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Introduction

Jennifer Moye

This casebook focuses on the clinical assessment of capacities in older adults, particularly those with late-onset neurocognitive conditions and late-life expression of lifelong neuropsychiatric conditions (e.g., schizophrenia). It is a case-based follow-up to *Assessment of Older Adults With Diminished Capacity: A Handbook for Psychologists* (American Bar Association and American Psychological Association [ABA/APA] Assessment of Capacity in Older Adults Project Working Group, 2008), which is available to download for free at http://www.apa.org/pi/aging. The psychologist handbook was one of three prepared by a working group from the ABA Commission on Law and Aging and the APA. Responding to concerns from members, the two organizations aimed to provide guidance regarding the assessment of capacity for psychologists, lawyers, and judges (the judges handbook was created in conjunction with the National College of Probate Judges). These handbooks have been extensively distributed, and much of the material within them is still current. However, translating the concepts from the handbooks into practice can be challenging. This casebook for clinicians seeks to respond to the challenge of translation by offering clinically oriented examples of challenging issues.

WHAT ARE "CAPACITIES"?

This book focuses on clinical (as opposed to judicial or legal) assessment of capacities. In this book, this term is used in a fairly specific way—meaning a clinical assessment and opinion as to whether a person has the requisite ability

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to perform a task or make a decision that is being questioned by another (e.g., can this person with dementia consent to this high-risk surgery?). What sets the assessment of capacities apart from neuropsychological assessment is that it focuses on function—mapping to the specific task not global function—and emphasizes supports and all means to enhance function, taking into account the person's values as well as the risk of the situation. Chapter 1 discusses the relationship of clinical and legal definitions and the ever-evolving use of the term *capacities* (plural) to reflect multiple task- and context-specific functions, as opposed to the broader, more all-encompassing terms *competency* (which some take to mean a global quality) or *capacity* (which some take to mean a specific task—i.e., singular). Of note, this casebook deals with *civil* matters, meaning the ability to perform tasks and make decisions germane to one's personal life—health care decisions, financial decisions, residential decisions, and relationship decisions. These are distinct from criminal matters, which arise when an individual is being prosecuted for a crime, such as competency to stand trial, to waive Miranda rights, to be held criminally culpable, and, in some states, to undergo execution.

To be clear, some of the chapters in this book do present capacities in legal contexts, such as when a change to a will made by an older adult is being disputed in a court by heirs or when criminal charges are brought for financial exploitation of an older adult. But the book's focus is on the clinician's assessment rather than the legal or the judicial finding.

HOW CAN WE SUPPORT AUTONOMY?

A common and often excruciating dilemma in clinical care is the tension between promoting autonomy and protecting from harm. This challenge is represented in the ethical principles of many professional organizations for health care providers. In psychology, the dilemma is found in Principle E: Respect for People's Rights and Dignity from APA's *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017). Immediately following the endorsement of self-determination, Principle E states that "special safeguards may be necessary to protect the . . . welfare of persons or communities whose vulnerabilities impair autonomous decision making" (APA, 2017), illustrating this tension between autonomy and protection. Central to resolving the conflict between autonomy and protection is the issue of capacity. For example, consider an older woman who previously had been conservative with spending and now, with the onset of dementia and since her husband died, spends more than half of her monthly income wiring a "tax fee" to a person in advance of receiving a promised lottery winning. Is she making a bad decision but one she has the right and ability to make—a vote for autonomy? Or is she having difficulties in decision-making and subject to financial exploitation—a vote for protection? Would things change if she were provided social, emotional, and practical support? What if she refuses these? What if she spends so much on the "tax fee" that there is not enough money left for food and heat?

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Often these dilemmas cannot be solved without a clear view as to the person's "capacity" to make that decision. In general, the clinical decision-making scale leans to the side of promoting autonomy and safeguarding self-determination, in line with respecting people's rights and dignity (APA, 2017, Principle E) while avoiding harm (APA, 2017, Principle A and Standard 3.04). The bar to intercede against self-determination is set high and should be approached with the utmost care. For this reason, the clinical assessment of decisional or functional abilities relevant to capacity questions is the subject of this book, in the hope of continuing to promote best practices.

IS CAPACITY EVALUATION OF OLDER ADULTS INCREASING?

Many clinicians who work with older adults find that they are increasingly asked to assess a person's decisional or functional abilities. Two trends contribute to this increased demand: the aging of our society and the growing prevalence of dementia. Regarding age, it is worth emphasizing that older age on its own does not necessarily mean a loss of decisional or functional abilities. This point is important because historically some statutory definitions of an *incapacitated person* included the term *advanced age*. The characterization of *advanced age* as a cause for legal incapacity is ageist and discriminatory. However, the expanding older population will cause almost all health service providers to see an increase in their caseload of older adults. They will likely face more questions about the decisional or functional abilities of some of those older adults in navigating circumstances in later life, such as changes in financial arrangements (e.g., wills, donations) in the context of neurocognitive disorders (i.e., dementia) or staying in a home that is increasingly hard to care for because of hoarding and self-neglect.

Regarding dementia, it is worth emphasizing that most older adults do not have dementia and that although there are normal cognitive changes with aging, these would not be expected to influence critical decision-making abilities to a significant extent. However, the risk of dementia increases strongly with age. Dementia has many causes, including Alzheimer's disease, considered the most common cause of dementia, as well as vascular dementia, dementia with Lewy bodies, and other forms. As of 2018, an estimated 5.7 million adults in the United States had Alzheimer's dementia, and by 2050, an estimated 13.8 million adults may have Alzheimer's dementia, barring medical breakthroughs (Alzheimer's Association, 2018). Dementia by definition places an individual at particular risk for decisional or functional difficulties, and thus the increasing prevalence of dementia contributes to the rising demand for assessment.

