Small Groups review – 20 minutes

Review the results of your assessment of Mark that was developed in small group discussion in Activity #4. Based on that assessment, discuss what should be the next step in the case planning process:

Task 2: Large Group Sharing – 25 minutes

Each small group gives a brief report to the large group, including:

- Basic background information on Mark

- The result of your assessment of Mark's ability to make decisions regarding his health care,

- The next step in the case planning process.

Case Study #4: Rob and Wilma Benson

Task 1: Small Groups review – 20 minutes

Review the results of your assessment of Rob and Wilma that was developed in small group discussion in Activity #4. Based on that assessment, discuss what should be the next step in the case planning process:

Task 2: Large Group Sharing – 25 minutes

Give a brief report to the large group, including:

- Basic background information on Rob and Wilma

- The result of your assessment of the Benson's ability to make decisions regarding their living situation, emotional well-being, health care and financial planning

- The next step in the case planning process.

Case Study #5: Sharon Delay

Task 1: Small Groups review – 20 minutes

In your small group, review the results of your assessment of Sharon that was developed in small group discussion Active Learning #2. Based on that assessment, discuss what should be the next step in the case planning process:

Task 2: Large Group Sharing – 25 minutes

Give a brief report to the large group, including:

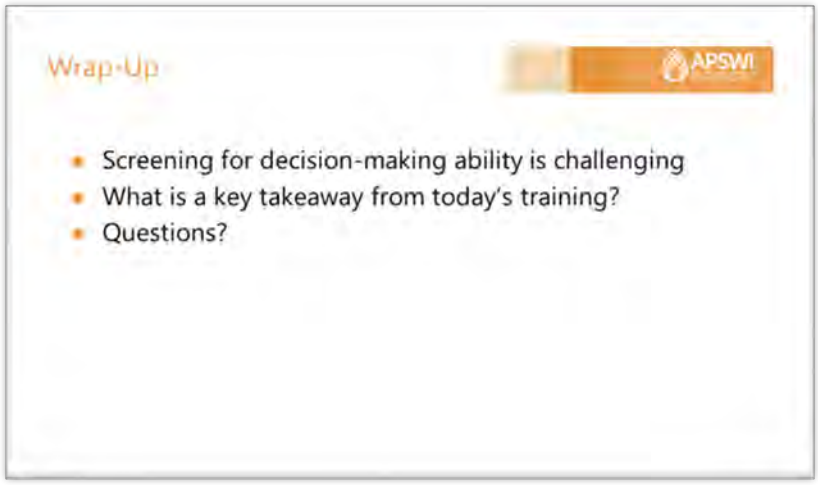
- Basic background information on Sharon

- The result of your assessment of Sharon's ability to make decisions regarding her health care,

- The next step in the case planning process.

WRAP-UP
Time Allotted: 15 minutes

Slide #53: Wrap-up



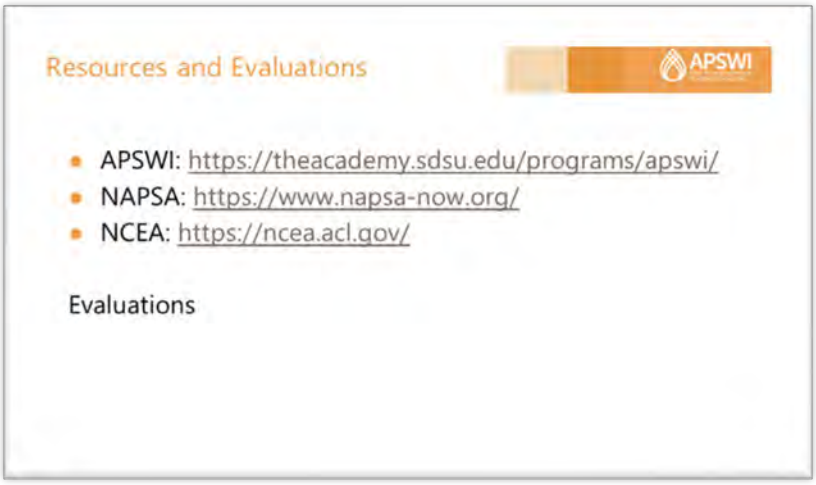
Remind participants that screening for decision-making ability is one of the biggest challenges in an APS professional's role. There are so many factors to consider including medical, biological, and environmental conditions. There are many tools used, including most importantly- the APS professional's assessment and interview skills.

Share that a Transfer of Learning: Desk Guide is in their Participant Manual as **Handout #14** and can be found on APSWI's website under the Transfer of Learning Tab: https://theacademy.sdsu.edu/programs/apswi/financial-abuse-training/transfer-of-learning/.
The Desk Guide can be used in the field to refresh their memory prior to meeting with clients or with their Unit or Supervisor.

Ask for volunteers to provide one key takeaway they have from today's training.

Ask if there are questions or comments about their experience today.

