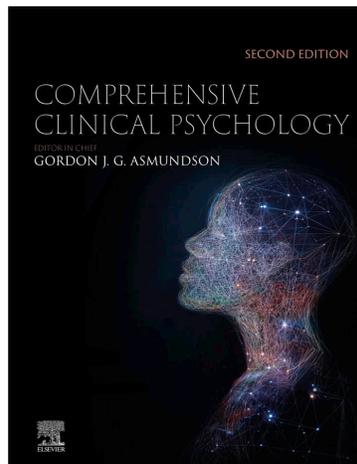


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7.08 Understanding the Decisional Capacities of Older Adults

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Capacity assessment of older adults is a growing field of clinical practice and empiricism, and is steeped in the fundamental tensions between two core ethical principles: autonomy (self-determination) and protection (beneficence; [Berg et al. 2001](#)). The term *capacity* refers to a person's ability to perform a certain task or make a certain decision, and is determined by a clinical assessment. In contrast, the term *competency* is used in a legal context, referring to a judgment made by the Court. In the past 20 years, issues of decision-making capacity have extended outside the judicial courtroom and are relevant to a broad range of professional disciplines including physicians, mental health workers, adult protective service workers, police, judges, and attorneys. Psychologists are increasingly called upon to conduct assessments and offer opinions about an individual's capacity. Always at the center of an assessment are the older adult and his or her concerned family members. This chapter addresses the very complex topic of decisional capacities in older adults, which involves knowledge of medical and psychological syndromes, clinical assessment, ethics, and the law ([Moye and Marson, 2007](#)). The next section provides a historical context of capacity.

7.08.1 Historical Context of Capacity

The history of the legal components of capacity can be traced back to early 15th century English law which preceded American jurisprudence. A legal concept of capacity emerged in the late medieval period and focused on feudal land and estate ownership issues, and eventually evolved to embrace other concepts including guardianship of the person and estate ([Moye et al., 2013](#)).

The earliest documented consent to treatment case emerged again from England in 1767 in *Slater v. Baker & Stapleton* wherein two physicians were found liable for embarking on a non-standard intervention (rebreaking and resetting a patient's bone with a partially healed break) without consent; expert testimony suggested their intervention was unorthodox and not consistent with "the usage and law of surgeons." Fast forward to American law in the early 20th century in the case of *Schloendorff v. Society of New York Hospital (1914)* in which U.S. Supreme Court Justice Benjamin Cardozo pronounced: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." By the middle of the 20th century, the United States developed standards such as *understanding* and *appreciation* to define medical consent capacity (see [Moye et al., 2013](#), for a detailed history), and the concept of capacity evolved to have a presence in both law and medicine.

Particularly in the United States, public policy also influenced a growing understanding of decision-making capacity. The combination of the patient rights movement and the principle of informed consent placed high value on individual autonomy and self-determination in decision-making. For example, the Community Mental Health Act of 1963 resulted in a massive shift from institutionalization to community-based services ([Dumont and Dumont, 2008](#)) and set the groundwork for extending capacity assessment into the domains of managing one's finances and living independently in the community. Additionally, the disability rights movement produced legal protections for persons living with disabilities ([Americans With Disabilities Act of 1990](#); [Developmental Disabilities and Bill of Rights Act of 1975](#)), and established that disability should not be understood solely as a medical phenomenon but an interaction between a medical impairment and physical and societal barriers ([Bagenstos, 2009](#)). One can easily

see the policy shift from “fixing” a medical problem to considering the person’s functioning as it interacts with the environment. Models of capacity (Grisso, 1986) began to emerge at this point and focused on the interactive component of capacity, and was later refined to include the contextual and functional aspects of capacity (Grisso, 2003). Although early models were not directed to older adults specifically, each of the aforementioned social movements emphasized individual autonomies in decision-making and thus, placed decision making capacity front and center. However, the changing demography has made questions of capacity in older adults a central concern. The following sections highlight the complex intersection of aging and decisional capacity.

7.08.2 An Overview of Aging and Decision-Making Capacity

The simple biological fact that cells are mortal implies that no one escapes aging. Perhaps the greatest shock about aging is that it occurs far before we are ready to accept it. Understandably, the single most feared of the age-related pathologies are disorders of the brain that lead to dementia. The next most feared are cancer, bone weaknesses, fractures, arthritis, incontinence, muscular atrophy, Parkinsonism, ischemic heart disease, prostatic hypertrophy, and pneumonia—all of which increase the body’s susceptibility to infection (Lewis and Maron, 1992), and when superimposed on the natural aging process, can turn a normal stage of life into a chronic pattern of illness, disability, or premature death.

Aging has become a serious “problem” simply because people are living longer today than they did previously. For example, at the turn of the 20th century, aging and its associated infirmities were not considered problematic because relatively few reached the age of 65 years (Oeppen and Vaupel, 2002). Contemporarily, the United States Centers for Disease Control and Prevention reported life-expectancy rates at birth, in 2017, of 78.6 years, with the average life expectancy for males at 76.1 and 81.1 years for females (Arias and Xu, 2019). The scientific advances in medicine and policy improvements in public health are largely responsible for the extension of human life expectancy; and now, more than ever, science must shift its focus to ensuring that quality of life occurs in the “third chapter.” But, quality of life is subjective and culture-bound, and increasingly viewed as individualized in today’s trending “person-directed” systems of care.

In today’s health care environment, older adults are expected to play a more active role in managing their own care and treatment, including setting and striving to achieve health enhancement goals, coordinating their medical procedures, researching and making decisions around advance directives and treatment options, and integrating new technologies into their daily lives. All of these behaviors must be achieved against a backdrop of age-related cognitive changes that may impact an older adult’s ability to comprehend and consent to medical treatments. In addition to medical-related decisions, older adults are making important decisions about their finances, wills and trusts, living situation, and relationships.

In the United States, neuropsychologists and psychologists are tasked with assessing capacity on a range of domains (Blum, 2015; Moye and Braun, 2010), particularly as the likelihood of dementia among older adults increases (Plassman et al., 2007). Medical and legal professionals are also asked to assess testamentary and decision-making capacity of individuals. Many disorders, such as dementia, affect one’s capacity do so because they have a direct consequence on cognitive functioning, including insight and awareness (Alexander et al., 2019; Marson et al., 1996). As such, professionals are increasingly offering expert opinions on capacity to guide guardianship proceedings (Demakis, 2013; Gibson and Greene, 2013; Moye et al., 2007a; Wood, 2004). Recommendations outlined by the *Uniform Guardianship and Protective Proceedings Act (1997)* and the *Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (2017)* in the United States allow physicians, psychologists, and other qualified professionals to perform capacity evaluations in determination of guardianship. In a recent review of United States laws in 51 jurisdictions (50 states and the District of Columbia), Rothke et al. (2019) found that the majority of states utilized psychologists to perform capacity evaluations either independently or as part of a team, while only eight states recognized physicians as qualified to make determinations of guardianship. The interplay between legal and medical professionals in their respective roles as assessors has been a source of empirical and practical inquiry in Australia where there is no nationally recognized paradigm for conducting capacity assessments (Purser et al., 2015). While the intent of guardianship is to protect a person, it also significantly alters an individual’s life through the removal of basic rights such as the right to vote, make health care decisions, make donative gifts, decide where to live, and whether to sell a property. Thus, the key determining factor about whether an individual requires a guardian must not focus solely on a medical diagnosis or advancing age, but also consider the individual’s functional and decision-making abilities (Moye et al., 2007a).