WHO SHOULD READ THIS BOOK?

As noted, this book is a follow-up to the free ABA/APA Psychologist Handbook. As such, it assumes readers have read that book or are familiar with the foundational concepts therein, particularly a conceptual framework for

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assessing capacities, distinctions between legal and clinical capacities, and steps to be taken in investigating referrals and planning assessment approaches. Thus, this book is aimed at health service providers with a strong foundation in psychological or neuropsychological assessment and some exposure to the assessment of capacities who are looking to enhance their assessments of capacities and to learn from others. For example, this book is relevant for a mental health clinician working in a consultation-liaison role in a medical hospital, within a rehabilitation or skilled nursing facility, or on a home-based care team. This book may also be useful to those in psychology doctoral training programs or advanced training programs in other disciplines (e.g., psychiatry, social work). This book is likely less relevant to forensic psychologists or psychiatrists who address criminal capacities practicing in the court setting with legally involved persons.

This casebook focuses on older adults with dementia and other neuropsychiatric or neurocognitive disorders but does not focus on adults with intellectual or developmental disabilities, although, of course, they may become "older adults." There are complex legal, ethical, cultural, and clinical issues relevant to persons with disabilities that are beyond the scope of the content and expertise contained herein. However, the disability community has been essential in leading a rethinking of legal concepts of capacity, as described in Chapter 1.

COMPARING VA AND NON-VA HEALTH CARE SETTINGS

This book contains 12 chapters, four of which are contributed by authors who work in the U.S. Department of Veterans Affairs (VA) health care system. This may bear some explanation for those who work in non-VA settings or for international readers. At the time that this book was written, within the United States, the structure of health care—both the ownership of hospitals and clinics and reimbursement for services—is highly complex and hotly debated. There are private and publicly owned hospitals, private (e.g., health care insurance companies) and public (e.g., Medicare and Medicaid) insurers, and the VA. The VA comprises a single payor, like Medicare, but also is an integrated health care system across the continuum of care (e.g., acute medical, rehabilitation, long-term care, home-based care), although those who receive VA-funded care also have the choice to receive care out of the VA network providing certain stipulations are met (paid for by the VA or other insurance if they have it). Without going into extensive detail beyond our purposes here, it is worth noting some similarities and differences of the VA setting versus the non-VA setting, which may inform the interpretation of cases.

Readers will find some cases presented herein set within a rehabilitation context. Here, the VA setting is fairly similar to a non-VA setting. Persons may be admitted to a rehabilitation setting after an acute hospital stay to receive rehabilitation necessary to support their return to functional independence, which is more straightforward if the acute admission was physical in nature

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(e.g., hip replacement) and more complex if neurocognitive changes occurred (e.g., a stroke). Unlike an acute hospital stay that may be measured in days, a rehabilitation stay is more likely to be measured in weeks. Outside the VA, the primary insurer of older adults is Medicare, which pays for approximately 3 months of rehabilitative care, although copays apply; thus, there are financial pressures to discharge within the coverage period. Within the VA, care is paid for via a capitated model (meaning the facility receives one lump sum to provide for all care for 1 year based on the individual's complexity); thus, there are financial pressures to discharge because care needs to be distributed across many persons within a fixed budget.

What is different about the VA care described in this book may be more similar to that found in other countries with single-payor or national health care systems. In the VA, as in other non-U.S. settings, individuals may move between care within the same system—for example, from medical rehabilitation to home care or from inpatient psychiatry to adult foster care, with a unified medical record, health care providers working together, a single payor, and no profit incentive. Also, when needed and for those who qualify, the VA provides long-term care akin to skilled nursing home care or long-stay psychiatric hospitals, which outside the VA in the United States are typically paid for via Medicaid. Within the VA, the provision of long-term care is integrated with other care (e.g., if a person in long-term care needs surgery, this would happen within the same health care system). Thus, for some of the VA cases presented herein, there may be care processes, settings, reimbursement, and supports not currently available within privately funded care in the United States.

HOW IS THIS BOOK ORGANIZED?

Following opening chapters on legal and conceptual foundations and on the social context for capacities, each chapter focuses on a specific type of capacity or situation. The chapter authors review the issue and present case examples.[1] A criticism of the ABA/APA Psychology Handbook is that the examples provided were completely uniform in presentation and did not reflect true-to-life variability in how different clinicians may approach these issues. In contrast, here the authors showcase their approach and reflect on their reasoning in more diverse formats. Chapter 1 reviews important foundational concepts and examines changing definitions of capacities. Chapters 2 to 4 describe assessment of capacities in diagnostic contexts: dementia, schizophrenia, and traumatic brain injury. Chapters 5 to 8 focus on assessment of capacities when there has been an allegation of elder abuse, neglect, or exploitation. Chapters 9 and 10 depict specific clinical issues that may be especially fraught with ethical

[1]Although the case examples in this book are based on the authors' real experiences, the identities of the individuals involved in these examples have been properly disguised to protect their confidentiality.

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tensions: sexual consent and medical aid in dying. Chapter 11 addresses challenges that clinicians might encounter working with surrogates who may have decisional difficulties or be unfit, and Chapter 12 focuses on possible concerns when working with families in conflict. Together, this set of 12 chapters highlights key questions, ethical dilemmas, and pragmatic approaches to difficult decisions when assessing capacities.

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