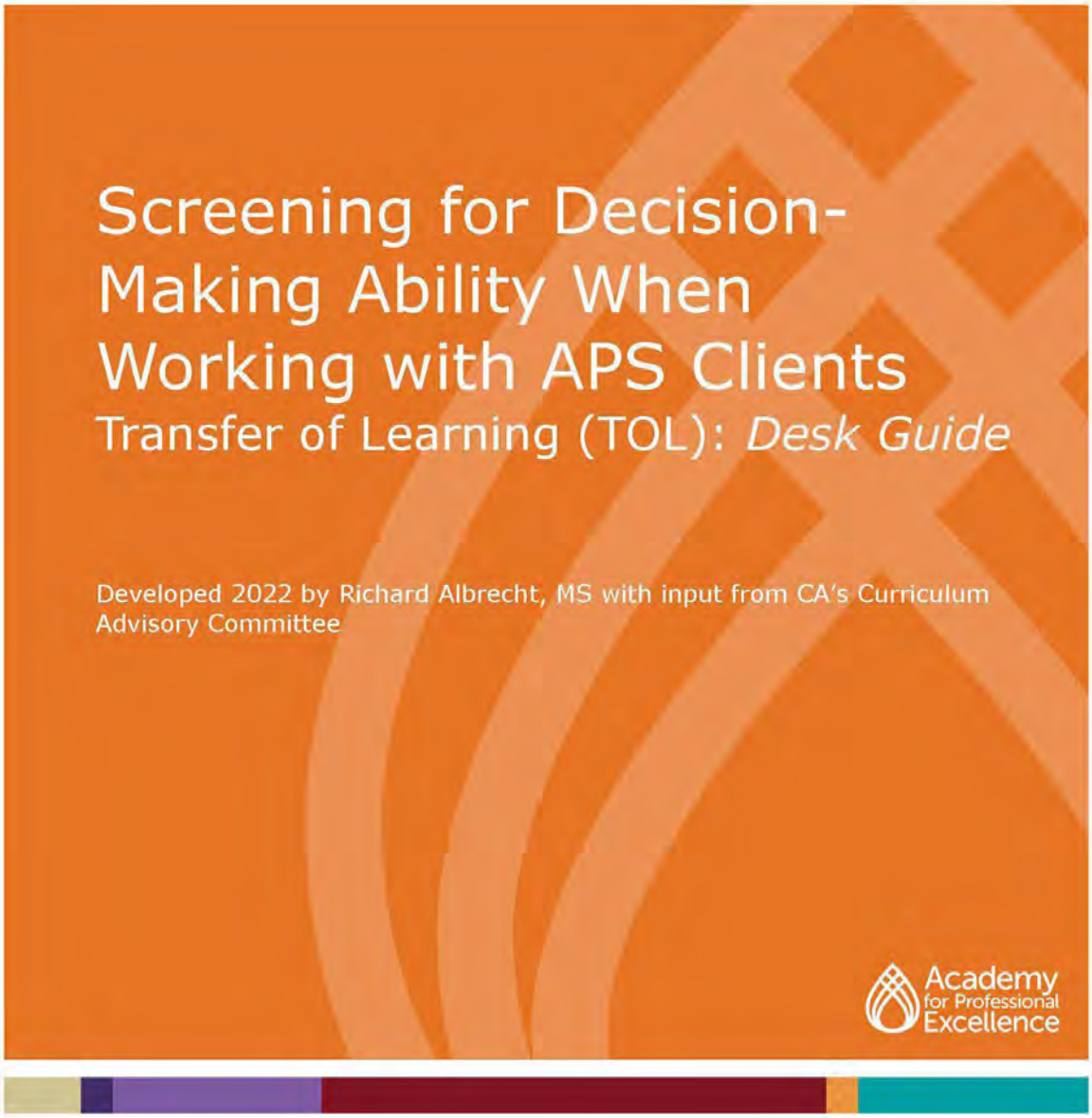
Slide #54: Resources and Evaluations



- **Share** APSWI, NAPSA and NCEA resource information.
- **Have** participants complete evaluation.

Thank you very much for your participation in today's training.

HANDOUT #14- TRANSFER OF LEARNING: DESK GUIDE



APSWI
Adult Protective Services Workforce Innovations

The Academy for Professional Excellence is a project of the San Diego State University School of Social Work

SCREENING FOR DECISION-MAKING ABILITY WHEN WORKING WITH APS CLIENTS
Desk Guide

How to Use:

This Desk Guide is a Transfer of Learning (TOL) designed as a companion to NAPSA Core Competency Module 17: Screening for Decision-Making Ability When Working with APS Clients, both eLearning and Instructor Led Training (ILT) modalities. This can be used to compliment the material from either training modality, not in lieu of completing the training.

This TOL can be used in a variety of settings to include:

- As a refresher Instructor-Led Training (virtual or in-person) with support from a facilitator after staff have completed Module 17
- During supervision when coaching staff around the skills of screening for decision-making ability
- Unit Meeting as a group activity paired with a case scenario or added discussion with guidance from a Supervisor or Lead Staff
- Individually as a memory jog when in the field prior to interviewing clients
- BONUS: brainstorm with colleagues screening questions for various allegations where decision-making is in question.

Overview of Screening for Decision-Making Ability:

Why do we need screen for decision-making ability in protective services?

- It is an important aspect of the work we do and has a major impact on the clients we serve.
- We need to have a firm understanding of decision-making and where it intersects with protective services. Often, we will have cases where we are asking the following: can the client remain in this situation, can the client make the decision to refuse intervention, can the client understand the risk of their situation, or can the client engage in certain behaviors.
- Frequently, we will interact with a client that displays some level of cognitive impairment, and it is important for us to determine their ability to make decisions about their life.

Decision-making is task specific and is on a continuum. We must screen for decision-making ability as it relates to the specific circumstances that are present for that client. Financial management, medical treatment, sexual consent, and marriage are all different types of decision-making capacity.

Domains of decision-making

1. Orientation – is the client able to understand where they are, the current timing, and who they are (and where they are at in their life)? Remember, decision-making capacity and ability are not determined just because someone is, or isn't, alert and oriented.
    a. Example questions: "What season are we in?" "What day of the week is it today?" followed with "What day will it be tomorrow?".
2. Attention – is the client able to focus on the conversation, the current environment, and the situation?
    a. Example statement: "Tell me what you understand of what I just shared." or "Can you summarize the information I provided."
3. Memory – both short-term and long-term memory are important in the decision-making process. Short-term memory allows us to retain recent information, while long-term memory is pulled from to evaluate how we have dealt with similar situations in the past.
    a. Example questions: "What did you eat today?" (Short term) and "What is your Date of Birth" or "Who would call if something was wrong. Can you show me how you would call them?" (Long term)
4. Language – can the client understand spoken language, are they able to communicate their choices or thoughts (either verbally or in writing). Do they have language impairments that need considered during the screening process?
5. Visual-spatial – can the client understand the relationship between their environment and situation. Does the client understand what can and can't be possible in their current environment, as it relates to changes or adaptations?
6. Executive function – the "command center". This cognitive system is highly complex and can be influenced by sensory deficits. This domain is discussed in more detail below.

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Attributes of decision-making

1. Receive and comprehend relevant information
    a. Is the client able to receive and comprehend relevant information relating to their situation? This ability can be impacted by sensory deficits such as vision or hearing impairments. We may have to modify how we communicate information to a client so they can overcome these deficits.

2. Express choice consistently
    a. Is the client able to consistently express their choices? Do they maintain their choice or desire over time? Is the client able to consistently express the reasons for the decisions they are making?

3. Appreciate nature and significance of condition
    a. Does the client understand the nature and significance of the situation they are in? Do they understand the severity of the medical condition or financial situation they are currently in? Can the client communicate the risks that their situation puts them in? Is the client able to communicate possible outcomes if their situation is not addressed?

4. Balance risk, benefits, and burden of choices
    a. As adults, we are assumed to have the ability to make decisions. We've all heard about people making "bad decisions", but is it truly a bad decision or a decision that we do not agree with? Cultural awareness is an important aspect of assessing this attribute. Culture can play an important role in decision-making. It can increase the burden or effort required, it can minimize the benefit of interventions offered or accepted, and it can also be the basis for refusal. It is important for APS professionals to understand the relationship between culture and choice.

5. Communicate rational choices
    a. Just about everyone can communicate a choice. What we want to screen for are **the reasons** that the choice is being made. Is the client able to provide rational reasons for the choices they are making, are the reasons based upon values and beliefs that may be different from our own? Is the client able to communicate the "why" and does it make sense for their situation?

Dr. Bryan Kemp provides a framework with four questions APS professionals can use when screening someone's ability to make informed decisions. In the table below, the **Framework Questions** are numbered, the framework examples are on the *left,* and examples of how to ask these questions for a financial abuse allegation where decision-making ability is of concern is on the left. Blank spaces are provided to allow for developing additional questions for other specific situations where decision-making is in question (e.g. sexual consent, medical treatment, etc.).

1. Can they understand their situation?	
Do you realize you have a significant cut on your leg?	Do you think some people are financially taken advantage of?
2. What is the quality of their thinking process?	
What can you do to treat the cut?	What would you do if someone was taking advantage of your finances?
3. Is the client able to demonstrate and communicate choice consistently?	
Do you want to get treatment on your leg?	Do you want to report the financial abuse? (why or why not?)
4. Does the client appreciate and understand the nature of their situation?	
What will happen if you do not get treatment for the cut?	What are some things that might happen if (name of Alleged Perpetrator) continues to use your debit card?