Historically, probate law viewed capacity as an absolute and global concept. However, in recent years, the law has shifted toward a more task- or decision-specific standard of capacity, recognizing that a person can have capacity in one area and not in another (Moye et al., 2008; Carroll, 2010). As a result, capacity evaluations have evolved to include neurocognitive, psychological, and functional assessments using a broad spectrum of domain-specific measures (e.g., Damakis, 2019; Lichtenberg et al., 2016; Marson et al., 2000). Questions about capacity around healthcare and financial decision-making, testamentary (i.e., will) and contractual, donative, sexual consent, participation in research, driving, and even voting are answered through careful assessment (see Moye and Marson, 2009) which includes a working knowledge of neurocognitive disorders in later life. In the US, psychologists who completed an American Psychological Association (APA) approved doctoral program have proficiency in assessment and thus, are positioned to conduct capacity evaluations (Lichtenberg et al., 2015a,b). The APA (2012) guidelines require that psychologists develop competency in

- information gathering and integration of data (record reviews, interviews, behavioral observations, and collateral interviews);
- selection of standardized tests, measures, and appropriate questionnaires;

- interpretation, diagnosis, and treatment recommendations; and
- report writing and communication of results to examinees, their families, and treating professionals (APA, 2012).

Despite the seeming goodness-of-fit for psychologists to conduct those evaluations, few are familiar with the term capacity or associated interventions employed to assist persons with diminished capacity. Some psychologists might feel less comfortable testifying in court or have limited knowledge about legal proceedings and working with attorneys. To address those concerns, in 2003, the APA and the American Bar Association (ABA) formed a workgroup to develop a series of handbooks for judges, attorneys, and psychologists. The purpose of the workgroup was to arm those three professions with discipline-specific guidance in making and understanding capacity determinations. The workgroup published the first handbook, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, in 2005. The second handbook, *Judicial Determination of Capacity of Older Adults in Guardianship Proceedings: A Handbook for Judges*, was published in 2006. And, in 2008, the final handbook, *Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists* was produced. The handbooks are available online at www.apa.org/pi/aging and www.abanet.org/aging (American Bar Association and American Psychological Association Assessment of Capacity in Older Adults Working Group, 2008). Similarly, the British Medical Association and the Law Society have produced a guide for legal and medical professionals when assessing mental competency/capacity (British Medical Association and the Law Society, 2015). And, in Australia, national guidelines have been modeled from a combination of the New South Wales Attorney General's *Capacity Toolkit* (2008) and a six-step capacity assessment model developed by Darzins et al. (2000).

For US psychologists, the APA/ABA handbook provides a conceptual framework that involves a multiplicity of factors that must be weighed when offering an opinion about a person's ability to make a decision or perform a task that has a specific definition in the law. Those factors include functional elements, diagnoses, cognitive underpinnings, psychiatric and emotional factors, values and preferences, risk considerations, and recommendations to enhance capacity (American Bar Association and American Psychological Association Assessment of Capacity in Older Adults Project Working Group, 2008). And, all of these must be viewed through a multicultural lens to include family traditions and religious beliefs (ABA/APA, 2008).

Embedded in the assessment process is the psychologist's understanding of their state's legal standards for incapacity including requirements for capacity evaluations in cases of guardianship as well as probate court standards. Legal standards can be confusing due to the inconsistency between clinical concepts and the vagueness of legalese used in the standards. To address the standard, a neuropsychological test battery will need to consist of measures assessing a person's ability to receive, evaluate, and communicate information, in addition to assessing memory and executive functioning. Additionally, functional and decisional capacity measures tailored to address the legal standards should be included in the test battery. The 1997 definition of an incapacitated person, as defined by the US Uniform Guardianship and Protective Proceedings Act (National Conference of Commissioners on Uniform State Laws, 1997), is

someone who is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance (pp. 2–3).

In 2017, the term *incapacitated person* was determined by the US Uniform Law Commission (ULC) to be "demeaning and even offensive" (National Conference of Commissioners on Uniform State Laws, 2017) and was amended in a new act, The Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act. One of the overarching aims of the Act was to reflect a person-centered philosophy in the language used. For example, replacing "ward" and "incapacitated person" with "adult subject to guardianship" and "individual subject to conservatorship." Within that philosophical vein, the Act requires that such individuals be provided with plain-language explanation of their rights and are included in decisions affecting them. Additionally, the Act requires that person-centered plans are created by guardians and monitored by courts to ensure individual's preferences and values are upheld and to reduce instances of exploitation by guardians. For a comprehensive review of the Act, visit <http://www.uniformlaws.org>.

An important aspect of the new model Act is its replacement of the definition for *incapacitated person* with "adult subject to guardianship," stating that such a person is one who:

lacks the ability to meet essential requirements for physical health, safety, or self-care because the respondent is unable to receive and evaluate information or make or communicate decisions, even with appropriate supportive services, technological assistance, or supported decision-making; and the respondent's identified needs cannot be met by a protective arrangement instead of guardianship or other less restrictive alternative.

National Conference on Commissioners on Uniform State Laws, 2017, p. 36.

Important to note here is the omission of the term *capacity* in the new definition with an emphasis on an individual's *abilities* as well as the addition of "supportive services" and "supported decision-making." Supported decision-making (SDM) is "an alternative to and an evolution from guardianship" (Martinis, 2015, p. 109) and is rooted in the current understanding that disability arises when there is misalignment between a person's abilities and strengths, and the demands of the environment. Generally speaking, people employ SDM in everyday decisions where consultation with family members, friends, and colleagues occurs around situations where choices are weighed for risks and benefits. In this way, SDM is akin to "what happens for most adults when they make

decisions such as whether to get car repairs, sign legal documents, and consent to medical procedures: they seek advice, input and information from friends, family, and professionals who are knowledgeable about those issues, so they can make their own well-informed choice" (Martinis 2015, p. 109).

In recent years, researchers have proposed an integrative social-ecological framework for assessing personal, environmental, and social factors to determine the level of support needed by individuals with varying levels of cognitive impairment (Bertelli et al. 2017; Marinis et al., 2017). Additionally, the phrase "less restrictive alternative" speaks to the clinical aspect of assessment and interventions. While the revised definition reflects a comprehensive and holistic approach that most clinicians adopt in their assessment of an individual's abilities and conceptualization of strengths, the new model Act represents a radical shift in how we understand legal capacity. Important to note is that the new model Act is just that—a model. Most states have yet to enact the new definition and continue to use the terminology to define an incapacitated person and neglect emphasizing supports and SDM although traction is beginning to take hold in this new direction.

