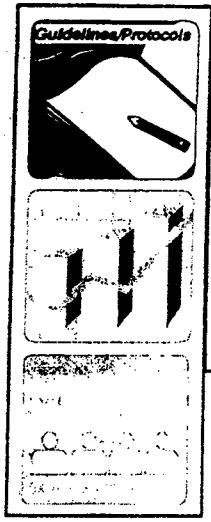

Assessment of Competency and Capacity of the Older Adult: A Practice Guideline for Psychologists

- Algorithm for Clinical Assessment
- Ecological Validity
- Examples of Guideline Applications
- Legal Context for Competency Assessments

March 1997

National Center for Cost Containment
Department of Veterans Affairs
Milwaukee, WI

(See especially pg. 6)

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Prologue

The ability to control aspects of one's own life, such as making independent decisions about a living situation, management of finances, or medical care options, is central to a sense of self. Loss of decision-making abilities, whether temporary or permanent, can be devastating to an individual and his or her family. And because the impact of a legal determination of incompetency in one or more domains of life can be far-reaching, all such decisions must be made with the greatest care. The document that follows is intended to provide guidance to professional psychologists, who are frequently called upon to make recommendations to other providers and often to the courts on the decisional capacity of an older individual. It includes a useful algorithm on the clinical assessment for competency determination of the older adult. The document was developed through a thorough review of the professional literature and the consensus of a group of VA and non-VA experts, supplemented with reviews and comment by a wide variety of other experts in the field. It is the first in an intended series of practice guidelines on geropsychological issues to be developed for the use by VA psychologists.

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Executive Summary

This practice guideline provides a reference for psychologists in the Department of Veterans Affairs for making decisions in conducting clinical assessments for decisional capacity and competency in older adults. The guideline was developed by a panel of subject matter experts both within and outside of the Department of Veterans Affairs. Drafts of the guideline were also reviewed by other subject matter professional groups for clinical utility and standards of care.

The guideline integrates psychological research, clinical experience, and available standards of care in recommending a conceptual framework and procedures to be followed in evaluating and communicating findings about cognition, mental health and specific capacities needed by courts in making competency determinations. In addition to recommending evaluation strategies and test selection, the guideline identifies important assessment considerations in working with older adults. The guideline addresses the critical issue of sensitivity to individual rights for self-determination and autonomy and include a review of the legal context in which psychological evaluations for competency determination are made. The limitations of the guideline are noted along with implications for further research. Also appended are examples of the use of the guideline in specific clinical situations.

This practice guideline supports the commitment of the Department of Veterans Affairs to provide quality health care to veterans. It is this commitment to quality care and responsiveness to the needs of veterans which is the ultimate purpose and goal of this guideline.

Background and User's Guide

The majority of the assessment instruments referred to in this Guideline are described in the Geropsychology Assessment Resource Guide (1996) published by the NCCC. This Resource Guide reviews over 160 assessment instruments for use with an elderly population. The Guide briefly describes each instrument, provides information on reliability, validity, and normative data for elderly patients, and identifies the vendor or source for each instrument. Copies of both the Geropsychology Assessment Resource Guide and this practice guideline are available in all VA Medical Center Libraries and can be additionally obtained at a nominal fee from:

National Technical Information Service (NTIS)
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161

703.487.4650

To order the Geropsychology Assessment Resource Guide, 1996 Revision from NTIS, request publication PB-96-144365.

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I. Introduction

A Geropsychology Technical Advisory Group (hereafter referred to as the panel) was formed in February 1996 to examine ways to enhance the care of older adults provided by psychologists in the Department of Veterans Affairs (VA). The panel was composed of both VA and non-VA psychologists with subject matter expertise in geropsychology and neuropsychology. The panel made an early decision to develop a practice guideline to promote assessment and treatment activities with the objective of enhancing the quality of care of older adults. The decision to develop this practice guideline additionally supports the VA's health care goals in developing guidelines to assist practitioners by recommending health care decisions and behaviors that positively influence clinical and financial outcomes of their activities.

This document describes both the process used in developing the guideline and a recommended planning and decision framework for the psychologist to follow in conducting an assessment of factors affecting competency in the older adult. Section II details the process used in developing the guideline. Section III describes the scope of the guideline, including a definition of the clinical task and the target patient and practitioner groups for whom this guideline was written, and Section IV identifies principles used in preparing the guideline. Section V contains the practice recommendations themselves.

The limitations of the guideline and the need for additional research which emerged from the literature review by the panel are summarized in Section VI. In addition to the Summary which follows that section, this document also contains appendices designed to educate and assist the psychologist in using this guideline. The appendices include a description of legal issues involved in competency assessment, a review of ecological validity issues, and examples of the use of the guideline in a variety of clinical situations. The references in support of the recommendations contained in the guideline are included for more detailed review by the reader.

II. The Guideline Development Process

A. Panel Selection and Qualifications

The panel was composed of psychologists with training and experience in providing clinical services to older adults. Four of its nine members have special training in neuropsychological assessment. Three of its members participated in the development of a published guide of geropsychology assessment instruments with reliability, validity, and age-norm data for an older population. Another member had recently published a review of theoretical frameworks for competency in cognitively impaired older adults. Although the guideline was to be developed for use within VA, a decision was made to include two non-VA subject matter experts to broaden the professional experience base of the panel. Assistance in review of the guideline for forensic issues was obtained from a subject matter expert who had recently provided a chapter on clinical assessment for legal competence of older adults in a book published by the American Psychological Association. Technical guidance in the development of this practice guideline was provided by staff of the VA's National Center for Cost Containment.

B. Selection of Guideline Topic

The decision to develop a practice guideline for clinical assessment to support competency determination in older adults was based on a needs assessment process. The panel first developed a list of the most frequent assessment and treatment activities of psychologists in geriatric and extended care settings. This list of activities was then transmitted by electronic mail to 950 psychologists and other mental health practitioners in the VA with a request to identify the activity which would most benefit from a practice guideline. The same request was directed to members of Psychologists in Long Term Care (PLTC), a group of VA and non-VA psychologists organized to study and share concerns of psychologists working in long-term care settings. Both VA psychologists and the PLTC identified assessments used in competency determination as the clinical activity most in need of a professional guideline.

C. Procedural Decisions

In planning for the development of the practice guideline, the panel reviewed both the *Template for Developing Guidelines* published by the American Psychological Association (APA) in 1995 and the *Interim Manual for Clinical Practice Guideline Development* published by the Agency for Health Care Policy and Research (Woolf, 1991). The decision was made to adopt key recommendations supported by both documents, including review of relevant literature, promotion of empirically based research findings, and review by external groups. Also helpful in the development process and review of the work of the panel was the use of an instrument for assessing the development and content of clinical practice guidelines published by the Institute of Medicine (Field & Lohr, 1992).

Following the selection of the guideline topic, panel members met to define the scope of the guideline (see Section III) and to determine principles to be used to guide its recommendations (see Section IV). Panel members were given assignments for preparing different portions of the guideline document to include reviews of relevant literature for each section.

D. Review by External Groups

Feedback on the scope and guiding principles identified by the panel was requested of the group of psychologists and mental health practitioners in the VA and the PLTC group members who helped identify the clinical activity most in need of a practice guideline. Drafts of the guideline were reviewed by 15 Psychology Services in the VA. Also identified were a number of professional groups that the panel believed could be useful in providing a subject matter external review of the clinical utility and appropriateness of the guideline. Feedback was requested and received from reviewers provided by the following APA Divisions: Clinical Psychology (12), Psychologists in Public Service (18), Adult Development and Aging (20), and Clinical Neuropsychology (40). The panel also requested the National Alliance of the Mentally Ill to review the guideline for patient and family concerns.

Feedback received from all reviewers on drafts of the guideline was quite positive. Of specific comment from reviewers was the evaluation of the guideline as appropriate, justified by available research, and generally within the abilities of clinically trained psychologists to administer and interpret findings without specialized training in neuropsychology and geropsychology. Reviewers of a first draft suggested a clearer

distinction between the clinical assessment and legal processes for determining competency. Also recommended was use of the term capacity as a substitute for competency to reflect this emerging language in state laws. Although use of the term competency was not completely eliminated in the text, later reviewers found increased use of references to capacity assessment to better identify the assessment process when used in support of legal competency determination. Suggestions from reviewers to reorganize some of the document material for better clarity were also adopted.

E. Follow-up Review

It is the plan of the panel to request feedback from VA psychologists in the use of this guideline, both in terms of evaluating changes in practice as a result of the publication of the guideline as well as for recommendations for changes in the guideline. Given the increased focus on assessment of the older patient and anticipated research in further developing this area of assessment, the recommendations for test selection and procedures will need to be updated to maintain the usefulness of this guideline. It is anticipated that this feedback process will be used to revise or update the guideline within a three year period.

III. Scope of the Practice Guideline

A. Definition of Clinical Task

Assessment for competency determination in this guideline is defined as a clinical assessment process designed to assist courts and other practitioners to determine whether a patient has the capacity and judgment to appropriately participate in specific decisions. These include decisions regarding medical care, such as consent to treatment and advance directives, and decisions affecting the welfare of the patient regarding living arrangements, legal contracts, financial affairs, and other matters (Lichtenberg & Strzepek, 1990). The guideline is intended to assist clinicians in assessing the presence or absence of deficits in cognitive abilities and other areas of functioning which would affect competency at the time of the assessment. The etiology of or the transitory nature of deficits affecting judgment and decision making may emerge in the evaluation, and further assessment procedures may be needed requiring additional skills or knowledge if information about the etiology or permanence of these deficits is required.

The development of this practice guideline for clinical assessment in support of competency determination also requires an appreciation of the fact that competency denotes a legal status of the patient and, as such, can only be determined by a relevant court of jurisdiction. Since the legal definition of competency varies among states, it is beyond the scope of this practice guideline to define competency in a legal sense. Psychologists receiving referrals for competency assessment should in fact redefine such referrals as psychological evaluation requests to supply cognition, mental health, and specific capacities data for courts to use in making the legal determination of competency. While clinical evaluations of competency by psychologists do not in themselves alter a patient's legal status, the clinical evaluation data needed to assist in this determination must be based on the psychologist's understanding of relevant state laws. Equally important in this match between clinical evaluation data and legal definitions is the fact that clinical evaluations may not proceed to adjudication and because of this are at risk for becoming de facto competency determinations. Should the clinical evaluation be involved in adjudication, the assessment report and its findings should stand up to scrutiny under legal standards (Melton, Petrila, Poythress, & Slobogin,

1987). This guideline provides professional guidance for psychologists involved in assessments that are most likely to provide relevant data for a legal determination of competency. Psychologists involved in these assessments are also urged to review Appendix A for an important discussion of issues involved in legal determinations of competency.