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Executive function

It is important for APS professionals to understand the importance of executive function and how to screen for possible deficits. Here are some aspects that executive function is involved with:

1. Abstract reasoning
   - Can I see the overall picture or goal from the small details or tasks? Can I form or follow theories?

2. Adapting to change
   - What have I historically based this decision on and what has changed? Technology and access to information, and misinformation, requires us to modify behaviors and approach.

3. Planning and evaluating
   - What do I need to do to reach my goal? What steps are necessary?

4. Anticipating outcomes
   - If I go down this path, what are the possible outcomes? How likely are some of those outcomes? How does a particular outcome fit with what I am basing my decision on?

5. Inhibiting inappropriate behaviors
   - The last time I did this, I did not get the desired outcome. I also didn't like the response and way that my behavior was accepted.

6. Managing time
   - This is especially important for multi-step responses. Are my time realistic? Can I complete in the desired time frame while planning for interruptions?

Executive function and problem solving.

1. Perception
   - Are there any perceptual deficits that impact a client's able to receive information? Intellectual deficits can also impact a client's ability to perceive the significance of information.
     - Example – you are cooking dinner and start to smell something.

2. Recognizing a problem
   - If a client is not able to recognize that there is a problem, they will not see a need to change their situation or behavior. This aspect is also part of the change process, or stages of change.
     - You recognize that smell as something burning.

3. Foreseeing outcomes
   - This ability is a testament to abstract thinking. The ability to envision outcomes that have not, or may not happen, requires abstract thinking. The ability to see possible outcomes or the progression of their situation and the timing of those outcomes is an important aspect of decision-making. Are these possible outcomes immediate or imminent, or are they longer-term outcomes that may impact the client in three or five years?
     - What will dinner be like if I don't address the situation?

4. Formulating a plan
   - Is the client able to put the steps together, in a semblance of order, that are necessary for addressing the situation? Are they able to provide enough detail to understand the steps necessary, or effort required?
     - I want my meal to be enjoyable, so here is what I need to do to fix it. Do I need to start everything over? What order do these steps need to be taken?

5. Executing the plan
   - What steps is the client able to do for themselves, what steps do they need assistance with, are the expected actions reasonable based upon the client's circumstances.
     - I need to follow these steps to address the burnt portion of dinner.

6. Evaluating the plan
   - This is a critical aspect of problem solving. If a client is not able to evaluate the effectiveness of the plan, or if it accomplished the goals for the situation, they may still be at risk or have unmet needs.
     - Because I started the meal over, and changed how I prepared it, I now have the meal that I anticipated, and it is delicious.

Factors that may impact decision-making ability

1. Mental health – there are numerous different mental health conditions and situations that can impact decision-making ability. Depression is a commonly over-looked condition in older adults and can have a profound impact on decision-making. Depression can impact motivation or perceiving a better situation and can hinder a client's ability to see the value in making a change.
2. Medications and medical conditions – Just like with mental health, medications and medical conditions can impact decision-making ability. Acute conditions such as urinary tract infections can mimic the symptoms of a neurocognitive disorder, but once treated the client is back to their normal level of cognitive functioning.
3. Timing of interview – Individuals with neurocognitive disorders may function better at certain times of the day. It is important to try and assess their ability during the times that they do their best.
4. Cultural impact of decision-making –the impact that cultural differences have in the decision-making process can be profound. As part of the screening process, APS professionals need to evaluate if there are cultural reasons that are influencing the decision-making process.

Interview as a screening tool

It is important to remember that your interview is a method of screening for decision-making ability.

- Screening questions can be interwoven throughout the interview to minimize the impact on rapport you have with the client.
- Provide as much information as necessary, or in ways that the client will understand, to assist with screening their ability to make decisions. Complex situations such as medical conditions and treatment or financial eligibility for benefits may need to be discussed using language that the client will better understand.
- Use questions to assess the "**WHY**" – there may be very justifiable reasons that the individual is behaving a certain way, or wants things done a certain way. "Why is this important to you?", "If you could change your situation, what would you want to be different and why is that important to you?"

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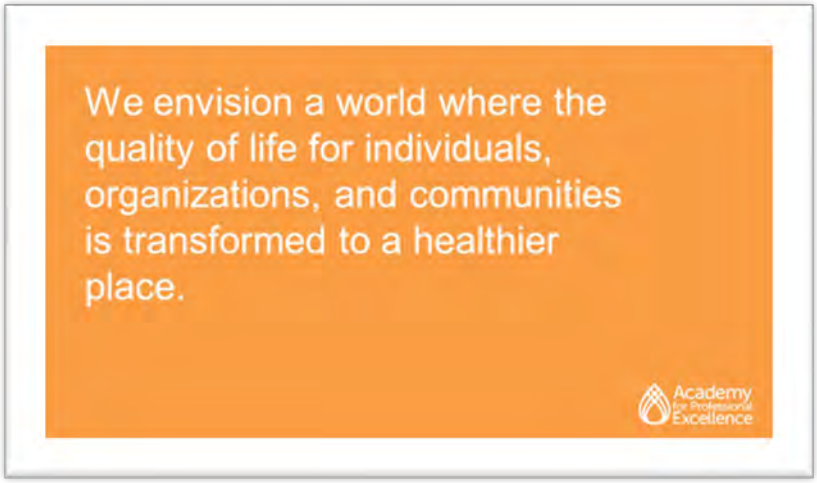
Slide #55-56: Thank You



APENDIX- HANDOUT #1
APS TARC BRIEF-CAPACITY SCREENING IN ADULT PROTECTIVE SERVICES: GUIDANCE AND RESOURCES

APS TARC
Adult Protective Services Technical Assistance Resource Center
enhancing effectiveness of APS programs

In Brief

Capacity Screening in Adult Protective Services: Guidance and Resources

Introduction

Adult protective services (APS) case workers and/or law enforcement are often the first to encounter situations where an older person or person with disabilities who is a victim of abuse, neglect or exploitation may also have impaired decision-making. Issues involving decision-making capacity are complex, cross-disciplinary and include knowledge of medical syndromes, clinical assessment, ethics, and the law (Moye & Marson, 2007).

APS caseworkers do not perform clinical health or capacity assessments unless specifically qualified or authorized by state law. They may perform an initial capacity screening or assessment when they suspect that an older person or person with disabilities suffers from impaired decision making. The needs/risk assessment process outlined in the Final National Voluntary Consensus Guidelines for State Adult Protective Services Systems, published by the Administration for Community Living in 2016, identifies several domains that could help APS caseworkers screen for indications of cognitive impairment. When concerns are identified, APS can refer the client to qualified professionals such as physicians, geriatricians, psychologists, or psychiatrists to administer professional, comprehensive capacity evaluations. Screening tools, in general, are helpful in determining whether clients have the ability to make informed decisions, to give or deny consent for APS services and/or to meaningfully participate in care planning (Falk & Hoffman, 2014).