The recognition for SDM is being realized internationally as well. For example, the United Nations Convention on the Rights of Person with Disabilities (UNCRPD, 2008) promoted a paradigm shift which incorporates SDM as a least restrictive intervention (Standing Committee on Social Issues, Parliament of New South Wales, 2010; Then et al., 2018). It requires States to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity" (Article 12(3)). Other jurisdictions including the Adults with Incapacity (Scotland) Act 2000; the Mental Capacity Act 2005 in England and Wales; and the Mental Capacity (Health, Welfare, and Finance) Bill for Northern Ireland have incorporated legal frameworks for SDM (Davidson et al., 2015).

A recent review of the literature on SDM by Bunn et al. (2018) in the U.K. identified important barriers and opportunities to promote culture change within the medical field to better support older adults with complex needs. Key variables highlighted in their review exceeded beyond the simple notion that resources and tools (i.e., treatment literature) are the primary enhancers to SDM. Rather, the researchers concluded that understanding and assessing both patient's and caregiver's values around care, building systems and infrastructures that support patients' autonomy and their ability to communicate and engage with information related to their care, and taking the time to build trust and alliance between care providers and older adults were critical components to engaging in SDM.

7.08.3 Cognitive Aging and Age-Related Disorders Impacting Decisional Abilities

Neurocognitive disorders such as Alzheimer's disease and Lewy body dementia are insidious in nature, meaning that an individual's cognitive and functional abilities decline over time. In most cases, individuals who first receive a diagnosis of one of these degenerative diseases are typically fully autonomous and considered to be their own decision-maker. The range of symptoms associated with a degenerative disease process such as impaired memory, visuospatial abilities, attention, processing speed, and judgment can affect an individual's ability to make safe decisions in a range of contexts. However, the presence of a neurocognitive disorder does not infer incapacity (Grisso and Applebaum 1998a,b) nor should it be generalized to make a global judgment; rather, cognitive abilities must be conceptualized as both decision and domain specific.

7.08.4 Terminology

Two terms widely used to describe cognitive impairment are *mild cognitive impairment* (also referred to as "MCI") and *dementia*. The Diagnostic and Statistical Manual-5 (DSM-5), revised in 2013, now refers to MCI as "mild neurocognitive disorder" and dementia as "major neurocognitive disorder." Cognitive abilities should be viewed as a continuum, ranging from normal, age-related cognitive changes, to mild neurocognitive disorder, to major neurocognitive disorder. Another important term referring to altered mentation is *delirium*, which commonly occurs in older adults receiving care in inpatient medical settings. Symptoms of delirium include problems with focusing, disorganized thinking, confusion, disorientation, and an altered state of consciousness that resembles psychosis. The key indicator of delirium is the rapid onset at which the cognitive changes occur, and due to its nature can negatively impact a person's decisional capacity. Delirium as well as psychiatric comorbidities are considered treatable conditions that when addressed medically can potentially restore capacity.

The term *mild cognitive impairment* (MCI) was first used in the 1990s to describe the phenomenon of "benign senescent forgetfulness," initially introduced in 1958, in older adults who did not have dementia (Heinik, 2010). Although the definitions or descriptions of MCI (now referred to as "mild neurocognitive disorder") have varied over time, the general understanding of the phenomenon includes the observation by the client, friend, family member, or health care professional that there has been some deficit in one or more mental abilities and includes poor memory. However, unlike dementia (now referred to as "major neurocognitive disorder"), the older adult is able to function independently and does not meet criteria for dementia, in addition to having good general intellectual functioning.

Much research has been conducted on understanding the pathway from early onset of memory impairment associated with mild neurocognitive disorder to the progression of functional decline indicating major neurocognitive disorder. The DSM-5 criteria differentiate between major (formally known as dementia) and minor (formally known as MCI) neurocognitive disorders based on the degree to which cognitive decline negatively impacts one's independent functioning with everyday tasks such as managing

finances or medications. Early detection through screening and diagnosis is critical with regards to treatment options and in assisting with family planning (Borson et al., 2013; Boustani et al., 2003). Several causes of neurodegenerative disorders in older adults include Alzheimer's disease, Lewy Body disease, Parkinson's disease, vascular disease, and frontotemporal dementia (for an in-depth review of the disorders, see *Alzheimer's Disease and Dementia* by Mast and Yochim, 2017).

7.08.5 Assessing Capacities in Persons With Dementia

Health care decisions can range from simple and low risk, to complex and high risk, with everything in between. With increasing age, the development of dementia also increases; and those with a diagnosis of dementia are at further risk for multiple medical, neurologic, and mental health comorbidities. Presence of cognitive impairment, at the mild level, rarely triggers questions around decisional capacity. In those situations, family members or the older adult may seek an evaluation secondary to noticing behavioral changes that raise concern. More common is the situation where noticeable changes in the older adult's daily functioning prompts an assessment. For example, a daughter might seek an evaluation after learning that her father recently became lost while driving to his neighborhood grocery store and discovering that his mortgage had not been paid for several months. Her concerns deepen after noticing expired food in the refrigerator and stacks of mail unopened on the table. She wonders whether her father should continue to drive and manage his finances, and whether he is safe to live alone. For the clinician, additional questions arise regarding his baseline functioning and potential contributing factors that may explain a change in his behavior such as chronic medical conditions, medications, metabolic imbalances, presence of a psychiatric disorder, or motivation. Using the aforementioned American Bar Association (ABA) and APA's conceptual framework (2008) for making a clinical judgment, the assessment in this scenario would focus on the person's ability to continue living independently through careful evaluation of how much support the person would need to maintain independence given current cognitive abilities.

Judgments of incapacity to make medical decisions can vary by both diagnosis and setting. In a review of 43 studies examining capacity in various contexts, Sessums et al. (2011), found that only 2.8% of health older adult controls lacked medical decision-making capacity when compared to 20% of those with mild cognitive impairment and 54% of those with Alzheimer's disease. In terms of setting, the study concluded that incapacity determinations were highest among nursing home residents (44%) when compared to incapacity determinations among hospital inpatients (26%).

Given the prevalence of incapacity in various settings and among diverse diagnostic presentations, psychologists working with persons with dementia will also likely be interacting with a patient's surrogate decision-maker(s). Surrogate decision-makers can be both traditional and nontraditional. For example, immediate family members have conventionally been considered the most appropriate surrogates given the relationship characteristics between a patient and his or her family members, such as spouses, parents, adult children and siblings (Buchanan and Brock, 1989; Lo, 2013; Beauchamp and Childress, 2013; Hamann, 1993; American Medical Association Opinion, 2014). Further, traditional surrogates have been assumed to hold the most advocacy for the patient's autonomy and to have the best insight around the patient's values and preferences (Buchanan and Brock, 1989; Lo, 2013; Beauchamp and Childress, 2013; Hamann, 1993). However, in the US, nontraditional surrogates, such as long-term unmarried partners and grandchildren, who may be ethically qualified, are not legally recognized without presenting a legal document such as a health care power of attorney or health care representative form. This is not the case in other countries, such as Australia and much of Europe, where unmarried partners are recognized as surrogate decision-makers. In India, the role of a surrogate decision-maker is typically assumed by the spouse or the elder son in the family, although most clinical decisions are made by a collective mandate from all family members (Kalra et al., 2015). In 2006, India passed legislation that invalidated surrogate decision-making related to end-of-life decisions stating that "it creates complications" based on the cultural values of choosing life-sustaining interventions in the face of conflicting medical advice. The amended statute recommends forming a panel of three medical experts or moving the High Court to make health care decisions, particularly related to advance directive such as Do Not Resuscitate (DNR) or to withhold or withdraw life-sustaining treatments (Law Commission of India, 2006).