It can be additionally noted that the VA has a special responsibility to make determinations of the desirability of appointing a representative payee for VA funds. This determination is independent and separate from a legal decision regarding competency to handle other, non-VA funds. Although this determination is not made in a court, a psychologist responding to a request to assess abilities to handle VA funds should consider the concepts for the clinical evaluation of specific capacities contained in this practice guideline in making this determination.

The determination of legal competency requires a balancing of social values: the right of an individual to make autonomous decisions versus the social obligation to take away that right, at least on a temporary basis, as a benevolent action to protect the individual or society. When health care professionals participate in assessments for legal determination of competency, typically the judgment concerning how to balance these social values is the task of the court.

It is clear that competency is a complex construct with many clinical meanings and different definitions within the legal system (Hankin, 1995; Robertson, 1985; White, 1994). Psychologists involved in evaluations relevant to determining specific capacities involved in competency will be aided by developing a conceptual framework specific to the competency evaluations they perform (Kaplan & Price, 1989). This guideline is intended to assist psychologists in developing that framework.

B. Practitioner Group for Which the Guideline was Developed

The following practice guideline is designed to direct the professional activity of doctoral level licensed clinical or counseling psychologists in the VA, and those they supervise, who have been requested to perform an assessment to evaluate cognitive capacity, judgment, and mental health status affecting competency as part of a clinical treatment or administrative process. No special credentials in geropsychology or neuropsychology are assumed, but responsible practice will require an adequate knowledge of clinical disorders and psychological assessment methods relevant for older adult populations. Although the guideline was developed for VA psychologists, the guideline may assist in guiding the practice of psychologists in other long-term care or clinical settings.

It can be noted that the practice guideline described in this document represents the best thinking about how to conduct clinical evaluations for use in competency determination currently supported by psychological research, clinical experience, and available standards of practice. As such, it is recommended that VA psychologists be knowledgeable about and use it in guiding professional practice decisions. There will be unique situations, however, in which deviations from this guideline may be required. Good practice will suggest that such deviations are noted and justified as serving the best interests of the patient. Section VI additionally notes limitations of this practice guideline and implications for further assessment development and research.

C. Target Patient Population and Setting

The following practice guideline is not limited to setting and may be utilized by psychologists for helping courts determine the competency of older adults who are being evaluated in inpatient, outpatient, primary care, and extended care settings. Since the literature review in support of the guideline recommendations was primarily focused on issues of assessment of decision making capacity in older patients, this guideline may have limitations in applicability for assessment of competency factors in younger patients with decisional capacity deficits produced by traumatic injury or other conditions.

IV. Guiding Principles Used in the Development of the Practice Guideline

A. Ethical Considerations

Psychologists performing clinical evaluations for legal determination of competency must conduct such assessments in a manner consistent with the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992). Of particular general relevance are requirements to provide services only within the psychologist's boundaries of competence and the psychologist's respect for the rights of others to hold values, attitudes, and opinions that differ from their own. Sensitivity to cultural, individual, and role differences among psychological service providers and their patients are also important ethical considerations and are described further in the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (American Psychological Association, 1990). Additional ethical and professional issues are addressed in the sections below.

B. Patient Considerations

Informed consent for the evaluation must be addressed with the patient. The reasons for and possible uses of the evaluation must be fully explained to the patient along with a discussion of confidentiality and limits of confidentiality. Since patients referred for competency evaluations may be under acute stress and/or exhibit signs of behavioral or psychological impairment, it is imperative that the explanation be presented in as simple and straightforward a manner as possible. The patient's understanding of the context of the evaluation and awareness of deficits needs to considered. In some cases, lack of awareness of mild difficulties can have more severe life consequences than keen awareness of more significant deficits.

Given differences in educational achievement among older adults and possible cognitive decline, it is incumbent on the psychologist to tailor the interview process and testing instructions to the patient's level of understanding. Older adults may have less experience and feel less comfortable with a testing situation. Every effort should be made to conduct as much of the interview and evaluation as possible in the patient's primary language and to obtain an interpreter when necessary to enhance understanding.

As well, it is important to understand the patient's (and family's) views about the causes of cognitive deficits and behavioral problems that have led to the assessment. In an excellent brief report by Buchwald, et al. (1994), attention is called to the notion that all patients from an ethnic or

linguistically minority background have culturally based models for explaining illness (such as "hot" and "cold" forces, blood loss or conditions of the blood, or social transgression). These explanatory models are often at variance with Western biomedical thinking and thus can make it difficult to conduct needed assessments, since the rationale for such inquiries may be at odds with the patient's and family's belief system. Buchwald and associates provide a number of specific examples of how culture influences illness behavior, along with specific concrete suggestions for how practitioners might respond and accomplish their agendas (while at the same time, showing respect for the beliefs of the elder minority veteran).

The psychologist must attend to sensory and physical problems frequently encountered in older adults in planning the testing environment and interpreting the results. A determination must be made of whether the patient can adequately read, see, and hear any stimulus material in the assessment. The psychologist should determine if the patient has brought along hearing aids, glasses, or other visual aids and is using them during the assessment sessions. A well-lit, quiet room with the psychologist using large print materials and frequent rest breaks is critical and adds reliability and validity to the results. Physical limitations due to arthritis or Parkinson's disease can impede test performance but not necessarily impede decision making capacity.

C. Assessment Activity Considerations

The evaluation of factors affecting competency must be guided by both clinically useful as well as cost-effective procedures. Assessment for competency should, at a minimum, augment a clinical interview with performance-based, empirically validated instruments with age and education-based norms for older adults. The assessment should include an evaluation of cognition as well as other clinical conditions which would affect judgment and decision making. Since competency involves a match between person and environment, the assessment should additionally strive to use ecologically valid measures which have direct relevance to the specific abilities in question. The assessment process for competency determination further requires that the clinician collect information on the decision demands of the environment, such as the types of decisions to be made, the context of those decisions, and the potential consequences of decisions to be made.

To assist psychologists in selecting instruments to assess capacity and competence in the older adult, this practice guideline will identify assessment instruments which meet the requirements listed above. As such, the identification of specific instruments is not intended to recommend the use of these instruments alone. The assessment expertise of the psychologist should guide the use of instruments which are not mentioned or may later be developed which meet the recommendation for using empirically validated instruments with age, education, and cultural norms for older adults.

Assessment data should be obtained from a variety of sources including, when possible, family and staff in addition to the patient. Serial evaluation sessions are preferable to single session evaluations in that some patients manifest variable daily functioning (fluctuating capacity) which can only be discovered across several time periods.

V. Practice Guideline for Clinical Assessment of Factors in Competency Determination

The purpose of this practice guideline is to assist VA psychologists with decisions about appropriate assessment procedures for the evaluation of critical factors related to legal competence and other aspects of decisional capacity. The guideline details five important steps in the clinical assessment of specific capacities in older adults: referral clarification; planning to insure an ethical, appropriate, and valid assessment; the assessment activity itself; the synthesis and communication of assessment data; and planning for applicable and appropriate follow-up evaluation. These steps are briefly described in Table 1 and are summarized in a clinical algorithm at the end of Section VII. Appendix C also provides examples of the use of the guideline in a variety of clinical situations. The essential considerations and activities in each of these key steps are described below.

A. Referral Clarification

Psychologists have the responsibility to clarify the referral question and ensure that their services are used appropriately. The receipt of a request to evaluate competency functioning does not necessarily mean that the recipient should conduct an evaluation or that an evaluation should even be made. First, the psychologist must always act within his/her own level of professional competence and area of specific privilege. The psychologist who lacks any training or experience in working with older adults and who lacks knowledge of relevant state law regarding competency should not conduct the evaluation. Although a psychologist may be experienced in some areas of evaluation of factors affecting legal competence, a specific assessment area may be in question, such as the ability to manage a complicated family trust, about which the psychologist has little expertise. Even if the psychologist has the requisite skill to address the referral, there may be other considerations, such as the existence of a dual relationship, which may preclude participation in the assessment. If a psychologist has been treating a patient for several years, the competency evaluation might best be provided by another psychologist.

Second, the psychologist has the responsibility to determine if other health care professionals are making a reasonable request for psychological services. Prior to contacting the patient, the psychologist needs to determine if the referral source understands what is being asked and what the possible outcomes are. There are times when an assessment is not needed. For example, in a case where the unresponsive patient has a durable power of attorney for health care assigned to another person, the issue may be activation of the power of attorney and not competence or guardianship. The psychologist's role here may be staff consultation about local policy and not assessment. Sometimes well-intentioned but rushed hospital discharge planners may ask for an evaluation in order to expedite placement. Those involved in these assessments know that court hearings for competency determination and protective placement often take weeks and that nursing homes may not admit the person in question until the legal process is complete or least in the final stages. In this case, the psychologist needs to work closely with the health care team and family in order to complete a timely assessment and/or to ensure that alternatives to guardianship are considered.

After the psychologist has conferred with those making the request and determined that the request is appropriate and consistent with local policy, the psychologist must clarify the referral question(s). Competence is not an easily defined, discrete concept. There is always a specific reason why the psychologist is being consulted, and it is often not clearly stated. The psychologist must also understand the circumstances

Table 1

Key Steps in Assessment for Competency Assessment in the Older Adult

Step	Activity
A. Referral Clarification	Review of consultation request and clarification of referral, including decisional capacity in question and qualifications of psychologist.
B. General Assessment Planning	Assessment decisions to ensure an ethical, appropriate, and valid assessment, including obtaining informed consent.
C. Assessment	1. Clinical interview with patient, family, and health care informants to assess the patient's values, goals and preferences. 2. Performance-based assessment of cognitive functioning. 3. Clinical assessment of mental health factors. 4. Performance-based assessment of specific decisional capacities.
D. Synthesis of Data and Communication of Findings	1. Determination of key findings and developing conclusions. 2. Preparation of written report which synthesizes patient history, interview, and performance-based assessment data bearing on the specific decisional capacity in question, including conclusions and recommendations. 3. Discussion of assessment data and conclusions with patient and relevant family members.
E. Follow-up Evaluation	Evaluation of impact of recommended interventions and assessment of changes in functioning.

under which the person is allegedly unable to function under legal standards for competency. What specific areas of skill and function are at issue? In what circumstances and places? What other resources does the patient have to assist him/her in this matter? Why is this question being asked now? Was there a critical incident? Are there any major changes (e.g., surgery, relocation) which have had or might have a significant impact on this individual's ability to make decisions? Consultation with other members of the health care team at the start of the evaluation will significantly improve the quality of the assessment process and the outcome.