A comprehensive capacity evaluation should include:

- physical and neurological examination,
- short- and long-term memory assessment,
- assessment of executive function,
- examination for any existing psychological disorders, and
- diagnosis of any existing addictive syndromes.

Unfortunately, not all APS jurisdictions have access to resources to assess each of these areas; nonetheless, it is important that APS advocate for the most comprehensive evaluation possible.

Due to the complexity of the issue, this brief is broken into several sections. Part I focuses on screening for decision-making capacity including terminology and important terms to understand; an explanation of what capacity is and civil capacities (aka capacity to do what?). Part II explores the relationship between capacity and abuse; and why APS professionals need to understand capacity. Part III provides information on capacity screening including cognitive domains and screening tools.

Part IV identifies research on capacity screening; research to practice highlights; and available training and resources.

Part I: Understanding Capacity Terminology

Below is a list of the terms used throughout the brief that are important for APS professionals to understand:

Capacity Assessment/Evaluation – A functional assessment and clinical determination related to a person's capacity to decide (decisional capacity) and implement a decision (executional capacity) in various domains. The six civil capacities identified for psychological assessment that are particularly important to APS client populations are "medical consent capacity, sexual consent capacity, financial capacity, testamentary capacity, capacity to drive, and capacity to live independently" (American Bar Association Commission on Law and Aging & American Psychological Association, 2008). The assessment process typically requires specific materials, supervised testing experience, and/or credentials.

Capacity Screening – Brief tools and/or questionnaires used to determine if a referral for further assessment/evaluation is required.

Competency – A global assessment and legal determination made by a judge in court. (Dastidar & Odden, 2011).

(Mental) Capacity – An individual's physical or mental ability; a legal status presumed to apply to all adults (unless proven otherwise). Capacity is generally defined in law in reference to a specific task (e.g., capacity to execute a will) (American Bar Association Commission on Law and Aging & American Psychological Association, 2008).

Decision-Making and/or Decisional Capacity – Decisional capacity is the ability to adequately process information in order to make a decision based on that information (National Center on Elder Abuse, 2015). In the literature, the term decision-making capacity is often used interchangeably with capacity, or to describe capacity domains that are specifically and only decisional in nature (American Bar Association Commission on Law and Aging & American Psychological Association, 2008).

Diminished Capacity – A reduced ability to understand the nature of one's acts in one or more domains. A person may have capacity in some domains but not in others (American Bar Association Commission on Law and Aging & American Psychological Association, 2008).

Executive Function – The ability to plan, sequence, monitor, and inhibit complex goal-directed behavior. Executive function involves judgment, insight, and problem solving, and poor executive function is expressed behaviorally as lack of interest or disinhibition (Schillerstrom, et al., 2013).

Incapacity – 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. Clinical incapacity is a judgment about one's functional abilities (National Center on Elder Abuse, 2015).

What is Capacity?

Capacity is complex, multidimensional, and affected by many factors. It is the "cluster of mental skills", such as:

- memory and logic,
- behavioral and physical functioning that people use in everyday life,
- a continuum of decision-making abilities,

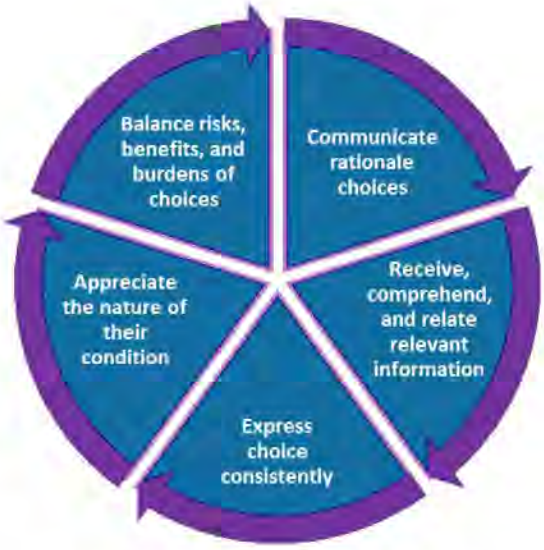
- contextual, and varies by the complexity of the task or the decision,
- an element that should always be evaluated in relation to the particular act that is at issue (e.g., signing over a home, creating a will, marrying, testifying about abuse)."

(Judicial Council of California & Mosqueda, 2012)

The Judicial Council & Mosqueda (2012) state, "capacity is rarely lost completely or globally, except in very severe cases. For example, in the early phases of dementia/Alzheimer's disease, the older adult can often recall, state their desires, and testify appropriately."

The NAPSA Core Competency Module 17 on *Assessing APS Clients' Decision-Making Capacity* offers a helpful graphic to consider the attributes of capacity and how they are interrelated. In general, the more important the decision and the results of the decision, the higher the level of capacity required.

Attributes of Capacity



An individual's decision-making abilities may vary as a result of physical or mental stress, the complexity of the decision, and can vary from day to day or from morning to evening. Differentiating a physical disability, such as stroke-related aphasia, from decisional incapacity is critical (Ramsey-Klawsnik, The Complexities of Cognitive Capacity, 2014). Medications, medication interactions and sensory deficits can also play a role.

Medical conditions such as malnutrition, dehydration, urinary tract infections (UTI), trauma, and depression can cause temporary confusion or delirium and disorientation. Delirium is an acute confused state, disturbance in alertness, consciousness, perception and thinking that has a sudden onset. It can be caused by infection, dehydration, chemical imbalance, head trauma, or anesthesia, etc. It is a medical emergency that is reversible and treatable (National Center on Elder Abuse, 2015).

Consideration also needs to be given to the role of cultural variables in decision-making. Language, immigration status, economic status, perceptions of institutions, perceptions of disability, and the role of family in care and decision-making is critically important (American Bar Association Commission on Law and Aging & American Psychological Association, 2008).

In a report prepared by the National Ethics Committee (NEC) of the Veterans Health Administration (VHA), they concluded "in clinical practice, decision-making capacity is often assessed informally or inconsistently and misconceptions about decision-making capacity and its assessment are surprisingly common" (Ganzini, Volicer, & Fox, 2004). Based on a study of clinicians and ethics committee chairs, the NEC identified "Ten Myths About Decision-Making Capacity". While the frame of reference is health care/patients, the points made relate to anyone working with clients who may have reduced decisional abilities.

1. Decision-making capacity and competency are the same;

2. Lack of decision-making capacity can be presumed when patients go against medical advice;
3. There is no need to assess decision-making capacity unless patients go against medical advice;
4. Decision-making capacity is an "all or nothing" phenomenon;
5. Cognitive impairment equals lack of decision-making capacity;
6. Lack of decision-making capacity is a permanent condition;
7. Patients who have not been given relevant and consistent information about their
8. treatment lack decision-making capacity;
9. All patients with certain psychiatric disorders lack decision-making capacity;
10. Patients who are involuntarily committed lack decision-making capacity; and
11. Only mental health experts can assess decision-making capacity.

(Ganzini, Volicer, & Fox, 2004)

Civil Capacities - Capacity to Do What?