To understand the characteristics of nontraditional surrogate decision-makers who make medical decisions in US hospital settings, Comer et al. (2018) surveyed 364 patient/surrogate dyads consisting of hospitalized patients aged 65 years and older who lacked decision-making capacity based on a physician's assessment and who also had a surrogate available. The researchers concluded that nontraditional surrogate decision-makers (i.e., nieces, nephews, and friends) did not differ from traditional/legal, first degree family members serving as surrogate decision-makers in terms of communication patterns with the patient. For example, the amount of time (i.e., in-person, weekly) spent with the patient was almost identical between the traditional/legal versus nontraditional surrogate groups (71.2% and 80.8%, respectively). Additionally, both groups equally reported discussing the patient's medical preferences with the patient (96.9% of traditional surrogates and 89.2% of nontraditional surrogates). Findings from the study shed light on the notion that state statutes should broaden the list of authorized surrogates to include nontraditional decision-makers such as grandchildren who may adequately fill the responsibility of conveying the patient's desires, needs, and goals, particularly when immediate family members are not available.

When assessing capacity in persons with dementia, clinicians need to be well versed in the current diagnostic criteria to ensure an accurate diagnosis. The *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition; American Psychiatric Association, 2013) outlines the diagnostic standards for neurocognitive disorders that require a decline in at least one cognitive domain (complex attention, executive function, learning and memory, language, perceptual-motor, and social cognition), contributing to functional deficits. The degree of cognitive decline from baseline and the impact of the disease on functioning (mild vs. major neurocognitive

disorder), the degree of certainty regarding etiology (possible vs. probable), the presence or absence of behavioral disturbances (e.g., mood, agitation, psychosis), and the severity level of the disability (mild, moderate, severe) must be considered.

Differential diagnosis is key when assessing capacity in older adults due to the multitude of chronic health conditions that can have a negative impact on decision-making abilities. In situations where such conditions are transient or responsive to treatment, there is the potential for capacity to be restored. For the unseasoned clinician, misdiagnosis or omission of considerations for such conditions could lead to permanently removing a person's rights and autonomy secondary to a decision of incapacity due to a dementia diagnosis.

Clinicians are obligated to promote a person's decision-making capacity, thus maximizing his or her ability to exercise autonomy. When assessing capacity for medical treatment, for example, medical information should be presented using language the person understands, avoiding medical jargon and tailoring terms to the person's level of education. Clinicians should be mindful of the person's need to wear glasses or use of hearing aids to improve communication. When possible, clinicians should avoid interviewing a person who is experiencing heightened pain or other distressing symptoms (Sessums et al. 2011) as those experiences may affect performance on formal testing as well as ability to fully participate in a clinical interview (Caplan and Shechter 2008).

7.08.6 Medical Factors Impacting Decisional Capacity

Age-related changes in cognition have been well documented in the literature (Salthouse 1991; Wilson et al., 1997), but may not be entirely explained by the biological aging process. Rather, cognitive deficits can occur secondary to medical diseases that are common among older adults (Fozard et al., 1990). In fact, a report from the 2004 Medical Expenditures Panel Survey found that 49% of all adults in the United States have at least one chronic medical condition, and 26% have two or more (Egede et al., 2016). Among adults aged 65 or older, 72% have two of more conditions (Vogeli et al., 2007). Outside of the United States, a similar pattern was documented among older Taiwanese adults, with over 60% of respondents in one study reporting at least one chronic medical condition (Chen et al., 2017).

Given the strong contributions that medical comorbidities play in the development of cognitive impairment, considerable research has been devoted to understanding ways to prevent dementia and cognitive decline. The National Institutes of Health consensus conference in 2010 identified the following factors with good evidence for lowering risk of dementia and cognitive decline (Plassman et al., 2010). Each factor can be conceptualized as reversible contributors to cognitive decline and should be considered as part of any assessment.

- **Cardiovascular management.** There exists a strong connection between heart health and brain health. Poor cardiovascular health is a risk factor for vascular dementia and Alzheimer's disease, and when left untreated or poorly managed, can result in rapid decline or greater disability in dementia (Baumgart et al., 2015).
- **Diet.** Nutritional intake high in fruits, vegetables, and whole grains, and low in sugar and saturated fats, are associated with improved heart health and lower risk of dementia. Mediterranean diets have been shown to lower risk for Alzheimer's disease and dementia (Lourida et al., 2013).
- **Exercise.** Regular physical exercise has been associated with preventing impairments or postponing further decline in physical and cognitive functions, particularly consequences associated with activities of daily living (ADLs) (Heyn et al., 2004).
- **Cognitive engagement.** Engaging in mentally stimulating activities has been associated with positive impact on cognitive functioning, among people with and without cognitive impairment (Marioni et al., 2012; Middleton and Yaffe, 2009; Aguirre et al., 2013).
- **Social engagement.** Because loneliness and isolation have been associated with increased risk of dementia (Wilson et al., 2007), social activity and engagement have been found to mitigate the association between mild cognitive impairment and immobility (Steere et al., 2019). Further, studies have shown that social network, leisure activities, and physical exercise improve physical health, and can decrease the occurrence of specific medical conditions such as cardiovascular disease (Baumgart et al., 2015).

While the aforementioned lifestyle factors can aid in the prevention or slowing of cognitive decline, other factors can lead to diminished mental capacity. Factors such as electrolyte imbalance, dehydration, sleep disturbance (insomnia or hypersomnia), medication effects, malnutrition, vitamin deficiencies, fatigue, pain, and inflammatory processes all play a role in attention, concentration, processing speed, and one's ability to effectively encode and retrieve information. The range of issues affecting brain functioning and physiological states is vast and beyond the scope of this chapter; however, Kaye and Grigsby (2007, pp. 61–87) effectively summarized some of the more important biomedical conditions that influence a person's cognitive status.