B. General Assessment Planning

Before proceeding with the evaluation, the psychologist must approach the patient and obtain informed consent to conduct the evaluation. Careful consideration and accommodation must be given to potential cultural, language, and cohort barriers. Some older patients may be frightened or confused by the request, and it might be appropriate to have a significant other or familiar caregiver present during the request for consent. The basic principles of informed consent apply, i.e., demonstration of an understanding of what is proposed, weighing of alternatives, risks, and benefits, and an appreciation of having a choice and the consequences of choice. With clarification of the referral question, the psychologist will know what is expected from this evaluation and will be able to follow appropriate local and state requirements for documenting informed consent. The psychologist should also know if the patient already has an attorney or a court appointed representative who should be contacted before proceeding. The limits of confidentiality and all the possible outcomes must be clearly stated. The state, health care providers and institutions, and family members may all be involved in the outcome which may radically change the manner in which the patient has lived. Even after the initial consent is obtained, it is advisable to involve the patient in decisions about the assessment process as it unfolds.

The situations in which psychologists are asked to consult are often not the easy ones. There must be a plan in place to deal with refusal to consent and, perhaps more typically, the inability to consent. When the patient is unresponsive and unable to give consent, should the psychologist proceed? At times like this, the psychologist must consult with other members of the health care team and expert peers. There may be situations in which the psychologist will proceed and document what was observed at bedside and found in the medical record. If that patient's condition is life-threatening or it is most likely that consciousness will not return, proceeding without clear consent from the person may be appropriate. Consultation with relevant family, the court, and the patient's legal counsel about such situations is advised (see Appendix A). However, if the patient has just had an acute medical illness or is delirious and no immediate medical decision is required, it is much more appropriate to wait until the condition has cleared or stabilized and then approach again for consent. Determining if, when, and how to proceed relies upon sound clinical judgment, supervised experience, and consultation with expert peers.

Once past these hurdles, the psychologist can plan the assessment of the specific question of decisional capacity. Appropriate social, medical, psychiatric, and legal data relevant to the referral question must be gathered. The patient's perception of the problem and plans to cope with the situation must be determined in an interview. The value system of the patient must be understood and appreciated. Other members of the health care team can provide valuable insights about the patient's functioning. For example, these insights can guide assessment planning by indicating when

and how to maximize performance. The psychologist also needs to identify what information from other professionals will be needed in order to write a well integrated report. If the patient consents, it is often useful to interview key family members to develop an awareness of the premorbid level of functioning and of the patient's life-long pattern of choices and values.

It is important to provide adequate privacy and to maximize the performance of the patient in the interview and testing. The results can be significantly affected by the time of day for frail, hospitalized elderly persons. Unless the situation is urgent or otherwise impossible, multiple assessment sessions are strongly advised. Sensory deficits must be accommodated. Care must be taken not to fatigue the patient. Cultural and cohort differences must be respected and integrated in the assessment. Prior training and experience in geropsychology is helpful in developing rapport in these situations.

C. Assessment Domains

1. The Clinical Interview

An evaluation for the purposes of assisting in legal competency determination should begin with a clinical interview. The clinical interview should include an informal assessment of mental status and a thorough assessment of psychosocial factors bearing on the competency issue in question. The informal assessment of mental status should consider the patient's appearance, level of alertness and orientation, thought content and process, presence of delusions and hallucinations, range of affect, mood, use of speech and language, and reports of harm to self or others. Many of these factors may then be assessed more formally and in greater detail as explained in the mental health section of this guideline.

In addition, the clinical interview is an opportunity to understand the patient's perspective on the specific capacity issues in question. This can include questions regarding the patient's beliefs and values about the issues in question, how these decisions have been made in the past, what experiences influence their current decisions, what are the patient's social network and degree of social support, what role have family and friends played in these decisions in the past, and how important are autonomy, altruism, privacy, and like considerations in the patient's decision making. When medical decision making is considered, a clinical interview may include questions about fear of death or value of life, concern about being a burden on others, concern about being dependent on others, experiences which continue to make life meaningful despite disability, and other related values (Doukas & McCullough, 1991; Karel & Gatz, 1996; McCullough, Wilson, Teasdale, Kolpakchi, & Skelly, 1993). Such interviews with informants can determine the consistency of current values with past values, or differences between the patient's values and those seeking guardianship. Questions about these topics may reveal that the patient's neuropsychiatric condition (e.g., dementia, schizophrenia) affects their belief system or ability to articulate their belief system, or, such questioning may reveal consistent and clear values despite limited decision making ability.

2. Cognitive Assessment Guideline

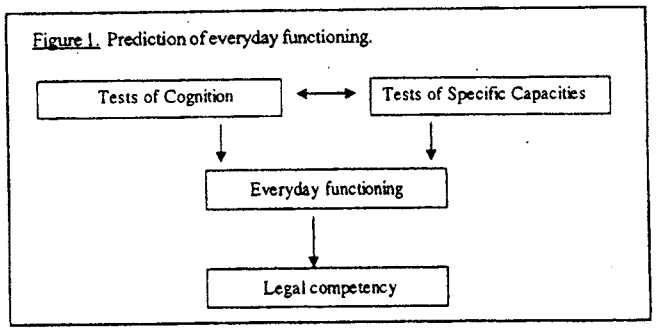
An assessment of cognition should be completed when a psychologist is asked to evaluate an older adult in regards to legal competencies for several reasons. First, many competency related questions focus on cognition. For example, questions about an older individual's capacities to manage their health and financial decisions often concern whether the process of decision making is rational and reflects adequate understanding and reasoning. Competency questions which arise in late life often stem from conditions that are primarily cognitive in nature, such as dementia. An evaluation of cognition can be used to describe qualitative aspects (e.g., strengths and weaknesses) in cognitive functioning.

Second, an assessment of cognition may potentially disclose the etiology and anticipated stability or reversibility of any observed impairment. Such information is crucial in indicating the permanence of conditions underlying competency determinations. An evaluation of cognition can be used to suggest or determine the reason for cognitive dysfunction.

Third, other competency related questions may focus more on function, such as capability of independent living, for which cognition plays a central role. Cognitive abilities may be the key to successful and consistent everyday functioning. An evaluation of cognition can be used to predict aspects of everyday functioning relevant to the specific capacities in question.

Evaluation of both cognition and specific capacities is necessary in a comprehensive assessment as they provide different and often complementary information in predicting everyday functioning, as diagramed in Figure 1. For example, in an evaluation for determining competency for asset management, a cognitive test may be informative about abilities for appropriate judgment and reasoning, while a specific capacity test may be informative about abilities to handle money and be knowledgeable about basic financial concepts. Both are likely important in evaluations where legal standards for competency for asset management are applied.

Figure 1. Prediction of everyday functioning.



The prediction of everyday functioning from tests of cognition, namely ecological validity, has received less attention in the scientific literature than the prediction of diagnoses, but it is also critically

important in comprehensive evaluations for determining legal competencies. Because of this, a review of research regarding the relationship of tests of cognition to everyday functioning in older adults is provided in Appendix B. The following three sections outline issues which bear upon test selection and interpretation for evaluations concerning legal competencies. A general background in psychological test selection, administration, and interpretation is presumed.

Test Selection: Planning for cognitive assessment requires attention to the selection of assessment methods and instruments with sufficient normative data and adequate reliability estimates for the elderly population. Furthermore, psychologists should select tests that have been validated to support the "appropriateness, meaningfulness, and usefulness of the inferences made from the test scores" (Standards for Educational and Psychological Testing, 1985). As noted above, in addition to directly providing information about cognitive functioning, an evaluation of cognition in the context of competency determination is generally concerned with two types of inferences: the likelihood of specific diagnoses (e.g., dementia, delirium) and the prediction of everyday functioning (e.g., driving, medication compliance). Interpretation of cognitive assessment data refers back to information on the validity of specific tests in predicting diagnoses and everyday functioning in older adults.

Complicating Factors: Cognitive assessment of older adults requires attention to factors other than disease related dysfunction that may complicate the test performance of older individuals. These factors include sensory deficits, speed of processing, floor effects, and individual differences related to education, ethnicity, and cohort. A brief review of these issues follows. For more information, readers are referred to Benton and Sivan, (1984), Ganguli et al. (1991), Loewenstein, Arguelles, Arguelles, and Linn-Fuentes (1994), and Schaie (1994).

One of the most common confounds in psychological assessment of older adults is the potential for sensory changes to appear as cognitive deficits. For this reason, psychologists assessing the cognitive functioning of older adults should insure that the individual can see and hear test stimuli. Test procedures developed for younger adults may not be appropriate for an older adult with sensory impairment.

Older adults, on average, demonstrate slower speed of processing and reaction time than younger adults (Bashore, Osman, & Heffley, 1989) which can confound interpretation of performance on cognitive tests that are timed, particularly those requiring the division of attention to multiple sources of information (Mazaux et al., 1995). Because of this, psychologists assessing older adults should choose tasks that are not timed, or if timed, insure that test scores are compared to age appropriate normative groups to minimize the potential confound of cognitive versus speed of processing impairments.

Individuals may present with a wide range of performance on standardized tests, from defective to superior. Tests developed for normal populations do not discriminate well for patients with significant cognitive impairments (Chapman & Chapman, 1973). These tests may be useful in indicating that an individual is impaired relative the normal population, but generally suffer from floor effects when used to answer questions about patients with dementia. Tests developed for the normal population may be insensitive to change, and may mask degree of impairment between two ability domains relevant to questions of differential diagnosis, prognosis, and treatment outcome (Christensen, 1989). For this reason, psychologists assessing cognitive functioning should insure that the test is of appropriate difficulty level for the individual patient. Ideally, tests used for a dementia

evaluation should span some range of functioning between healthy and impaired, and utilize a mechanism for manipulating difficulty level across this range (Christensen, Multhaup, Nordstrom, & Voss, 1991).