The six civil capacities identified for psychological assessment that are particularly important to APS client populations include "medical consent capacity, sexual consent capacity, financial capacity, testamentary capacity, capacity to drive, and capacity to live independently" (American Bar Association Commission on Law and Aging & American Psychological Association, 2008). Medical consent, sexual consent, financial capacities and capacity to live independently are highlighted below.

Medical Consent Capacity – Medical consent capacity involves a variety of healthcare related capacities such as the capacity to consent to medical treatment, the capacity to manage one's healthcare and medications, and the capacity to appoint a healthcare proxy in case of one's incapacity. The capacity to manage healthcare and medications is strongly linked to the capacity to live independently.

The ability to consent to medical treatment involves cognitive "functional" abilities based on four case law standards including "expressing a choice, understanding, appreciation, and reasoning" (American Bar Association Commission on Law and Aging & American Psychological Association, 2008).

Sexual Consent Capacity – Sexual consent capacity requires balancing the rights of individuals to engage in sexual expression with the need to protect the individual as a member of a group that may be vulnerable to abuse (Tang, 2015). The definition of sexual abuse in many states is based on the issue of consent to sex. Legal standards and criteria for sexual consent vary across states and knowledge of an individual's state law is necessary. It is important to note that there are no universally accepted criteria for capacity to consent to sexual relations, and the standards and criteria vary across states. According to the ABA & APA Assessment of Older Adults with Diminished Capacity (2008), "the most widely accepted criteria [for sexual consent], which are consistent with those applied to consent to treatment, are: (1) knowledge of relevant information; (2) understanding or rational reasoning; and (3) voluntariness." Syme and Steele (2016) offer this breakdown of the criteria and questions to consider:

1. Does the individual possess the "knowledge" needed to make the decision? This covers areas such as basic knowledge of sexual activities in question, illegal sexual activities, and appropriate times/places for sexual activities present.
2. Does the individual display a "reasoned understanding" or demonstrate an ability to take into account relevant knowledge (i.e., nature of the situation) and weigh the risks and benefits of engaging in it

(i.e., appreciate the potential consequences)?

3. Does the individual demonstrate "voluntariness" or the ability to make a decision without undue influence or coercion (i.e., autonomy)? This may include the ability to take self-protective measures against coercion when making a sexual decision.

Financial Capacity – Financial capacity is a medical/legal construct meaning the capacity to independently manage one's financial matters consistent with personal self-interest and values. It involves both performance skills such as counting coins/currency, completing a check register accurately, paying bills and using good judgment. It is important to have knowledge of an individual's lifetime values and approach to managing money and finances. More broadly, financial capacity also includes specific legal capacities, such as contractual capacity, donative capacity, and testamentary capacity. Financial capacity is sensitive to medical conditions that affect cognitive and behavioral functioning such as dementias, Parkinson's disease, psychiatric disorders, substance abuse disorders and developmental disorders (American Bar Association Commission on Law and Aging & American Psychological Association, 2008).

Testamentary Capacity – Criteria for testamentary capacity vary across states but according to the ABA & APA Assessment of Older Adults With Diminished Capacity (2008), there are generally four criteria identified including "a testator must have (1) knowledge of what a will is; (2) knowledge of that class of individuals that represents the testator's potential heirs ("natural objects of one's bounty"); (3) knowledge of the nature and extent of one's assets; and (4) a general plan of distribution of assets to heirs." It is important to note that the functional elements of testamentary capacity are almost completely cognitive and to "exercise this capacity, a client must communicate and work with an attorney, which introduces a professional relationship and some element of social discourse into the exercise of this capacity" (American Bar Association Commission on Law and Aging & American Psychological Association, 2008).

Capacity to Live Independently – In most states, the most relevant legal standards for the capacity to live independently are those which are defined in state guardianship law. They may include one or more of the "four tests": 1) a disabling condition; 2) a functional issue and/or the inability to meet essential needs to live independently; 3) a cognitive problem; and 4) a necessity component (e.g., a guardianship is necessary because less restrictive alternatives have failed). In some states, legal guidance relevant to independent living may be provided in the APS statutes (American Bar Association Commission on Law and Aging & American Psychological Association, 2008). The ABA/APA (2008) proposes the assessment of capacity to live independently "requires the integration of understanding what is required to live independently, the functional ability to apply one's knowledge ("application"), and the ability to problem solve and appreciate consequences of potential choices ("judgment"). Additional considerations include if the individual is a danger to themselves due to limited functional abilities and/or cognitive or psychiatric disturbances, and can they comply with the assistance/supports that would allow them to live independently.

Part II: The Relationship Between Capacity and Abuse

Why APS Professionals Need to Understand Capacity

At the heart of APS work is balancing duty to protect the client with their right to self-determination. In

addition, APS should follow the ethical principle of "Do No Harm", because inappropriate or insufficient intervention may be worse than no involvement at all. Discerning if APS clients can make informed decisions about their situations and care is one of the greatest challenges faced by APS caseworkers. The following case example reflects the complexities:

Myrtle Jones, age 75, lives alone and has recently paid $20,000 to a contractor for repairs on her house. Myrtle's daughter, who lives out of state, claims her mother fell victim to a "scam" contractor who came to the door and told Myrtle she needed a new roof. The daughter also claims Myrtle is missing appointments and has stopped seeing friends. A concerned friend called the daughter recently to report that she stopped by to see Myrtle and she did not open the door. The friend could see garbage piled in the hallway. The daughter is concerned and calls APS.

Fast forward - The APS case worker knocks on Myrtle's door and she refuses to open it. Myrtle says, "she is fine and does not need her daughter and government getting into her affairs." She insists the APS worker leave immediately.

The APS caseworker is concerned but leaves. The caseworker documents the encounter and reports the situation to their supervisor. What does APS do next?

Staffing this case with a supervisor and, potentially an MDT, allows the APS worker to get insights from others and to determine whether a capacity assessment is warranted. Additional visits, potentially with an APS nurse, may help the APS worker establish a relationship and gain access to the home.

APS case workers screen for cognitive impairment when assessing client functioning, safety, and risks. The purpose of screening is to determine if further assessment is required. Assessment and/or evaluation is a more comprehensive process typically requiring specific materials, supervised testing experience, and credentialed professionals.

According to Dr. Holly Ramsey-Klawsnik, "case planning decisions hinge on capacity and APS caseworkers need to understand what mental capacity involves, indicators of cognitive loss, effective strategies for gathering and documenting capacity information, and indicated next steps when clients are in danger due to limited capacity. APS workers must also understand how their state law specifically defines capacity and practice accordingly" (Ramsey-Klawsnik, The Complexities of Cognitive Capacity, 2014).

Demographics

According to U.S. Census Bureau, Population Projections, the number of Americans age 65 and older is projected to nearly double from 52 million in 2018 to 95 million by 2060; a rise from 16 to 23 percent of the total population (Population Reference Bureau, 2020).

Moye and Marson (2007) state, "the prevalence of cognitive aging, dementia, and medical and neurological comorbidities increases dramatically with age. Such cognitive and physical changes are intimately linked with declines in everyday functioning that include loss of decision-making skills." It is estimated 40–50% of persons over the age of 85 have some degree of cognitive impairment, placing them at increased risk for mistreatment (Abrams, et al., 2019). How medical conditions effect decision-making abilities varies across individuals and may affect some aspects of decision making and not others. It is recommended practitioners use a "sophisticated and functionally oriented capacity assessment" (Moye & Marson, 2007).