7.08.7 Psychiatric Contributors to Decision-Making Capacity

Clinicians must consider common psychiatric comorbidities that may impair decision-making capacity, such as psychosis (Dunn et al., 2006; Okai et al., 2007), severe depression (Hindmarch et al., 2013), and bipolar disorder (Adida et al. 2008, 2011, Clark et al. 2005). Persons with serious mental illness may be evaluated for decision-making capacity, particularly in cases of guardianship. Schizophrenia, for example, has been shown to impair attention, memory, new learning ability, executive functioning, and processing speed, all of which impact real-world functioning (Bechi et al., 2017). In the United States, the lifetime prevalence (i.e., the

percentage of the general population that will experience a given condition at some point during their lifetime) of schizophrenia and schizophreniform disorders, combined, is 0.5% (Kessler et al., 2005b) and of Bipolar II disorders, 3.9% (Kessler et al., 2005a). Mental illness may be considered a disabling condition and can certainly impact a person's ability to manage finances or communicate decisions around medical treatments. For example, a patient who has a fixed delusion about a life-threatening medical condition and paranoia toward their physician or delusions about the medical condition itself (e.g., a malignant tumor believed to be placed by aliens to monitor a person's thoughts), would likely lack the capacity to make a decision to refuse life-saving treatment. Similarly, an older adult with a diagnosis of Bipolar disorder would likely not be able to manage their finances during a phase of mania. However, one recent study found that among persons referred specifically for a capacity evaluation, those with psychiatric conditions were no more likely to be found incompetent than those without psychiatric conditions (Demakis and Reeve 2015). Another important finding from Damakis' and Reeve's research (2015) was that those respondents who were single or not living at home were more at risk for being judged incompetent.

Psychiatric comorbidities are also common in persons with dementia and may negatively affect decision-making capacity thus, clinicians must ensure that they adequately assess psychiatric symptoms as they are potentially treatable conditions (Rothke et al. 2019).

7.08.8 Cultural Considerations in Assessing Decision-Making Capacity

The older adult population in many countries of the world, including the U.S., is more racially and ethnically diverse than ever before. The U.S. Census Bureau, for example, projected that between 2018 and 2060, the share of the older, non-Hispanic white population will fall from 77% to 55% (U.S. Census Bureau, 2020). Furthermore, the population of people who identify as "Two or More Races" is projected to be the fastest growing racial and ethnic group over the next several decades, followed by Asians and Hispanics. Cultural differences within the older adult population must be taken into consideration with accompanying historical, economic, and social factors. Psychologists' attention to cultural norms in terms of individualistic versus collectivist values is also an important component in assessing capacity. For example, consider the 89-year-old widower and Army Veteran whose value was independence and who was adamant about making his own treatment decisions, but was failing at home and declining help from others. On the other hand, consider a 76-year-old Chinese widow who was a mother and wife, from a culture that prioritized the collective good and family responsibility, and who leaned heavily on her family to provide care at home and to assist in all treatment decision-making. Clinicians should be aware of these differences so as to factor them into their assessment and clinical judgments when assessing for decisional capacity.

The cross-cultural differences between the aforementioned examples highlight the importance of values and beliefs that are reflected by an individual's country of origin. As noted by Karel (2007), values and beliefs are foundational to an individual's views on health care, aging, familial roles, finances, and end-of-life. From an ethical perspective, Western health care places emphasis on patient autonomy and self-determination which is evident in the type of interventions used such as advance care directives and powers of attorney. This is contrasted with other cultures who encourage collective decision-making involving family members and a patient's community. A recent study evaluating the role of values in influencing medical decision-making among Japanese and Americans found that Japanese participants placed more emphasis on information-sharing as an interdependent exchange compared to their American counterparts who valued greater independence, referred to as power-sharing (Alden et al., 2015). The study's findings highlight the importance of assessing values as critical influencers in medical decision-making and tailoring decisional supports (i.e., education on illness, treatment options, etc.) to the individual to assist in the decision-making process. With regards to assessment, special consideration of cultural aspects include language, immigration status, level of acculturation, socioeconomic status, attitudes about institutions such as hospitals and mental health treatment centers, as well as perceptions about disability and the role of the family in providing care (ABA/APA, 2008). For additional guidance in working with culturally diverse populations, the reader is encouraged to review the *Multicultural guidelines: an ecological approach to context, identity, and intersectionality* (APA 2017b at <http://www.apa.org/about/policy/multicultural-guidelines.pdf>).

7.08.9 The Referral and Assessment Process: What, When, and How?

Referrals for assessment come from myriad sources including physicians, family members, an older adult (i.e., self-referral), Adult Protective Services, geriatric care teams, attorneys, or the Court. The referral process can be fraught with confusion based on the terms "capacity" and "competency" as they are often used interchangeably among referring parties and thus, requires clarification by the psychologist. Also embedded in the referral question is the intended course of action—for example, the evaluation may be sought to pursue guardianship, or to transition a person into a higher level of care (i.e., assisted living or skilled nursing community), or to determine a safe discharge from a hospital setting to home. A psychologist receiving a referral stating, "assess for capacity" must determine the "what" and the "when" as those two areas can be influenced by specific contextual factors. For example, a psychologist may be asked to assess an older adult's capacity to return to independent living following a stroke. Delaying the assessment until the individual has received rehabilitative care would likely provide a more accurate picture of their overall functioning along with least restrictive alternatives to maximize independence. In some cases, and in some settings, it may not be

immediately apparent what question the assessment would attempt to answer. This is illustrated when a care team in an adult day health program—for example—might use the term *capacity* to describe an individual's *ability* to do a certain task such as refuse medications. Such a referral would state: "Mrs. Smith is refusing her medications. Please assess for capacity." In this situation, *capacity* may be confused with *ability*. Thus, several questions would need to be asked to clarify the team's request, such as:

- What does the team know about the person's mental status? Does the person have a current diagnosis of dementia or a mental health disorder? Has the team previously assessed the person's cognitive functioning using a screening tool, such as the Montreal Cognitive Assessment (MoCA, Nasreddine et al., 2005)? In other words, is there evidence suggesting a decline from baseline cognitive functioning?
- Does the person have a medical condition or a mental illness that would make this choice a risky one to their overall health status?
- What is the person's reason for refusing the medication? What does the team know about the person's values, religious background, and cultural beliefs?
- What approaches have the team tried? What's worked and what hasn't?
- Is there anyone involved in the person's life for shared or supported decision-making?

In the aforementioned scenario, the referral question is a relevant one to the person's plan of care although may not necessitate a capacity evaluation. However, the same scenario may have an alternate approach and outcome if presented differently by the team. Consider if the referral question was presented as such: "Mrs. Smith is a 77-year-old recently widowed woman with uterine cancer who is refusing the recommended treatment by her oncologist. She has a diagnosis of depression and lives with her daughter. Please assess for her capacity to consent to medical treatment."

A first question when receiving a referral is to inquire about specific events or behaviors that prompted the concerns. The ABA/APA (2008) handbook offers preassessment questionnaires and forms to assist clinicians in obtaining information. Specifically, the handbook provides a capacity worksheet for psychologists to use that includes a pre-assessment screening, informed consent section taking into account the patient's understanding of their situation or the decision at hand, prompts for the assessor to know the legal standards for the capacity in question and functional elements for consideration, record review, collateral interview, followed by data garnered from the assessment such as functional, cognitive, and psychiatric elements. Finally, the worksheet assists with integration of findings to include diagnostic impressions and prognosis, and steps to enhance capacity (p. 46–50).