A number of factors contribute to increasing heterogeneity with aging, including age-graded life experiences, such as educational attainment; history graded influences, such as cultural phenomena experienced by certain cohorts; and non-normative influences, such as multiple medical-comorbidities (Baltes, 1987; Schaie, 1994). An older individual's cultural, language, and educational background potentially affects performance on standardized tests of cognitive functioning. Many standardized tests lack normative data for aging populations, and when available lack normative data that are informative about the role of cohort and individual diversity on test performance for older adults (Lichtenberg, Manning, Vangel, & Ross, 1995; Loewenstein et al., 1994).

A number of publications address the issue of choice of measures to assess cognition in ethnic or linguistic minority elders. Valle (1989) described the difficulties of applying "culture free" or "culture fair" tests to assess cognitive capacity in dementia patients and argued for careful understanding of the influence of acculturation on cognitive and behavioral function. He pointed out that most "ethnic elderly" are likely to remain close to the traditional end of the acculturation continuum, in terms of formal education (likely to be very low or even non-existent), language preference (likely to be original language even if some English language skill is present), and beliefs about their deficits (likely to be influenced by religious and folk concepts rather than by an understanding of normal vs. abnormal aging). While he focused on Hispanic older adults, (as did Taussig & Ponton, 1996), many similar points were made by Baker (1996) in her writings about cognitive assessment of the African-American elder. Although language is less of an issue, literacy may be, along with certain health conditions (such as hypertension) that may increase risk for certain kinds of cognitive impairment and not others. Analogous arguments were raised by Teng (1996) with regard to Asian elders: she discusses the many problems that can arise with translation of English words into the Chinese language, for example, where the months of the year are numbered Month 1, Month 2, and so on (versus having names, as they do in English), and argues for more use of language-free tests to assess cognitive function, whenever possible.

In summary, selection of tests and interpretation of test scores in standardized assessments of cognition in older adults is fraught with potential confounds. Sensory deficits, reduced speed of processing, inappropriate difficulty level of tests, and individual differences in cohort, culture, language, and education, confuse the relationship among deficits and may mask the true etiology of observed deficits. Psychologists should be knowledgeable of and make appropriate modifications to address these common pitfalls in the cognitive assessment of older adults.

Cognitive Domains Relevant to Specific Capacities in Question: Cognitive assessments for specific capacities should adequately assess all cognitive abilities potentially relevant to the capacities in question, and in most cases will represent a compromise between brief cognitive screening (e.g., Mini Mental State Examination) and a full neuropsychological evaluation (e.g., Halstead Reitan Battery). In selecting which domains to assess, psychologists should utilize two criteria: use tests for abilities relevant to the specific capacities in question and use tests for abilities affected by the presenting condition. In addition, a key part of an evaluation of an older adult's cognitive functioning when competency issues are raised is the assessment of insight or awareness of deficits which may predict the individual's potential to manage and compensate for any cognitive impairments.

Finally, tests used to assess cognitive domains should be culturally fair.

Tests of cognitive abilities relevant to specific capacities may include learning and memory when individuals must learn and remember new information to make informed decisions; reasoning and executive function when individuals must use judgment or reason through options; language when individuals must communicate preferences; and visual-spatial reasoning when individuals must manage driving, home, or self-care. Clinical judgment and familiarity with the literature concerning the relationship between cognition and everyday functioning (Appendix B) will assist appropriate test selection.

Tests of cognitive abilities relevant to the presenting condition will vary by the deficits associated with various presenting conditions. In cases of dementia or delirium, abilities to assess may include attention and concentration, memory, reasoning and executive functioning. A general background in neuropsychiatric conditions affecting older adults and related psychological assessment methods will assist in appropriate test selection.

In regards to choosing culturally fair tests, specific test batteries containing validated and reliable tests of cognitive function can now be found for certain groups of ethnic elders. Valle (1993) described a neuropsychological test battery that is particularly sensitive for use with non literate Hispanic elders, based on work done with colleagues at the UCSD Alzheimer's Disease Research Center. Mungas (1996) followed up on this work by developing a series of measures with no linguistic bias that can be used with Spanish speaking elders of minimal formal education, as well as with English speaking elders in the same situation, using pattern recognition, spatial localization, verbal and nonverbal conceptual abilities, and others. Similarly, a very new and brief series of measures to assess cognitive function in Asian elders was developed by Teng et al. (1994) using measures of attention, concentration, and short and long term memory, abstraction, and others.

A brief definition of cognitive abilities and tests for geriatric populations follows. For more information, readers are referred to the Geropsychology Assessment Resource Guide, 1996 Revision (1996), LaRue (1992), Lezak (1995), Lichtenberg et al. (1994), McKitrick, Friedman, Thompson, Gray, and Yesavage (1997) and Thompson, Gong, Haskins, and Gallagher (1987). These core domains are described as distinct abilities for conceptual ease, although they may extensively co-vary, especially when neuropathology affects diffuse areas of the brain.

Attention and concentration abilities concern the individual's capacity to focus upon and provide sustained attention to stimuli. Some tests of attention also evaluate an individual's capacity for divided attention, or ability to attend to two different tasks at the same time, and selective attention, or ability to attend to a particular signal and ignore others. An assessment of attention and concentration provides important information about these domains, and is also important in establishing the ability to adequately focus on other tasks, such as tasks relevant to the competency question and necessary for subsequent cognitive testing. Tests used to assess attention in geriatric populations include Digit Span (WAIS-R), Visual Attention (DRS), Trails A of the Trail Making Test, Mental Control (WMS-R), Paced Auditory Serial Addition Task (PASAT), and letter or figure cancellation tasks.

Primary memory is also called immediate memory or working memory. It consists of memory for a limited amount of information which is retained for a limited duration, as long as attention is maintained on that information, and often involves prefrontal areas of the brain. Secondary memory, also called recent memory, is considered the relatively permanent acquisition of information, of unlimited quantity regardless of the focus of current attention. In secondary memory, material may be retained indefinitely following a delay, and often involves prefrontal and temporal areas of the brain. Assessment of primary and secondary memory in both verbal and visual modalities may be informative in diagnostic determination (LaRue, 1992). Remote memory concerns the ability to retrieve very old and potentially well-learned information.

The assessment of memory is especially important when the specific capacity in question relies upon adequate memory, such as memory for treatment related information sufficient to support the weighing of risks and benefits in a treatment decision. Tests often used to assess memory in geriatric populations include memory batteries (WMS-R, MAS) and selected subtests such as Logical Memory subtest (WMS-R), Visual Reproduction subtest (WMS-R), Paired Associate subtest (WMS-R), Recall and Recognition (DRS), Auditory Verbal Learning Test (AVLT), Object Memory Evaluation, and California Verbal Learning Test (CVLT).

The capacity to reason and problem solve involves a diverse set of abilities, including comprehension of information, organizing information and initiating activity, considering options and discerning the relationships between concepts. Reasoning and executive abilities often rely upon frontal and parietal areas of the brain. Difficulties with disinhibition, intrusion, impulsivity, and poor insight often typify dorsolateral frontal deficits, while apathy and poor initiation often typify orbitofrontal deficits. Understanding a patient's capacity for reasoning, organizing, planning, and initiating activity, and for understanding abstract concepts is important for many competency issues. Tests often used to assess verbal reasoning and executive function in geriatric patients, include Similarities (WAIS-R), Comprehension (WAIS-R), Trails B, and Wisconsin Card Sorting Test.

Language is comprised of numerous components, including phonological and syntactical knowledge, lexical knowledge, comprehension, naming, and fluency, and often reflects functioning in the dominant hemisphere. An assessment of language includes evaluation of abilities for speaking, writing, and reading. An assessment of these abilities to communicate may be especially important when competencies in question concern clear communication, such as the expression of treatment preferences. Tests used to assess language in geriatric populations include the Boston Naming test, the Vocabulary subtest (WAIS-R), the Controlled Oral Word Association test (COWAT), and portions of the Boston Diagnostic Aphasia Examination (BDAE) or the Multilingual Aphasia Examination (MAE).

Visuospatial abilities involve the ability to organize perceptually and act accurately on spatial demands of the environment. Visuospatial abilities often reflect functioning in the non-dominant hemisphere. An assessment of visuospatial abilities may be especially important when competency issues concern spatial and perceptual tasks, such as driving or cooking, as reviewed in Appendix B. Tests often used to assess visuospatial ability in geriatric populations include the performance subtests (WAIS-R), Hooper Visual Organization Test, Visual Form Discrimination Test, and Trail Making Test.

An assessment of awareness of deficit is important when performing an assessment for competency. An individual's awareness of his or her deficit may be key in predicting the ability to compensate for any observed deficit and may thus indicate the degree to which the individual may place him or herself in danger. For example, a patient with poor memory may still be able to independently manage

medications if he or she is aware of the deficit and can follow a plan for reminding him or herself to take medications. Awareness of deficit is typically assessed through clinical interview and observation, although tests are being developed (e.g., Anderson & Tranel, 1989).

3. Mental Health Assessment Guideline

It is well-known that the patient's overall mental health status can have a significant impact on cognitive function, judgment and decision-making. For example, a patient who is severely depressed and has little hope for what the future might bring may perform poorly on tests of cognitive capacity, simply because he/she does not attend to task instructions or does not put forth the required mental effort to complete tasks successfully. Similarly, poor judgment and decision-making ability might be apparent as a result of extreme pessimism about future events or the patient's poor self-appraisal of his/her ability to cope with stressful situations rather than any limitation in understanding due to physiological disorders. In patients with mild to moderate dementia due to structural or metabolic complications, the prevalence of affective disorders ranges as high as 30% with depression being the major culprit (Feinberg & Goodman, 1984; Reifler, Larson, Teri, & Poulsen, 1986). Deficits due to psychological factors are more likely to be temporary in nature and often can be alleviated substantially when appropriate treatment for the cause(s) is administered, even in patients with dementia. Therefore, it is important to determine the level of depression and anxiety or the presence of a thought disorder at the same time an assessment of competency is being made. It can also be helpful at times to have a clearer understanding of characterological tendencies which might hamper rational decision-making. For example, a fiercely independent person with an excessively rigid and inflexible interpersonal style, who is also showing mild cognitive slippage but still reasonably intact, might refuse treatment because it requires that he/she must assume an intolerable position of being dependent on others. Careful work with such individuals focusing more on their characterological components rather than the loss of cognitive capability can often help them arrive at useful rational decisions.