Additionally, due to advancements in medicine, public policy and advocacy, the life expectancy for persons with intellectual/developmental disabilities (I/DD) has increased significantly. It is projected that by 2030 the number of adults with I/DD aged 60 and older is projected to grow to 1.2 million. In addition, adults with I/DD can experience age-related changes in their mid-forties to mid-fifties, 10-20

years ahead of the general population. These age-related changes are linked to cognitive and physical functions include Alzheimer's disease and other related dementias, osteoporosis, mobility impairment, types of cancer, and diabetes (Kerins, 2019).

Client Vulnerabilities

Financial Exploitation – Research has found age-related cognitive impairments such as Alzheimer's disease are highly correlated with financial exploitation and poorer decision-making abilities. It is important to note that cognitive function is an important predictor of decisional capacity, but other factors may also influence these abilities. Lichtenberg et al., (2016) point to Boyle's 2013 work that highlights the fact that financial decision-making capacity differs from executional capacity. They state, "in nearly 25% of the couples studied, the person with dementia retained decisional capacity, even in the absence of executional capacity" (Lichtenberg, et al., 2016). This research points to individual differences and the complexities of financial exploitation cases. Thus, to protect the individual's autonomy, APS should not assume that all older adults are at risk for financial scams and theft.

Undue Influence – Undue influence, generally summarized, occurs "when a fiduciary or confidential relationship exists in which one person substitutes his own will for that of the influenced person's will" (Quinn M. J., 2018). Some states define the term, some cite it in probate, criminal or other sections of code. For that reason, it is recommended that APS caseworkers be familiar with how the term is applied in their state laws. Though cognitive deficits can make an individual more vulnerable to undue influence, undue influence and incapacity often occur independent of each other. Psychological manipulation over time is the constant in undue influence cases. The International Psychogeriatric Association Task Force on Testamentary Capacity and Undue Influence, comprised of professionals from the legal, medical and psychological fields identified three areas of risk for undue influence:

1. social or environmental risk factors such as dependency, isolation, family conflict, and recent bereavement;
2. psychological and physical risk factors such as physical disability, deathbed wills, sexual bargaining, personality disorders, substance abuse, and mental disorders including dementia, delirium, and mood and paranoid disorders;
3. legal risk factors such as unnatural provisions in a will, or provisions not in keeping with previous wishes of the person making the will, and the instigation or procurement of a will by a beneficiary.

(Quinn, Nerenberg, Navarro, & Wilber, 2017)

These areas of risk align with the domains and themes identified by Quinn, et al., when developing the *California Undue Influence Screening Tool (CUIST)*. Based on APS supervisor and caseworker focus group feedback, they identified four domains and related themes if present:

- Vulnerability of the victim. Themes: dependency on others, isolation, and fear.
- Influencer Apparent Authority (the many ways the role of power fits into the process of undue influence). Themes: Authority/power derived from victims' reliance on influencers for professional role, knowledge or direct care.
- Actions or Tactics Used by Influencer. Themes: manipulation, processes over time, and deliberate isolation.
- Fairness of the result or consequences (psychological repercussions and financial losses). Themes: loss of assets, physical harm, neglect, and self-neglect. On the

individual level themes include depression, shame, loss of motivation, and suicidality. (Quinn, Nerenberg, Navarro, & Wilber, 2017)

Self-Neglect – Research has found an association between decline in executive function and cases of self-neglect. Substance use disorders may also play a role in diminishing an individual's ability for self-care and can contribute to recidivism (Terracina, Aamodt, & Schillerstrom, 2015).

Sexual Abuse – Older adults with sensory impairments, physical frailty, mobility issues, memory and/or cognitive issues are more vulnerable to sexual abuse. According to Tang (2015), "a 2004 study of 120 adults, consisting of sixty individuals with intellectual disabilities and sixty without, found that the intellectually impaired adults were significantly less knowledgeable about almost all aspects of sex and appeared significantly more vulnerable to abuse, having difficulty at times distinguishing abusive from consenting relationships."

Late Onset Intimate Partner Violence (IPV) – "The late onset IPV describes a pattern of IPV that begins in late adulthood and is thought to be related to a) retirement, which may bring on new roles for the couple; b) disability, especially cognitive impairment; and c) sexual changes related to the aging process or cognitive impairment. For example, couples between the ages of 60 and 80 may still be sexually active, but forced/unwanted sex may cause injuries to reproductive tissue and increase the risk for sexually transmitted infections. Also, during this age period cognitive impairment may begin or progress to more obvious changes, resulting in demanding or forced sex from a long-term male sexual partner. In some cases, women who have been victims of long-term abuse by their male partners may become physically abusive toward their frail male partners" (Beach, Carpenter, Rosen, Sharps, & Gelles, 2016).

Part III: Capacity Screening – Cognitive Domains and Screening Tools

An effective APS cognitive screening tool is interviewing, interacting and observing the client during one or more home visits. When possible, assess at times best for the client utilizing multiple methods to "observe and document client statements, appearance, behaviors, home environment, functional abilities, and limitations but avoid premature conclusions or statements regarding the cause of problems observed" (Ramsey-Klawsnik, The Complexities of Cognitive Capacity, 2014).

"Natural assessments" can be less intimidating than brief screening tools, and both methods can be used in conjunction to facilitate rapport as well as to assess needs and supports and cognitive status.

Four basic questions to ask when assessing a client's ability to make informed decisions:

1. Does the client understand relevant information?
   Ask – Do you know you have a serious cut on your leg?
2. What is the quality of the client's thinking process?
   Ask – How can you get treatment for the cut on your leg?
3. Is the client able to demonstrate and communicate a choice?
   Ask – Do you want to get treatment for the cut on your leg?
4. Does the client understand the nature of their situation (risks and benefits)?
   Ask – What will happen if you do not get the cut on your leg treated?

(National Center on Elder Abuse, 2015)

Standardized screening tools can assist APS caseworkers in determining if a client needs further

assistance from a physician, psychiatrist, psychologist and/or attorney. Capacity assessment scales and tools should not be used alone but as a "package" of observations, interviewing, and assessments. Each tool has its strengths and limitations and it is important that the APS caseworker, if at all possible, not rely on only one assessment tool to determine whether a client needs a professional capacity evaluation.

Generally, there are six domains assessed by capacity assessment scales and screening tools, they include orientation, attention, memory, language, visual-spatial organization and executive functioning.