Contemporarily, Page and Matthews (2020) developed a useful mnemonic, "CURE," to help clinicians decide the level of assessment formality and the amount of data that would be required to answer a question of capacity. The CURE framework for planning capacity assessments involves an appreciation for the *complexity* of the capacity in question, the *urgency* by which the assessment is needed, the level of *risk* posed to the individual, and the *environmental* supports and adaptations to maximize the individual's engagement. The areas of complexity, urgency, and risk can range from low to high and are impacted by a person's situation (e.g., a patient's request to discharge from subacute care to home while still recovering from delirium) and medical status (e.g., a person with dementia starting a new medication with potential serious side effects) (p. 34).

Underlying the planning process is an appreciation for the level of assessment that is required for any given situation or setting. Using the CURE framework as a guide, Page and Matthews (2020) propose another useful framework for weighing the pros and cons of the different levels of assessment to be considered. The varying levels of approaching an assessment include: (1) *formal and comprehensive*; (2) *formal and abbreviated*; (3) *informal or bedside evaluation*; and (4) *consultation only*. *Formal* assessments involve using standardized measures that may be *comprehensive* in nature (e.g., cognition, functional abilities, mood functioning, and values/preferences) or may be *abbreviated* (e.g., using measures that assesses a specific domain of cognitive or functional abilities such as donative capacity or capacity to consent to a surgery) based on the complexity, urgency, or level of risk to the individual. Alternatively, other situations may arise that require flexibility from the assessor such as a *bedside assessment*. This type of assessment allows for a quick evaluation of the individual's abilities that is less burdensome; particularly in situations where the patient is unable to engage or maintain attention for an extended period of time secondary to a medical illness. One can easily identify a downside to this type of assessment including the lack of standardization that would impact a clinical judgment of capacity. Depending on a patient's length of stay in a hospital or rehabilitation facility, bedside assessments can offer opportunities for multiple visits by the assessor to track improvement over time secondary to medical or pharmacological stabilization, as well as for building rapport in situations where the patient presents with decreased motivation to participate in an evaluation. Finally, *consultation* occurs in situations where a physician or care team needs direction on as how to conceptualize capacity or what questions to ask that addresses an individual's understanding, appreciation, reasoning, and expression of choice (Paige and Matthews, 2020, pp. 35–36). The next section outlines two specific domains of capacity—medical consent to treatment and financial capacity and decision-making - and associated instruments to measure capacity and assist in the evaluation process.

7.08.10 Capacity to Consent to Medical Treatment

The capacity to consent to medical treatment is defined by most states' statutes under their advance directives law. The US Uniform Health Care Decision Act offers the following definition:

'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision

Uniform Health Care Decisions Act of 1993, 1994

Informed consent is a key aspect of decisional capacity in health care settings and requires that an individual's consent to treatment be "competent, voluntary, and informed" (American Bar Association and American Psychological Association Assessment of Capacity in Older Adults Working Group, 2008). In other words, the individual has the right to know all relevant information pertaining to their care and treatment options so as to make an informed decision about his or her treatment. The ABA/APA Handbook for Psychologists (2008) notes that capacity is only one element of testing for informed consent. A person may have capacity to consent to treatment but the decision could also lack informed consent due to not knowing the information or involuntarily agreeing to a treatment. Under advance directives laws, physicians are permitted to assess and make a determination of a person's capacity to consent to medical treatment. If a person's ability to provide consent is in question, the assessor may consider obtaining assent or including a surrogate decision-maker utilizing the APA Ethics Code Standards 3.10 and 9.03b for guidance (2017a).

7.08.10.1 Consent to Medical Treatment Instruments

The past 20 years has shown major empirical improvements in the development of assessment instruments and interview instructions used in evaluating capacity to consent to medical treatment. As Moye et al. (2006) highlighted, these "instruments are meant to aid clinical evaluation; however, a score on such an instrument is never meant to supplant clinical judgment" (p. 1056). Central to the statutory model, capacity instruments are used to assess functional abilities which is integrated with information about the diagnosis, cognitive abilities, and risk of harm (Moye et al., 2006). Table 1 lists instruments designed to assess capacity to consent to treatment and the unique aspects of each. Of note, the instruments vary in their use of structured vs. semi-structured interview format, use of clinical/hypothetical vignettes vs. presentation of actual treatment decision, use of scoring guidelines to determine capacity, and the ability to assess understanding, appreciation, reasoning, and expressed choice. For an in-depth discussion of the empirical underpinnings (i.e., inter-rater and test-retest validity) of each instrument, the reader is directed to Moye et al. (2007b).

Table 1 Instruments for the evaluation of consent capacity

<i>Instrument</i>	<i>Interview format</i>	<i>Clinical vignettes</i>	<i>Actual medical/ treatment decision</i>	<i>Scoring guidelines</i>	<i>Legal standards: U/A/R/EC^a</i>	<i>Notable qualities</i>
Assessment of the Capacity to Consent to Treatment (ACCT; Moye et al. (2007b))	Structured	X	X	X	U/A/R/EC	Includes an interview of the patient's values.
Aid to Capacity Evaluation (ACE; Etchells et al. (1999))	Semi-Structured		X	X	U/A/R/EC	Reflects legal standards in Ontario, Canada, and U.S.
Capacity Assessment Tool (CAT; Carney et al. (2001))	Structured		X	X	U/A/R/EC	
Capacity to Consent to Treatment Instrument (CCTI; Marson et al. (1995))	Structured	X		X	U/A/R/EC	
Competency Interview Schedule (CIS; Bean et al. (1996))	Structured			X	U/A/R/EC	Used specifically to assess capacity for electro-convulsive therapy (ECT)
Decision Assessment Measure (DAM; Wong et al. (2000))	Structured	X		X	U/A/R/EC	Meets legal standard for capacity in England and Wales, <i>not</i> in the U.S.
Hopemont Capacity Assessment Interview (HCAI; Edelstein (1999))	Structured	X		X	U/A/R/EC	Also includes two vignettes assessing financial capacity
MacArthur Competence Assessment Tool-Treatment (MacCAT-T; Grisso and Applebaum (1998b))	Semi-Structured		X	X	U/A/R/EC	
Perceptions of Disorder (POD; Applebaum and Grisso (1992))	Semi-Structured		X	X	Not explicitly identified	Precursor instrument to the MacCAT-T
Thinking Rationally About Treatment (TRAT; Grisso and Applebaum (1993))	Semi-Structured	X		X	U/R/EC	Precursor instrument to the MacCAT-T
Understanding Treatment Disclosures (UTD; Grisso and Appelbaum (1992))	Structures	X		X	U	Precursor instrument to the MacCAT-T

^aUnderstanding, appreciation, reasoning, expressing a choice.