To obtain a reasonable assessment of mental health factors and their contribution to a state of incompetence in a patient often requires information from multiple sources, including family members, friends and other professionals, and thus can be very time and labor intensive. One might argue that the added burden of such extensive efforts, may not be cost-effective. However, the prevalence of a dementia-like syndrome due to psychological factors, which is referred to as pseudodementia, is reported in some studies to be as high as 15% (Rabins, 1983). Furthermore, the overlap of symptoms in depression and early dementia, taken together with the fact that the former is eminently more treatable than the latter, renders this diagnostic decision one of the most important and difficult decisions the clinician must make. With that in mind, the favorable prognosis of identifying useful remedial pathways in even a small number of patients who might be perceived, and thus treated, as permanently incompetent can result in a substantially positive cost/benefit ratio. Of course, extensive evaluation of mental health factors may not be necessary in every patient. In the initial stages of assessing competency it is important, therefore, for the clinician to be exquisitely sensitive to the interplay of cognitive, behavioral and affective functioning in order to determine the pragmatic allocation of diagnostic resources to maintain an optimal cost/benefit balance. Behavioral responses to test materials, differential cognitive test profiles, and measures of affective functioning which are helpful for this purpose are reported in a number of studies below.

Mental Health Assessment Planning and Test Selection: Evaluation of the severity of psychological factors affecting mental status should include both a self-report measure and a behavioral rating scale. These two dimensions are highly correlated, but each can provide unique information which improves the sensitivity and specificity of a clinical diagnosis. Pachana, Gallagher-Thompson, and Thompson (1994) review measures of depression and Sheikh (1991) covers many of the instruments used to assess anxiety.

A brief but carefully crafted interview should be included in the assessment process. This could be modeled after one of the structured interview techniques, such as the Schedule for Affective Disorders And Schizophrenia (Endicott & Spitzer, 1978), the Comprehensive Assessment and Referral Evaluation (Golden, Teresi, & Gurland, 1984), the SHORT-CARE (Gurland, Golden, Teresi, & Challop, 1984) or the Structured Clinical Interview for DSM-III-R (Spitzer, Williams, Gibbon & First, 1992). These instruments typically require more time than is allotted for obtaining clinical data, but it is important to use a structured approach to maintain high reliability in the interview assessment. Whatever strategy is used, information concerning the extent and severity of the patient's current psychological symptoms should be obtained, along with the time of their onset, their duration in the current illness, and their prevalence in past episodes. The interview should cover a broad spectrum of symptoms that occur in various affective or thought disorders, and should reveal information about past family and psychiatric history.

A number of problems can be encountered that might complicate the diagnostic process. Older individuals are often hesitant to report symptoms of psychological distress, and the interviewer must be prepared to probe at some length in order to identify these. Frequently there is confusion concerning the possible role of physical symptoms. For example, problems with sleep may be due solely to arthritic pain and not to depression. Changes in eating habits leading to weight loss may be due to a loss of taste or having to eat alone. Loss of energy and fatigue may reflect other physical disorders. For acutely psychotic patients, thought blocking due to hallucinatory activity can mimic the aphasic symptoms and lack of sustained concentration of the patient with dementia. Underreporting of symptoms can often occur because patients, and unfortunately some clinicians as well, view them as a normal part of the aging process. It is not uncommon for example, to find older individuals who have been in an episode of major depression for years before they come to the attention of mental health professionals, simply because they have the belief that their experiences are a part of the aging process.

Although the remainder of the discussion will focus on the effects of depression on the mental status of the older adult, it is important to note that schizophrenic disorders, paranoid disorders and mania are prevalent in the older population (particularly in geropsychiatric inpatient and outpatient units as well as long-term care settings), and competency evaluations should be postponed until acute psychotic symptoms are adequately assessed and treated. One scale which may be used to assess psychotic symptoms is the Brief Psychiatric Rating Scale (BPRS: Overall & Gorham, 1962) which is an 18 item rating scale of psychiatric symptoms developed for use in an inpatient population which yields four general factors: thinking disturbance, withdrawal/retardation, hostile/suspiciousness, and anxious/depression. Based on patient interview, the clinician is asked to rate each symptom on a seven-point scale ranging from "not present" to "severe". It is widely utilized as a measurement of treatment response, and has been found useful in geropsychiatric research (Overall & Beller, 1984; Beller & Overall, 1984).

The Hamilton Rating Scale for Depression (HRSD: Hamilton, 1967) has long been the "gold standard" for determining severity of depression at any one point in time. However, there are problems with interrater variability in test administration which can affect severity scores. This problem has been addressed by Williams (1988) who developed a structured interview guide for the HRSD. Even with this improvement, reliability for some items is only fair. Further, the HRSD relies heavily on somatic symptoms which sometimes may be confused with symptoms due to other medical problems. When dealing with elderly individuals who have cognitive limitations, an unsophisticated interviewer may fail to discern some symptomatology because of unresponsiveness on the part of the patient (Lichtenberg, Marcopulos, Steiner, & Tabscott, 1992).

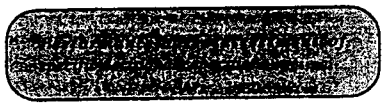
Since elderly patients who require evaluation for specific capacities typically are experiencing a number of complex problems, such as poor health and cognitive decline, it can be helpful to consider other instruments that are designed to account for such complicating factors. The Geriatric Depression Rating Scale (Jamison & Scogin, 1992) takes some specific characteristics of depression in the elderly into account in determining depression level. The Cornell Scale for Depression in Dementia (Alexopoulos, Abrams, Young, & Shamoian, 1988) uses information from interviews with both patient and staff members to assess level of depression in patients with cognitive limitations. The Dementia Mood Assessment Scale (Sunderland et al., 1988) combines information from direct observation of the patient in different settings along with a semistructured interview to obtain ratings of depression. While these measures are not yet in common use or are still in the developmental stages, they nevertheless can be valuable guides to the clinician in sorting out many of the complicating factors in attempting to determine the presence and severity of depressive symptoms. Less progress has been made in the development of interview-based ratings of anxiety designed specifically for special populations such as the elderly (Sheikh, 1991), but many of the issues are similar and the clinician can be aided by considering these when called upon to evaluate the presence and severity of anxiety symptoms.

Although a number of self-report scales are available to screen for depression, most have problems when used with elderly individuals who have cognitive impairment. Most were not specifically designed for use with the elderly, and therefore they do not include criteria characteristic of depression in this population, such as emptiness, feelings of envy, helplessness and a history of depressive feelings (Weiss, Nagel, & Aronson, 1986). Many include items assessing symptoms which could be increased as a result of other age-related problems. Nearly all involve response formats requiring frequency or intensity judgments which are difficult for elderly individuals with cognitive impairment. The Geriatric Depression Scale (GDS: Yesavage, Brink, & Rose, 1983) was designed to overcome many of these problems. A short-form is also available (Sheikh & Yesavage, 1986). The scale uses a simple yes/no format and has no items reflecting somatic symptoms that might be confusing. Validity and reliability studies have suggested its utility with frail and mildly demented elderly patients (Pachana et al., 1994), though some have reported it lacks sensitivity with nursing home patients (Kafonek et al., 1989). In general, the GDS appears to be a valid measure of mild to moderate depression levels in patients with mild to moderate dementia. It has been translated into numerous languages and may well be the best all-around self-report scale available at present with utility across a broad spectrum of geriatric patients and across a wide range of cultural groups. Few self-report measures of anxiety have been used with elderly patients, and those that have require reading and comprehension levels which render them questionable for use with frail elderly populations (Sheikh, 1991).

Careful observation of other patient behaviors can be helpful in distinguishing between a

psychological and an organic basis for problems in competency. As expected, patients who are having difficulty with decision-making due to severe psychological distress will show greater sadness, sleep disruption, and response inhibition (Feinberg & Goodman, 1984; LaRue, 1992; Reynolds et al., 1986). They will appear to have a rapid onset and fluctuating course, and generally show greater awareness of their problems (Wells, 1980). Patients with cognitive impairment due to psychological factors usually have fewer problems with IADLs and ADLs than patients with dementia due to organic factors (Reynolds et al., 1988). Depressed patients usually have more complaints about their cognitive problems, underestimate their capabilities and generally have a greater preponderance of negative perceptions of themselves and their situation (Mohs, Rosen, Greenwald, & Davis, 1983; Weingartner & Silberman, 1982). Depressed and anxious patients often spend little effort attempting to solve complex problems, and are prone to say, "I don't know" when posed with a complex question (LaRue, 1992; Strub & Black, 1988; Spar & Larue, 1990). However, if confronted with a serially repeated task which involves acquisition over time, patients with a psychological basis for their problems will show substantial improvement, whereas patients with an organic basis often do not (Thompson et al., 1987). In tasks assessing delayed memory, patients suffering from depression often show reasonable recall rates (roughly 80% of the material initially learned), whereas patients with dementia due to physiological factors rarely show this level of delayed recall (Thompson et al., 1987).

4. Guideline for Assessment of Specific Capacities



Determining the presence of a serious mental disorder is necessary, but not sufficient, for a legal finding of incompetency. The psychiatric literature (see Anthony & Liberman, 1986) indicates psychiatric diagnosis and symptomatology does not predict functional abilities such as work capacity or ability to live independently. Similarly, impaired cognitive functioning doesn't automatically warrant determining an individual is incompetent in relation to the specific capacity identified on the referral question. While there is emerging literature regarding the relationship of general cognitive abilities to specific capacities, psychologists are cautioned about the limitations of making inferences solely on the basis of cognitive assessment findings regarding the probable capacity of the person to perform adequately those real-world tasks in question (Grisso, 1994). Just as persons with prefrontal lobe damage may do well on cognitive assessment measures yet have impaired judgment in everyday decision making (Stuss & Benson, 1986), persons with dementia related memory impairment may still retain information long enough to provide informed consent (Kaplan, Strang, & Ahmed, 1988). Assessing the mental and cognitive status of older persons allows for inferences, but not a determination of their ability to function successfully in everyday life. For this reason, it is recommended that an assessment of the specific capacity in question be included when psychologists are asked to assess abilities and capacities relative to competency determination. Since this practice guideline is written to address psychological assessments relevant to a wide range of questions, the term "specific capacity" assessment is used here to denote a direct, performance based assessment of any specific task in question, to avoid confusion regarding the meaning and scope of the term functional assessment, as explained below.