Clock Drawing Tests (CDTs) – CDTs are brief, cost-effective screening tools which provide information on general cognitive functioning such as memory, information processing, visuo-spatial organization, and executive function. They can also offer clues regarding the area of brain change or damage. CDTs vary in the details of their administration and scoring. Royall et al., (1999) states, "the widest variations occur with regard to three aspects: (a) whether a pre-drawn circle is provided; (b) what time is to be set on the clock; and (c) whether the clock is drawn freehand or copied" (Royall, Mulroy, Chiodo, & Polk, 1999). The CLOX (Royall, Cordes, & Polk, 1998) is comprised of two parts, CLOX1 and CLOX2. The CLOX measures "Executive Control Functions (ECFs) or complex goal directed behavior in the face of novel, irrelevant, or ambiguous environmental cues" (Royall, Cordes, & Polk, 1998). The CLOX1 is sensitive to assessing executive function by requesting the individual draw a picture of a clock that says 1:45. The CLOX2 is sensitive to visuo-spatial organization and construction praxis and is a clock copying activity (Terracina, Aamodt, & Schillerstrom, 2015).

Confusion Assessment Method (CAM) – CAM is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The CAM includes four features found to have the greatest ability to distinguish delirium from other types of cognitive impairment (McCabe, 2019). It 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.

Geriatric Depression Scale (Short Form) - The Geriatric Depression Scale (GDS) has been tested and used extensively with older populations. Validity and reliability of the tool have been supported through both clinical practice and research. The Short Form is more easily used by physically ill and mildly to moderately demented patients and it takes about 5 to 7 minutes to complete. It is not a substitute for a diagnostic interview by mental health professionals but is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults; however, it does not assess for suicidality (Greenburg, 2019).

Lichtenberg Financial Decision Screening Scale (LFDSS) – The Lichtenberg Financial Decision Screening Scale (LFDSS), aka, "Financial Decision Tracker," is a brief, 10-item standardized web-based screening scale designed to assess deficits in financial capability and an individual's decisional ability at the point in time when the adult is making a significant financial decision (Lichtenberg, et al., 2016). The tool assesses a client's **choice, rationale, understanding,** and **appreciation** of a financial decision in the context of the client's values. It was developed to be used by financial and legal professionals and others such as APS caseworkers investigating potential exploitation. No-cost training and certification are required to use the tool.

Memory Impairment Screen (MIS) – The MIS is a brief four-item screening tool to assess recall memory. It is often used as a preliminary test, along with other screening tools, to evaluate the cognition of someone who seems to display some possible impairment in their ability to think and recall. It is recommended for use with the GPCOG and Mini-Cog in the Medicare Annual Wellness Visit by the Alzheimer's Association. Advantages include: a) it is very brief to administer, b) it does not require the client to write, c) it has consistent results when used in various languages and cultural settings, d) the client's education level does not affect the score, and e) it involves very little training to administer. Disadvantages include: a) it cannot be used with a client with visual impairment or who is illiterate, and b) it does not evaluate executive function or visuo-spatial ability (Heerema, 2020).

Mini Mental State Exam (MMSE®) – The MMSE® is a commonly used screening instrument for generalcognition that assesses orientation, memory, concentration, and language. According to the NAPSA Core Competency Module 17, Assessing APS Clients' Decision-Making Capacity, the advantages of the MMSE® include, "used by APS programs, psychiatrists, physicians, large normative data with age and education norms, translated into many languages, and it's brief to administer. The disadvantages include it doesn't assess the client's decision-making skills for specific tasks, does not detect mild cognitive impairment or degrees of far advanced cognitive disorders, the results may be influenced by the client's personal characteristics and experiences (e.g., educational background, occupational status, cultural background) and other variables, it can be incorrectly administered and interpreted (e.g., if cutoff scores are used and particularly if the client has low literacy), and it is copyrighted and there is a cost per form" (National Center on Elder Abuse, 2015).

Montreal Cognitive Assessment (MoCA©) – The MoCA© was developed as a quick screening tool for mild cognitive impairment (MCI) and early Alzheimer's dementia and assesses the domains of attention and concentration, executive function, memory, language, visuo-spatial organization, conceptual thinking, calculation, and orientation. The advantages include: a) it has been tested across a variety of cognitive disorders and in non-cognitively impaired older adults as well as tested across age ranges (49-85+ years old) and educational levels, b) it has been translated and tested in multiple languages, c) it has greater sensitivity in the detection of mild cognitive impairment, d) it integrates the clock tests, and e) a modified version, MoCA-B©, is offered for those with visual impairments, and there is an electronic version (Doerflinger, 2019). The tool takes approximately 10 minutes to administer. Disadvantages include: a) it can take longer and is more complex to administer than other cognitive screens, b) threshold scores may need to be adjusted for client's level of education and adjusted to control for possible over-identification of non-cognitively impaired individuals (Doerflinger, 2019). Training and certification to administer and score the MoCA© test is mandatory as of September 2019 to ensure consistency and accuracy.

St. Louis University Mental Status (SLUMS) Examination – The SLUMS is a brief oral/written method of screening for Alzheimer's and other kinds of dementia. It consists of 11 items that measure orientation, short-term memory, calculations, the naming of animals, the clock drawing test, and recognition of geometric figures. It takes approximately seven minutes to administer. Advantages include: a) simple instructions and administration, b) education corrected norms, c) it covers many cognitive domains, d) it detects mild cognitive problems, and e) it has been translated into various languages. Disadvantages include: a) it

has been less researched for reliability and validity than the MMSE®, and b) it requires the client to write (Rosenzweig, 2019).

Assessment of Capacity for Everyday Decision-Making (ACED)/Short Portable Assessment of Capacity for Everyday Decision-Making (SPACED) – ACED and SPACED are tools developed to address whether a person refusing an intervention is capable of making this decision (i.e., an informed refusal). The practitioner identifies a functional problem the client is having, and at least one option to solve that problem. They adapt the interview questions according to that functional problem and options. The resulting scores/data are client specific. The ACED is useful for assessing the capacity to solve functional problems of older persons with mild to moderate cognitive impairment from disorders such as Alzheimer's disease and can also inform the assessment of complex cases of the "self-neglect syndrome."

Karlawish (2012) highlights the common dilemma faced by APS caseworkers, "whether to respect an older adult's choice to continue a potentially harmful activity or to decline an intervention that might reduce that harm, or, instead, to take action. To help to address this dilemma, staff ought to include an assessment of their client's decision-making capacity. The more skilled they are in doing this, they better they can help a client make a decision that respects the client's autonomy" (Karlawish, 2012). ACED was developed to guide a clinical interview, so practitioners require practice and judgement and must be aware of issues with the client's literacy and the level of interviewer/interviewee trust.

The Executive Interview (EXIT25) – The EXIT 25 is a standardized multi-task assessment of executive function comprised of twenty-five tasks that can be administered in APS clients' homes. It takes 10-15 minutes to administer and does not require advanced training to score and interpret. According to Schillerstrom et al., "tasks include having the client name as many different words as they can think of that start with the letter "A," list the months of the year backward starting from January and respond appropriately to a spontaneous clap. Each item challenges the examinee to go against their habits to solve the task at hand" (Schillerstrom, et al., 2013).

Interview of Decisional Abilities (IDA) – The IDA is a method and training curriculum, including a semi-structured interview tool that helps APS caseworkers evaluate the decisional abilities of adult clients. IDA focuses on the client's ability to accept or refuse APS services and can be applied to physical, sexual, or emotional abuse; financial exploitation; self-neglect; and neglect by others. The tool offers a structure to engage clients in a conversation about risk (Abrams, et al., 2019). The interview can be administered at any point in the APS investigation and consists of three main components:

"Pre-IDA" – The APS caseworker selects the risk that presents the most imminent danger for the client from the list.