7.08.11 Financial Capacity

Financial capacity is a medical-psycholegal construct that represents two main facets of financial transactions: financial execution and financial decision-making (Moye and Marsen, 2007; Lichtenburg, 2020). Financial execution refers to the management of finances—for example, balancing a checkbook, paying bills, managing a bank account—which requires a certain level of *capacity* or ability to do so. While many people have the ability (capacity) to execute their financial affairs, they may make decisions that negatively impact their lives. Financial decision-making—as the other facet of financial transactions—is defined as the ability to make informed decisions through understanding, appreciation, reasoning, and expression of choice (Moye and Marsen, 2007). Embedded in financial capacity are specific types of legal transactions such as entering or executing a contract (contractual capacity), making a gift (donative capacity), or creating a last will and testament (testamentary capacity) (ABA/APA, 2008). The legal standards for each of these capacities can vary by state and jurisdiction. Generally speaking, the legal standard for testamentary capacity requires that the four capacity criteria to be met (i.e., understanding, appreciation, reasoning, and expression of choice); and, the absence of one of the criteria can result in a court's ruling to invalidate a will (ABA/APA, 2008). Donative capacity, on the other hand, has a more comprehensive standard in that *the party contemplating a donative transfer must understand the nature and effect of the act of making a gift* (ABA/APA, 2008).

When the ABA/APA *Handbook for Psychologists* was published in 2008, very few conceptual models for assessing financial capacity existed. A review of the ABA/APA (2008) chapter on financial capacity depicts one model informed by research conducted by Griffith et al. (2003) which outlined 18 tasks within 9 domains to determine overall capacity. The nine tasks included an assessment of: (1) basic monetary skills; (2) financial conceptual knowledge; (3) cash transactions; (4) checkbook management; (5) bank statement management; (6) financial judgment; (7) bill payment; (8) knowledge of assets/estate; and (9) investment decision making. The model served as an important contributor to informing research on financial capacity in dementia (Marsen et al., 2000; Griffith et al., 2003; Martinis et al., 2017; Sherod et al., 2009; Giannouli and Tsolaki, 2020; Gill et al., 2019). It is important to note here that “overall capacity” – as outlined in Griffith et al.'s (2003) early conceptual model—inferred that financial capacity was viewed as a global construct. And indeed, clinicians historically have been asked to make global judgments about a person's financial capacity to the exclusion of differentiating between financial execution and financial decision-making. While global judgments are relevant to guardianship and conservatorship hearings, they also have the potential to negatively impact an individual by completely stripping away that person's right to manage or execute certain financial transactions around which they demonstrate capacity while lacking the capacity to manage other tasks or make financial decisions. *Financial incapacity* is a legal construct that is characterized in conservatorship statutes and which requires the clear and convincing evidence demonstrating:

1. That an individual is unable to manage property and business affairs; and
2. That an individual's assets are at risk of being wasted or dissipated, or that money is needed for that individual and his or her dependents.

One can easily recognize the complexity of assessing for financial capacity and financial incapacity, and the specificity required from the referring party. Additionally, the capacity to manage finances and make financial decisions may increase risk for financial exploitation (Lichtenburg, 2020). Another component of financial capacity is decisional capacity; that is, the ability to make financial decisions (Grisso and Appelbaum, 1998a). Similar to assessing other domains of capacity, components of financial decision-making include expression of choice (the ability to express a choice about a financial transaction or situation); understanding (the ability to understand a financial transaction or situation and the choices around that transaction/situation); appreciation (the ability to appreciate the consequences of different choices associated with financial transaction or situation); and reasoning (the ability to reason and think logically about different choices presented by a financial transaction or situation) (Marson, 2016).

Cyber safety and security concerns are also relevant as more older adults are utilizing online banking and social media for a range of financial transactions. The US-based Consumer Financial Protection Bureau (<http://consumerfinance.gov>) considers financial exploitation of older adults as one of America's fastest growing forms of abuse. This is for multiple reasons including the ever-changing cyber security challenges that requires ongoing education, vigilance, and maintenance to protect one's identity and financial privacy. Research suggests that older adults are more likely to engage in risky password practices such as using the same password for multiple platforms, sharing passwords, and using passwords that can be easily guessed (Grimes et al., 2010). Persons with mild cognitive impairment or dementia are even more vulnerable to online financial exploitation and scams, given the fluctuating nature of cognitive decline inherent in the disease process. One study, conducted with community-dwelling Chinese-American older adults, showed that those with lower levels of cognitive functioning, poorer health, low financial literacy, and lower psychological well-being were more susceptible to scams, even when controlling for level of education and socioeconomic status (Alves and Wilson, 2008). The issue of cyber security presents real ethical dilemmas that challenges or potentially sacrifices an older adult's autonomy in the face of a concerned caregiver who wishes to protect the individual from online harm by overseeing all of their transactions and having complete control over passwords and access to bank accounts. Evaluating the risks and benefits of promoting autonomy of an older adult's online financial transactions while allowing a caregiver access to monitor financial transactions are only two options in a full spectrum of approaches to navigate the tension between autonomy and protection (Mentis et al., 2019).

7.08.11.1 Financial Capacity Instruments

Financial capacity, as a construct, is complicated to measure as its definition has been conceptualized in myriad ways (Marson, 2016). In the past decade, Marson and others have expanded financial capacity to include a broader set of skills beyond specific financial tasks such as budgeting and writing checks. Such skill sets and activities required for independent functioning involve judgment and abilities that vary from the basic such as counting coins/currency to higher-level abilities such as managing a checkbook and even more complex activities such as making investment decisions (Marson and Herbert, 2008; Marson et al., 2012). Given the conceptual complexity of financial capacity and the multiple domains involved, assessing financial capacity can be challenging. In recent years, several structured assessments for financial capacity have been developed. The reader is directed to the following literature reviewing specific aspects of financial capacity assessment:

- Clinical Interviewing for financial capacity (Pinsker et al., 2010);
- Measures of financial skills in adults with acquired cognitive impairments (Engel et al., 2016);
- Financial and testamentary capacity evaluation instruments and general procedures including neuropsychological and functional assessments as well as forensic assessment measures (Sousa et al., 2014);
- Financial exploitation measures used in prevalence studies (Jackson, 2018);
- Review and comparative analysis of psychometric properties and uses among measures of financial capacity (Ghesquiere et al., 2017).

Although few instruments are currently available in the assessment of financial capacity, an even lesser amount assessing financial exploitation are available to those working in the field of elder abuse and neglect. Financial exploitation, as defined by the US National Center on Elder Abuse (NCEA; www.ncea.acl.gov), is the improper use of a person's funds, property, or resources by another individual and is the second most common form of elder abuse, following emotional abuse (Acierno et al., 2010). Research has shown a positive relationship between cognitive impairment and financial exploitation (Wood et al., 2014) and that financial decision-making and cognitive functioning often decline in tandem (Han et al., 2016). Additionally, susceptibility to scams have been linked to impaired decision-making ability (Boyle et al., 2012). The interaction between financial decision-making and financial exploitation requires that psychologists extend past their traditional methods of assessment to understand the specifics of a case in relation to the legal question and legal standards.