The literature on functional abilities contains differences in what constitutes the domain to be included in a functional assessment. The types of specific capacities which may be assessed in the context of a psychological assessment runs the gamut from those psychologists think of as more func-

tional or behavioral (i.e., ADLs and IADLs) to more cognitive (i.e., decision making). In the field of geropsychology, functional capacities or abilities are usually defined in behavioral terms and measured by having the person perform an activity or task. Functional capacities or abilities as defined in the legal field refers not only to what the person can do or accomplish, but the person's ability to understand and make or communicate decisions (Anderer, 1990).

Evaluating a person's capacity to make treatment decisions or provide informed consent requires an assessment of decision making abilities in making choices. Consistent with the legal competency constructs, Grisso (1994) describes these abilities as a functional capacity (see Appendix A). When the determination of specific decisional capacities for legal competency is the ultimate concern of an assessment, the traditional distinction in geropsychology between cognition and behavior or function is often less useful. For example, an assessment of the specific capacity to manage finances focuses not only on behavioral performance on such tasks as counting change and writing checks, but also includes financial judgment and decision making consistent with the broader legal definition of functional capacity.

A person's utilization of a specific capacity to perform or express that capacity is a product of environmental, psychological, and biological factors (Kemp & Mitchell, 1992). Functioning is a product of the interaction of all of these factors and no aspect of functioning is attributable to only one factor. A person's capacity to live independently (e.g., in his/her own home) may be adversely affected by poor eyesight, difficulty ambulating, and lack of assistive devices in the home. Since environmental and biological factors can play such a crucial role in the functioning of an older person, it is important to evaluate their effect on the specific capacity assessed. When an impairment in the person's ability to perform or express a capacity is identified, this interactive perspective requires that biological, psychosocial, and environmental factors be examined to determine the cause. A person may be having difficulties with financial management due to the closing of a nearby bank and inability to go to another because of poor health and lack of transportation. Also this perspective provides a practical framework for making recommendations on ways to enhance functioning and thus assist the person in maintaining or retaining their independence.

Planning and Test Selection for Assessment of Specific Capacities: Clarifying what is the specific capacity being questioned is the first step. Evaluating how the capacity is expected to be utilized is then needed before test selection. In what context or environment is the person expected to utilize the capacity in question? What is the nature of the demands that will be placed on the person's ability to perform or express that capacity? The answer to these questions will determine how extensively the capacity in question is assessed and how the assessment findings are interpreted. For example, if the capacity to give informed consent is in question, is the person being asked to participate in a nonintrusive research study or to consent to high risk surgery? When assessing capacity for financial management the demands and expectations for a person residing in a nursing home with a fixed income primarily from social security are much different from a person living in the community managing a business. As with cognitive impairments, a person can compensate for limitations with specific capacities by relying on others for assistance and taking steps to minimize environmental demands.

The selection of functional instruments should be based on standards relevant to all test selection (e.g., reliability, validity, and availability of normative data). Ideally all items or tasks in an instrument should be directly relevant to the specific capacity in question and be objectively

scored according to well defined criteria. Most of these instruments appear to have high face validity. While of greater importance, ecological validity or prediction of everyday behavior is undetermined for many of the measures to be discussed. Functional instruments tend to be less empirically researched than cognitive tests but have the appearance of predicting successful independent performance of the capacity in question. Ecological validity is maximized when the specific capacity assessed is directly relevant to the area of competency in question and the environmental, biological, and psychosocial factors affecting the expression or performance of the capacity are integrated with the findings. (See Appendix B for further discussion of ecological validity.)

Most of the instruments to be discussed lend themselves to a process oriented approach to scoring and interpretation of findings. This approach focuses on the behavioral and cognitive processes that determine the person's responses and reveals the person's decision making or problem solving capabilities. The reasons given for an incorrect response may be more indicative of sound reasoning than haphazard reasons given for a correct response. Such qualitative data also helps determine the effect environmental, biological, and psychosocial factors have on the person's functioning. As Rutman and Silberfeld (1992) conclude, competence may be viewed as the degree of fit between a person's capacities, resources, and support and the demands of that person's environment.

When assessing a specific capacity, measures of the performance or expression of that capacity are recommended over self report and collateral report measures. Performance of the specific capacity in the environment in which the person will be utilizing the capacity is optimal. If the clinical setting is utilized, it should be modified to simulate the environment in which the capacity will be utilized. Numerous studies have shown poor correspondence between self-reports or collateral reports of an older person's abilities and direct observations of actual functioning (e.g., Sager et al., 1992; Weinberger et al., 1992). When functional instruments are administered by someone other than the psychologist, it is essential that the psychologist observe the administration or obtain information on actual performance. The psychologist should be able to clinically describe the person's performance on each task. Causes of deficiencies in specific capacities should be identified whenever feasible. When a deficiency in a specific capacity is reported, the court is most interested in the cause and if it can be remedied, whether it be impaired decision making ability or other mental or physical limitations.

The following section discusses many of the frequently used instruments as well as newly developed instruments that show promise. The section is divided into three domains: Activities of Daily Living; Instrumental Activities of Daily Living; and Decision Making Capacity. Other surveys of functional assessment scales can be found in the Geropsychology Assessment Resource Guide (1996), Kane and Kane (1981), Kemp and Mitchell (1992), Kovar and Lawton (1994), and McDowell and Newell (1987). Also included in this section is the assessment of driving ability. Driving ability can be viewed as a specific capacity or performance based ability involving motor, perceptual and cognitive skills

Activities of Daily Living (ADL) Measures: Kovar and Lawton (1994) note that the ADL was originally developed for assessing the potential of institutionalized persons to regain functioning. ADL measures have become the primary method of assessing the physical health of older persons in whatever setting they reside. The seven areas commonly assessed by ADL measures are grooming, dressing, eating, toileting, bathing, transferring, and ambulation. Most measures are completed by caregivers familiar with the person or by direct observation of functioning. The areas or functions are primarily defined in terms of independence or lack of assistance. The Katz Index (Katz, Ford,

Moskowitz, Jackson, & Jaffee, 1963) was the first measure developed and is the most widely used and researched of the ADL instruments. The Katz Index evaluates the person's level of independence for six ADL areas and provides a rank ordered score representing the combined pattern for all the ADLs. Branch, Katz, Kniepmann, and Papsidero (1984) expanded the Katz Index to include ambulation and grooming. The Physical Self-Maintenance Scale (PSMS) developed by Lawton and Brody (1969) is similar to the Katz Index. Another widely used instrument is the Barthel Index (Mahoney & Barthel, 1965). The Barthel Index is a ten item rating scale with scoring determined by the amount of assistance needed to perform a task. There is an expanded Barthel Index called the Barthel Self-Care Ratings (Sherwood, Morris, Morr, & Gutkin, 1977) that assesses 15 items.

The Performance Test of Activities of Daily Living (PADL) developed by Kuriansky and Gurland (1976) is a structured test of ADLs based on actual observation of a person's performance. The person is requested to demonstrate his or her ability to perform 16 tasks that assess basic ADL functions. The PADL was found to be a better predictor of functional status than either patient or caregiver self report (Kuriansky, Gurland, & Fleiss, 1976). As a performance measure, the PADL provides information on what mental or physical factors may be affecting the person's ADL functioning. There are a number of other more recent ADL instruments, however, they do not appear to provide any substantial improvement in psychometric performance or predictive power.

In summary, ADL instruments are of limited use in assessment of specific capacities. They do not assess the broader range of capacities more relevant to competency such as financial management and ability to prepare a meal. A person who can perform ADL functions may still have serious deficiencies in independent living. Also if a person is deficient in ADL functions, the need for a formal assessment is usually not required.

Instrumental Activities of Daily Living (IADL) Measures: The IADLs were developed to assess a complex range of functioning requiring more skill, judgment, and reasoning than ADL measures. The capacities assessed are considered instrumental or essential to everyday functioning. There appears to be no consensus on what activities are required to include in an IADL instrument. While the number of possible IADL tasks that can be relevant to everyday functioning seems almost endless, the tasks selected usually cover a range of activities and have high face validity. Performance on IADL tasks are expected to be more easily disrupted by psychiatric or neurological impairments than ADL tasks. IADL instruments that include the greatest range of capacities assessed are discussed below. Other shorter IADL instruments more suitable for survey purposes are excluded. Also instruments that directly assess actual performance are emphasized over instruments that rely on self report or collateral reports for the reasons previously discussed.

Lawton and Brody (1969) are recognized for developing the first widely used IADL instrument called the Instrumental Activities of Daily Living Scale. It assesses eight everyday activities (use of telephone, ability to shop, food preparation, housekeeping, laundry, transportation, responsibility for own medications, and ability to handle finances) on a varying scale from self sufficient to totally dependent. As a self report measure of performance, findings should be corroborated by interviewing staff or others knowledgeable of the person's functioning.

The Direct Assessment of Functional Status (DAFS) developed by Loewenstein et al. (1989) measures performance in seven domains (time orientation, communication, transportation, finances, shopping, grooming, and eating). The DAFS was developed to be sensitive to subtle changes in specific capacities that can occur with Alzheimer's disease and other dementias. Normative data are provided for Alzheimer's disease patients, older depressed patients, and elderly controls.

The Independent Living Scale, formerly known as the Community Competency Scale, was initially developed by Andersen (described in Grisso, 1986) and is comprised of 68 items summed into five scales (memory/orientation, managing money, managing home and transportation, health and safety, and social adjustment). Scores on two factors (information/performance and comprehension) may be derived from responses to items across the five scales. Each item requires the person to perform some function related to the scale in question. All items are objectively scored according to well defined criteria, and validity studies and normative data are provided in the manual. The ILS was specifically devised to identify areas of competence in forensic cases by assessing the degree to which older adults are capable of caring for themselves and their property.

The Structured Assessment of Independent Living Skills (SAILS) developed by Mahurin, DeBettignies, and Pirozzolo (1991) consists of 50 tasks representing 10 domains of everyday living (fine motor skills, gross motor skills, dressing skills, eating skills, expressive language, receptive language, time and orientation, money related skills, instrumental activities, and social interaction). The SAILS utilizes behaviorally anchored rating scales and offers a criterion based means of quantifying functional status. The SAILS was developed for use with elderly patients with dementia. While there were a limited number of subjects in the initial study, reliability and validity data are very good and the relations of SAILS scores to various clinical measures of cognitive ability are reported.