3 Steps of IDA – During each step the APS caseworker documents phrases and observations that support their judgements/scores.

1. The caseworker assesses client understanding of the general problem or risk, determining whether the client acknowledges that the problem exists or has been experienced by others. The client's understanding of the problem is then rated as a "yes," "no," or "maybe." If the rating is firmly "no," the interview may be stopped because the next steps would not apply.
2. The caseworker assesses whether the client has personal insight into the risk

discussed in Step 1. This step is administered because it is possible for an individual to understand a problem but deny that the problem applies to themselves. The client's appreciation is rated as a "yes," "no," or "maybe."

3. The caseworker assesses the client's ability to reason. The client is asked if they have a plan to address the risk. Or, the worker may propose a plan, especially in cases where the client has not demonstrated insight in the previous step. The APS worker inquires, separately, about the advantages and disadvantages of the plan, without attempting to persuade. This step is then scored as "yes," "no," or "maybe".

"Post-IDA" – The APS caseworker indicates the future direction of the decisional abilities assessment. Often the next step will be a case review with an APS supervisor. Referral for formal capacity assessment will be determined with a supervisor based on the complete APS assessment, the severity of risk, and the worker's judgments and supporting documentation on the IDA. (Abrams, et al., 2019)

The training curriculum and tool have been piloted with New York City APS, Massachusetts APS, and select counties in California. The tool is currently undergoing testing; no psychometric data is available to date.

Part IV: Research on Capacity Screening

Executive Function and Recidivism

In a study by the University of Texas Health Science Center at San Antonio (UTHSCSA) and Texas APS, researchers conducted a retrospective medical record review of APS clients referred to the UTHSCSA Department of Psychiatry for decision-making capacity assessments over four years. They found the "proportion of cases referred for capacity assessment that were recidivistic was higher (at 60%) than the baseline for the region studied (at 13.5%). They also found that both recidivistic and non-recidivistic cases had poor cognitive performance across multiple domains but recidivistic clients performed significantly worse on measures of executive function and were more likely to carry a dementia diagnosis" (Terracina, Aamodt, & Schillerstrom, 2015).

The authors cited the following observations and APS practice implications:

- There is a disproportionately high prevalence of older adults referred by APS for decision-making capacity assessments with executive function impairments compared to other cognitive domains.
- APS caseworkers appear more sensitive to memory, concentration, and orientation impairments than they are to executive function deficits. Though executive function deficits greatly affect self-care abilities.
- There is a large cost to investigating repeat alleged victims of abuse, neglect, or exploitation. Identifying risk factors for recidivism could significantly decrease caseloads, cost, and suffering.
- Executive function deficits may diminish APS clients' abilities to utilize least restrictive interventions offered by APS, predisposing them to recidivism.
- Identifying risk factors for recidivism, such as executive function impairments, may help target appropriate client interventions and supports to decrease reoccurrences.

(Terracina, Aamodt, & Schillerstrom, 2015)

Research to Practice Highlight: Michigan APS and Wayne State University, Institute of Gerontology – The Intersection of Financial Decision-Making and Financial Exploitation

On February 13, 2020, the NAPSA Research to Practice Interest Group hosted a webinar entitled, *New Findings in the Intersection of Financial Decision Making and Exploitation: Results from Michigan APS and the SAFE Program*. Presenter Dr. Peter Lichtenberg highlighted the partnership between Wayne State University, Institute of Gerontology and Michigan APS to 1) cross-validate the *Lichtenberg Financial Decision Screening Scale* (aka Financial Decision Tracker) and 2) provide training and certification to APS supervisors and caseworkers on administering, scoring and using the scale for statewide implementation. To date, the partnership has been fruitful for both research and practice and provided opportunities to change and adapt the scale for more practical use in the field as well as identifying gaps in knowledge and training for appropriate, uniform tool administration.

Over 400 caseworkers have been trained and certified and 700 plus *Lichtenberg Financial Decision Screening* (aka Financial Decision Tracker) scales administered (Lichtenberg P. , 2019). Responses from interviews with Michigan APS caseworkers who have been trained and certified to use the scales are overwhelmingly positive. One caseworker was able to save a client over one million dollars, another shared it helped them ask all the questions they need to cover with a client, and another shared it helped them communicate with other professionals.

From the data gathered from the scale to date, the top five financial decisions made by an older adult that prompted APS involvement including gifting of money, a big ticket purchase, giving money to a scammer, allowing access to personal accounts, and having someone take over finances (Lichtenberg P. , 2019). Based on the same collaboration with Michigan APS, Campbell et al. (2019) found out of 105 APS cases, workers determined that 61% (n = 64) of the cases had substantiated financial exploitation; the remaining cases did not. Thus, substantiated cases had significantly higher risk scores than non-substantiated cases (Campbell, Gross, & Lichtenberg, 2019).

Additionally, another research to practice program is SAFE (Successful Aging thru Financial Empowerment), offered by the Institute on Gerontology, Wayne State University in Detroit based on a program at the Lifespan Program in Rochester, New York. The program has four goals, including: 1) educating older adults on finances and financial management; 2) disseminating fraud and identity theft information to older adults and professionals serving older adults; 3) providing one-on-one services to older adults who are fraud or identity theft victims; and 4) determining if those older adults seeking services are more psychologically or cognitively vulnerable than those who are not financially exploited. In approximately two years, SAFE has provided one-on-one services to over 100 older adults and education to nine thousand older adults and professionals. The data on those SAFE participants suggest there is an important interconnection between fiscal, physical, and mental health and professionals working with older adults need to be mindful in screening and assessments. The data also suggested older clients who cannot resolve their credit or other financial issues demonstrated reduced cognitive and mental health functioning (Lichtenberg P. , 2019).

Conclusion

As Quinn et al., (2017) states, "there is no single, universally accepted assessment or screening tool that satisfies APS needs for detection of cognitive impairment." Additionally, there has not been a study or survey on which capacity screening tools are currently being used by APS programs nationally. One can surmise anecdotally from a review of the literature, APS caseworkers are using a variety of tools, both standardized and non-standardized, and there may be APS programs that do not use any tools in their investigation and case planning.

What is clear is there are obstacles to the use of capacity screening tools which warrant further research and discussion. These obstacles appear to include knowledge of tool availability, training to administer tools appropriately, costs related to training and/or administration of tools, and the use of standardized versus non-standardized tools.

Further research and discussion are needed to develop a consensus on "principles of practice" for APS capacity screening tools. Such principles may include a better understanding of how tools can enhance caseworker judgement, training requirements so that tools are administered correctly and for their intended purpose, and requirements for testing of tools, to name a few.

Training Resources: Adult Protective Services Workforce Innovations (APSWI)

- APS Core Assessing Client Capacity Instructor-Led Training
- APS Core Assessing Client Capacity eLearning
- Undue Influence eLearning Mini-Module
- Undue Influence Committed by Professionals eLearning

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