Until recently, assessment tools have primarily focused on financial decision-making, cognition, and domains of financial capacity, but have not included what Marson (2016) refers to as *financial function in the real world*. In response to that need, with the help of leading experts from multiple disciplines, Lichtenburg set out to develop three person-centered instruments that integrate contextual (financial situational awareness, psychological vulnerability, and susceptibility to undue influence and financial exploitation) and intellectual (expressing a choice, appreciation, reasoning, understanding, and consistency of values) factors (Lichtenburg et al., 2015a,b; Lichtenberg 2020). The instruments include the 10-item Lichtenberg Financial Decision-Making Screening Scale (LFDSS; Lichtenberg et al., 2020); the 34-item full scale Lichtenberg Financial Decision Rating Scale (LFDRS; Lichtenberg et al., 2015a,b); and the 14-item informant Lichtenberg Financial Decision Rating Scale—Friends and Family (LFDRS-FF; Campbell et al., 2019). All three scales can be found at <http://www.orderadultnestegg.com> along with training opportunities for psychologists to utilize the instruments in their assessments and clinical practice.

Lichtenberg's financial decision-making scales are especially useful in applying to cases of financial exploitation by virtue of integrating the aforementioned contextual and intellectual factors in determining the integrity of a person's decision. Another strength of Lichtenberg's scales is the inclusion of assessing for presence of undue influence. Undue influence involves one person taking advantage of a position of power over another person, and is a key psychological component underlying most cases of financial exploitation (Hafemeister, 2003). Conceptual frameworks (Quinn, 2000) have informed the development of several instruments to analyze issues of undue influence (see ABA/APA, 2008).

This section has provided a comprehensive review of two areas of capacity assessment: Medical consent to treatment and financial capacity (including financial decision-making, financial incapacity, and financial exploitation). Additional domains of capacity include sexual consent, ability/capacity to drive, capacity for independent living (see ABA/APA, 2008), and medical aid in dying (Carpenter and Merz, 2020).

7.08.11.2 The Report: Structure and Relevance

As discussed throughout this chapter, capacity assessments involve an intentional integration of multiple components to include the referral question, background history to presenting problem, review of medical records, collateral interviews, and testing data. The report should be structured in a way that outlines the aforementioned components of an evaluation with the addition of the clinician's diagnostic impressions, the patient's expected status trajectory, and recommendations. In cases involving a specific question of capacity related to a legal standard, the clinician should make explicit his or her opinion of whether the individual meets the statutory definition for incapacity for the specific domain assessed. Clinicians may also be asked to opine on the least restrictive intervention or living situation for the patient. Regarding recommendations, specific person-centered interventions should be offered to maximize the individual's cognitive and psychological functioning. Recommendations may include strategies for enhancing communication between the patient and his or her provider, or between family members. Caregiver family therapy or behavioral health treatment may be a helpful recommendation as would a review of medications by the patient's physician,

or a recommendation to return for future testing if capacity is expected to change in response to an intervention or with a change of condition. Sample capacity reports can be found in the [ABA/APA \(2008\) Handbook for Psychologists](#).

7.08.12 Expert Testimony

Clinicians who evaluate capacity should be prepared to testify as experts in guardianship and conservatorship hearings, and particularly, in criminal cases of financial exploitation and mistreatment. [Lichtenberg \(2020\)](#) presents four questions to those who are considering expanding into a professional role as an expert witness (p. 134):

1. Do I believe I have the training and clinical experience needed to be an expert in this particular case?
2. Do I have the assertiveness skills necessary to work with attorneys who often have a certain position they want supported?
3. Can I be an advocate for the older person's best interests in cases where I am able to form an opinion?
4. Can I handle the scrutiny and defend my position without losing my composure?

The questions lend themselves to an important self-reflection exercise that should be explored seriously and with some additional study into the area of court testimony. For a deeper dive, the author recommends texts by [Stanley Brodsky \(1999, 2013\)](#).

7.08.13 A Word on Ethics

Capacity evaluations have the potential to involve multiple ethical dilemmas for the clinician. Ethical considerations include, but are not limited to, issues surrounding informed consent, professional competency, assessment selection and administration, payment/reimbursement, confidentiality, advocacy, multiple relationships, autonomy and self-determination, and beneficence and non-maleficence. Though the literature to date has acknowledged the importance of ethics in evaluating capacities of older adults with mental illness or dementia ([Katona et al., 2009](#)), clinicians faced with ethical quandaries have few models to aid in the exploration of the multiplicity of aspects specific to a situation or context that may influence ethical decision-making, processes, and outcomes. In the area of geropsychology, Karel offers an ethical decision-making framework that encompasses five steps informed by the APA ethics codes, local policies, and the law, as a systematic way of clarifying or intervening in ethically or legally ambiguous situations ([Karel 2008, 2011](#)). The five-step model involves: (1) Clarifying the clinical issues; (2) Clarifying the relevant stakeholders and each of their values, goals, and interests; (3) Clarifying decision-making authority (e.g., identifying who has the right to make the decision in a particular situation); (4) Consideration of all ethically justifiable options (includes a review of pros and cons of each option as it pertains to each stakeholder's values and preferences); and (5) Implementing, evaluating, and reevaluating. With regards to the fifth step, Karel emphasizes the changing nature of a person's capacity over time which may necessitate reevaluation to appreciate appropriate interventions adjusted to the changes.

Another model that has been translated to resolving ethical dilemmas arising in assessing for testamentary capacity is Behnke's "four bin" model ([Roche, 2019](#)). Behnke's model (2014) proposes a "four bin" approach to ethical consultation in clinical practice settings that helps organize issues and questions that allows for a clinician to move forward with a decision. The four bins include: legal, clinical, ethical, and risk management. The *legal* bin involves issues related to federal and state laws (e.g., understanding the general four criteria for consent to medical treatment capacity). The *clinical* bin involves assessment and treatment interests of the client (e.g., evaluating the client in their home for ecological validity versus evaluating the client in a clinical setting). The *ethical* bin involves considerations informed by the APA Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code; [American Psychological Association, 2017a,b](#)) (e.g., informing the client of confidentiality parameters in court-ordered assessment situations). And, finally, the *risk management* bin involves the possible liability issues that may arise secondary to a range of possible interventions (e.g., documenting concerns regarding a client's capacity to consent to an evaluation in situations where the assessment findings may be contested in court). While each bin is different, Behnke emphasizes the overlap between the four categories. Behnke's model provides a useful framework for raising a clinician's awareness to approaching and resolving important ethical tensions in capacity assessments.

7.08.14 Conclusions

Understanding decisional capacities of older adults requires knowledge and skill competencies that may be relatively unfamiliar to psychologists who do not often work with older adults or have familiarity with geriatric care systems. This chapter reviewed some of the distinctive biopsychosocial and cultural aspects affecting or compromising decision-making capacity with an overview of ethical and legal issues central to assessment and intervention. Psychologists working with older adults must be familiar with the concept of decision-making capacity, and the clinical and legal interventions available to promote dignity while increasing advocacy for the safety of vulnerable older adults. Throughout the chapter, many resources including useful Web sites were referenced to provide practical information and guidance for psychologists toward expanding their knowledge and competence for ethical clinical practice with older adults.

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