The Assessment of Living Skills and Resources (ALSAR) was developed by Williams et al. (1991) as a comprehensive IADL rating scale based on interview and observation data. It focuses on the accomplishment of complex tasks essential to independent living. The person's skill and available resources are rated separately and combined to determine risk that the person will not be able to accomplish a task. Risk scores can be utilized to promote interdisciplinary problem solving and treatment planning. The ALSAR would thus lend itself to providing recommendations for ways to enhance a person's functioning.

The Adult Functional Adaptive Rating Scale (AFARS) developed by Spirrison and Pierce (1992) measures level of functioning in 14 areas (eating, ambulation, toileting, dressing, grooming, managing personal area, socialization, environmental orientation, reality orientation, receptive speech comprehension, expressive communication, memory, managing money, and managing health needs. It can be described as an informant based measure of ADL and IADL. It is administered to a well acquainted informant and can be supplemented with observation of and interaction with the person assessed.

ADL and IADL measures similar to those previously discussed are embedded in multidimensional batteries, such as the Older Americans Resources and Services (OARS) and its abbreviated version, the Functional Assessment Inventory (FAI), the Comprehensive Assessment and Referral Evaluation (CARE), and the Multilevel Assessment Instrument (MAI). See Kemp and Mitchell (1992) for discussion of these batteries. While primarily questionnaire measures, these batteries have the advantage of large sample descriptive data. Two other measures used primarily in rehabilitation settings worth mentioning are the Functional Independent Measure (FIM), which assesses motor and cognitive skills (Keith, Granger, Hamilton, & Sherwin, 1987), and the Cognitive Performance Test (Burns, Mortimer, & Merchak, 1994), which assesses performance on daily living

tasks particularly information processing.

Another set of measures that has recently been developed and that shows promise for use with elders is the Everyday Problem Test developed by Willis (Willis, 1993; Willis, 1996b). This measure assesses everyday cognitive competence within each of the IADL domains, including: (a) managing medications, (b) shopping for necessities, (c) managing one's finances, (d) using transportation, (e) using the telephone, (f) maintaining one's household, and (g) meal preparation and nutrition. Older adults are presented with 42 stimuli (six for each of the seven domains), and asked to solve two problems related to each stimuli. All stimuli are actual materials that elderly persons might encounter in their daily lives. For example, the older adult is shown a listing of emergency telephone numbers and asked which number should be dialed in a particular emergency situation. A second example would be that the older adult is shown the label for an over-the-counter cough medicine and asked the maximum number of teaspoons to be taken in a 24-hour period. The psychometric properties of this measure has been described by Willis (1996b); validity and reliability data are very adequate, and the measure has been used to assess longitudinal change in problem-solving performance for elderly persons with no known pathologies. Studies are underway to develop a normative profile for demented older adults in addition to the information available on normally functioning elders.

Decision Making Capacity: As Grisso (1994) describes, there are four types of abilities of concern to the law when determining a person's capacity to make treatment decisions. These are the abilities to express a choice, understand the information about treatment provided, appreciate the significance of the information for one's own circumstances, and process the information rationally. Assessing a person's decision making capacity should involve direct questioning of the person in each of these four areas. Grisso and Appelbaum (in press) have developed the MacArthur Competence Assessment Tool-Treatment (MacCAT-T) as a standardized clinical instrument for assessing a person's capacity to make decisions about his or her treatment. Grisso and Appelbaum had previously developed several standardized research instruments assessing decision making, which served as the basis for the development of the MacCAT-T. It utilizes a semi-structured interview format to assess and rate the person's level of understanding, appreciation, reasoning, and communication as it relates to the person's treatment options.

The MacCAT-T guides the assessor through the following three steps: preparation, in which information about the person and treatment options is obtained and prepared to construct the disclosure for the interview; the interview, in which guidelines for inquiry and probing are followed; and rating of the persons' performance utilizing a three point scale. One of the many advantages of the MacCAT-T is that its format is generalizable to most treatment scenarios, yet the inquiry is specific to the person's treatment choices in question (Winick, 1996).

The Hopemont Capacity Assessment Interview (HCAI) developed by Edelstein, Nygren, Northrop, Staats, and Pool (1993) is a semi-structured interview divided into two sections: Capacity to Make Medical Decision and Capacity to Make Financial Decisions. Preliminary results suggest that the HCAI is useful for determining the capacity of nursing home residents to make medical and financial decisions. Each section first examines an individual's understanding of the concepts of benefit, risk and choice. Hypothetical scenarios are then presented dealing with tasks directly relevant to medical or financial decision making in nursing homes and long-term care facilities (e.g., choosing to have or not have CPR). The HCAI was developed with the conceptualization that capacity is situationally or contextually determined and thus the capacity of individuals can vary across tasks/situations. The

HCAI also incorporates questions that allow the examiner to assess each of the four types of abilities rated by Grisso (1994) above. Pruchno et al. (1995) utilized a brief objective inventory which included the HCAI for comparison to a clinical psychologist's evaluation of competence to participate in decisions about medical care. Performance on the inventory was an accurate prediction of evaluation findings in their study of residents of a long-term care facility. Edelstein (1997) has developed standardized scoring procedures to accompany the instructions for its administration.

The Hopkins Competency Assessment Test (HCAT) was developed by Janofsky, McCarthy, and Folstein (1992) as a brief instrument for evaluating the capacity to give informed consent or write advanced directives. The HCAT is promoted as a screening tool to make an initial determination about clinical competency but is better described as an instrument to evaluate the patient's understanding of the consent process. The instrument consists of a short essay describing informed consent and durable power of attorney, followed by six questions about the material presented. There are three versions of the essay. The information is written at the 13th, 8th, and 6th grade levels. While HCAT scores were an accurate indicator of clinical competence as assessed by a forensic psychiatrist, concerns have been raised about its appropriateness for clinical use due to its narrow focus and failure to take into account what is the probable level of risk to the person of the outcome of their treatment decision (Englehart, 1992).

Driving Ability: There is increasing evidence that driving ability deteriorates with age or episodes of illness (see Cox, Fox, & Irwin, 1989). While society must be concerned about the elderly's ability to drive safely, driving is increasingly an instrumental task necessary for maintaining functional independence. Safe driving requires intact motor, cognitive and perceptual skills. These skills and thus the ability to drive safely can be severely compromised by disease processes such as a stroke or Alzheimer's disease. Yet having a stroke or a dementia diagnosis does not preclude retention of the ability to drive. Determining whether an elderly person's driving privileges should be restricted is problematic. There is little consensus and few guidelines on which to base such decisions. Certainly the driving demands should be considered. For example, is the individual only driving short distances on familiar routes, or driving long distances, in traffic, or in unfamiliar areas? Is the driving limited to non-peak daylight hours or night-time as well?

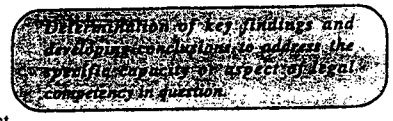
The on-the-road driving test is the most widely accepted method for determining driving competency despite the general lack of standardization and data on reliability or validity. Odenheimer et al. (1994) developed a systematic performance based road test that shows promise as a reliable and valid measure with elderly drivers. They do caution that road testing is a potentially risky activity. Also trained driving instructors with a properly equipped vehicle are generally not readily accessible. Clinical measures can be utilized along with or in lieu of on-the-road testing. Some centers offer driving assessments through computerized driving simulation tasks.

The psychologist, usually as part of a multidisciplinary team to evaluate driving ability can be called upon to assess a person's motor, cognitive, and/or perceptual skills. In the study of visual/cognitive correlates of vehicle accidents in older drivers, Owsley, Ball, Sloane, Roenker, and Bruni (1991) found that a measure of visual attention (i.e., size of the useful field of view) followed by mental status (the Mattis Organic Mental Status Syndrome Examination) were the strongest predictors of vehicle accidents. Irwin (1989) recommends that, as part of a comprehensive assessment of driving ability, the person's mental status, memory, selective attention, ability to follow directions, recognition of street signs and judgment/decision making relevant to driving (e.g., pull over when approached by an emer-

gency vehicle) be evaluated. Irwin has developed a battery that contains instruments to evaluate each of these cognitive skills as well as motor and perceptual skills relevant to driving. The latter three cognitive skills (following directions, sign recognition and judgment/decision making) regarding driving situations can be evaluated in the clinical setting. Inclusion of measures to evaluate these domains is recommended along with traditional cognitive and/or mental status measures. Self report measures of driving habits, abilities and accident frequency should be used with caution due to their questionable validity.

D. Synthesis of Data and Communication of Findings

1. Determination of Key Findings and Developing Conclusions



The outcome of the evaluation is to provide an integrated summary of the psychological assessment data in the context of the patient's medical, psychiatric, social and legal history. As in any psychological assessment, the task is much greater than simply noting the range in which test data fall. Qualitative analysis is critical. The psychologist is expected to pull together the patient's history, the interview, and the performance based assessment data in a way that addresses the specific capacity or aspect of legal competency in question.

There is no algorithmic formula for determining key findings or for arriving at opinions about capacity. The clinician must address the unique demands of each referral. However, a seven part analysis generally seems relevant to these evaluations.

First, are the data sound? In the planning phase, reliable and valid methods were identified for addressing the referral question. How well were the plans executed? In reviewing the examination process, does it appear that the resulting data are reliable? Were reasonable accommodations made--related to sensory impairment, ethnic and linguistic minority, and/or frailty– to maximize the patient's performance? If the psychologist is not satisfied with the reliability of the data, then additional assessment may be needed.

Second, is there some other condition that may explain the behavioral deficit noted on the referral other than incapacity? A finding of incapacity is made only after ruling out treatable conditions, and the psychologist must make parsimonious inferences from the data. New problems or conditions may have been uncovered in the course of the evaluation, and their impact needs to be considered. For example, if an acute state of delirium was found, conclusions about capacity may be inappropriate until the delirium is treated. The effect of any acute medical or psychiatric illness needs to carefully weighed before preceding with data analysis.

Third, is there enough information upon which to reach a conclusion? This includes the performance based data generated by the patient as well as a thorough understanding of the context in which the patient must exercise the capacities in question. The psychologist needs to be reasonably confident that the assessment data: (a) represent the patient's current baseline performance, (b) capture an adequate sample of the behavior in question, and (c) include an adequate understanding of the demands and resources in patient's environment. A review of Appendices A (Legal Context for Competency Assessments) and B (Ecological Validity) may be helpful in making this determination. If there is not enough information upon which to reach a conclusion, the psychologist may gather additional data or make referrals for such. For example, the psychologist may wish to complete or refer the patient for additional neuropsychological assessment, or for functional assessment by an occupational therapist, or for other diagnostic tests such as CT scan. These decisions are based on the psychologist's familiarity with the range of assessments and diagnostic tests commonly used for older adults and with the expertise available via other multi-disciplinary team members.

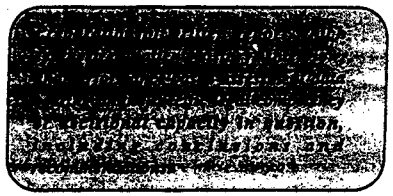
Fourth, what was learned from the assessment? The psychologist then reviews the strengths and weaknesses in the cognitive, functional, and mental health domains. This review should include a determination of the presence or absence of an Axis I diagnosis. Particular attention is given to assessment data directly related to the referral question.

Fifth, what is known about the environment in which the patient will be expected to function? Part of the assessment process is to learn about the environmental demands and the resources available to the patient. Sometimes these demands are specific and explicitly stated in the referral, e.g., can she manage her medications on her own for a week at a time? More often, the psychologist will have had to develop an understanding of the task complexity (see review by Willis, 1996a) regarding person-environment fit as it relates to everyday competence). It is also be important to consider to what extent the patient recognizes any need for assistance and to what extent he/she is able to communicate that need in his/her environment.

Sixth, how well do the patient's abilities fit with the environmental demands? The outcome of the first five steps should lead directly to the development of conclusions. It is important to note ways that the patient can compensate for behavioral deficit and still meet the demand. This may involve directing someone else in executing the task while still retaining decisional control. Generally, if the demand is greater than the patient can meet (either independently or by directing a proxy), then the patient is considered to lack the specific capacity in question. Appendix C offers some examples of how this guideline applies to actual cases. Ultimately, the clinician must describe the person/environment fit in each case.

Seventh, what will help the patient in performing the tasks in question in the future? The psychologist needs to develop strategies for family members or care providers to use to assist the patient. This may include ways to maximize the patient's independent execution of the task in question (see review by Kapp (1996) regarding alternatives to guardianship), or it may include a recommendation for guardianship. An analysis of the evaluation data utilizing these steps leads to a determination of key findings and conclusions about strengths and weaknesses in the patients cognition and mental functioning in reference to the specific capacity in question and in the context of specific environmental demands. The process of integration and interpretation of the evaluation data relies upon the psychologist's training in psychological assessment of the older adult, and specific education and training in the performance of such evaluations for the determination of specific civil competencies or capacities.

2. Preparation of Written Report



The report needs to include a discussion of the patient's current strengths and limitations, and should note specific recommendations for maximizing the patient's current ability to direct or participate in choices. Since abilities are rarely lost completely, professional opinions about competency should be made in relative rather than absolute terms. The contribution of potentially reversible factors needs to be addressed, including a time-frame for reassessment. The patient's abilities must be discussed in light of the demands of the current situation and environment, and the ultimate recommendation will be the least restrictive, one in which these abilities and demands can be balanced.

The written report needs to outline the reason for referral, the consent procedure, the methods utilized, the persons contacted, an integration of all the data, a specific response to the referral question, and recommendations. Depending upon the situation and local standards, a multi-axial diagnosis may be included. If the report is requested specifically for legal proceedings, the psychologist must know and conform to legal standards for the court of jurisdiction. These standards may require or prohibit the use of certain terminology or professional opinion.

3. Discussion of Assessment Data

It is important for the psychologist to provide feedback directly to the patient and relevant family members about the assessment data and the conclusions. The evaluation provides the psychologist an unparalleled opportunity to educate and support family members and professional caregivers about how to maximize positive outcomes for the patient. The feedback to the health care team and family members should highlight the compensatory skills available to optimize function and any needed adjustments in physical or social environment that will reduce the severity of deficits. Although the written report is an essential outcome of the evaluation, the ultimate outcome is the quality of life of the individual evaluated. At all points in the evaluation, attention must be given to the respect of the client and adequate privacy must be afforded. Written reports should only contain the information that is relevant and necessary to the referral. Any use of the case material for staff education must preserve the dignity of client and must preserve anonymity for those not on the health care team. Psychologists working within their official duties in the VA must carefully follow the stated procedures for release of information.

E. Follow-up Evaluation

Evaluation of impact of recommended interventions and assessment of changes in decisional capacity and competency functioning.

All reports should include a statement on the necessity of evaluating the impact on the patient's life of the recommended interventions concerning decisional capacity. In those cases where there are possible acute/ reversible causes of cognitive impairment and incapacity which may not be fully be resolved until after the initial evaluation is required to be completed, it is important that the psychological report also contain recommendations for re-testing as appropriate. Additional assessment should occur as soon as possible after the shortest time period which the clinician deems lengthy enough to reasonably expect significant cognitive improvement.

Relatives, lawyers, and other concerned professionals can be educated regarding the need for serial evaluations to document either continued incapacity or enough improvement to warrant re-adjudication. Since incompetence is not necessarily an all-or-none determination, the interests of the patients are usually best served by allowing them as much autonomy as they are currently believed to be able to handle safely. Interested parties must be encouraged to implement medical regimens, environmental management plans, family counseling, and/or cognitive rehabilitation strategies outlined in the report which might be reasonably expected to either reduce performance-debilitating stress or directly improve specific capacities. Family meetings should be scheduled to gather information and provide guidance regarding post-competency evaluation developments. In situations where the referral itself was vague or poorly conceived, follow-up consultation with the treatment team may be in order. The serious consequences emanating from a legal filing of incompetence necessitates ever-vigilant monitoring of the effect of the court decision on the patient to assure a continuing fit between current capacity and environmental demands which supports the patient's quality of life.

VI. Limitations of the Practice Guideline and Implications for Further Assessment Development and Research

Practice guidelines attempt to combine empirical research findings with expert opinion for the purpose of improving clinical care quality and consistency. The practice guideline described in this document in fact represents the best thinking about how to conduct clinical evaluations for capacities involved in competency currently supported by psychological research, clinical experience, and available standards of practice. In the process of developing a practice guideline, however, the complexities inherent in practice issues emerge as do the limitations of any given proposed guideline and areas where empirical research is lacking. It is incumbent on the developers of practice guidelines to share the limitations of their findings as well as the applications.

In the area of assessment in support of competency determination, disagreement exists among professionals regarding the concept of competency. Moye (1996) articulates the lack of consensus on constructs of competence and argues for the delineation of theoretical constructs and the empirical validation of measures and relationships among measures. Without such a theory-based approach to assessment, the validity of individual assessments relies heavily on clinical experience and disconnected research findings. Moye poses several models which relate cognitive abilities, behavioral function, and values to the construct of competency. These models are a good starting point for theoretically-driven research on the constructs of assessment of specific capacities.

Another problem area in assessments used for competency determination is diverse and changing state laws which must be addressed by the clinician (Hankin, 1995; Parry, 1988). Anderer (1990) notes that state legal definitions of competency have been moving from a generalized concept of incompetence to a more specific construct of incapacitated for...(specific area). Some states require a competent outcome, i.e., responsible decisions, to document competency. Other states require a competent process, i.e., informed decisions. (See also Appendix A.) The term "competency" is in fact giving way to language which addresses specific capacities.

Aside from the problems of legal application differences, there are five areas of assessment in need of additional research. The first and greatest need is for research to develop instruments with ecological validity or prediction of everyday level of functioning. In some areas such as medication compliance, self-care, cooking, or shopping IADLs, direct observation makes research on ecological validity relatively easy. In other functional areas such as driving or in cognitive areas involving medical decision making, ecological validity is harder to establish. Decision making is perhaps the most difficult area of capacity to research. Decision making can occur in the areas of medical care, hygiene, living arrangements, safety, and other situations. In each area, an optimally capable individual will be able to understand the risks, benefits, and alternatives to a particular choice and to express a preference which is consistent with his/her values, goals, and life history. The specific nature of each decision for an individual within a specific personal and environmental context calls into question the ability to design a generalized test of decision making capacity. Extensive research is needed to demonstrate that a generalized test of decision making capacity can successfully predict capacity in highly specific situations. In order to establish such predictive validity, agreement on a gold-standard of decision making would be required.

A second area for measurement research is in the continued development of normative data. Although many standardized tests are collecting normative data for the oldest-old, further research is needed on educational, ethnic/cultural, and medical influences on test performance.

A third area for increased research attention is the need to study assessment of specific capacities across the life-span. Most young and middle-aged adults enjoy a presumption of competence. In these age groups, only the mentally ill, mentally retarded, or physically impaired are likely to have their capacities questioned. Older adults, on the other hand, may experience a cultural bias of presumption of incapacity. Obviously we should not require a higher standard of functioning with advancing age.

A fourth area of research stems from a review of the literature which has shown that there are no validated measures of functional capacity for any group of "ethnic elders". Future research in this area would be very valuable.

A final needed area of research for assessment in competency determination involves attention to the issues of how to maximize performance, both in removing barriers to optimal performance during the assessment process itself as well as how to use assessment data to help understand conditions under which performance is maintained and maximized. Such research would have the additional benefit of helping to develop treatment strategies for individuals with deficits in decision-making and judgment.

In summary, the threatened loss of autonomy attendant to a decision of incapacity can have such a profound psychological impact on an elderly individual that the psychologist is ethically bound to report test results accurately and with reference to lack of known predictive validity as applicable. Being aware of the impact of our own personal values and judgments on our assessments is critical. The underlying ethical and social values of patient well-being and patient self-determination can help to guide our assessments. Finally, even if a client is judged to have deficits in decisional capacity affecting competency, a psychologist can encourage all concerned to include that individual to the greatest extent possible in decisions affecting the client's life.

VII. Summary

The clinical assessment of factors involved in competency determination of the older adult encompasses five critical steps. The first step details the importance of clarifying the referral question. This clarification is necessary to both identify the nature of the referral question, including decisional capacities for which information is requested, and to determine the needed training and experience of the psychologist to perform the assessment.

The second step involves planning to insure an ethical, appropriate, and valid assessment. Informed consent, consideration of age and cultural diversity factors, and a determination of assessment tools and methods needed to address the referral question are to be included. A review of existing medical, legal, and psychosocial data assists in this planning.

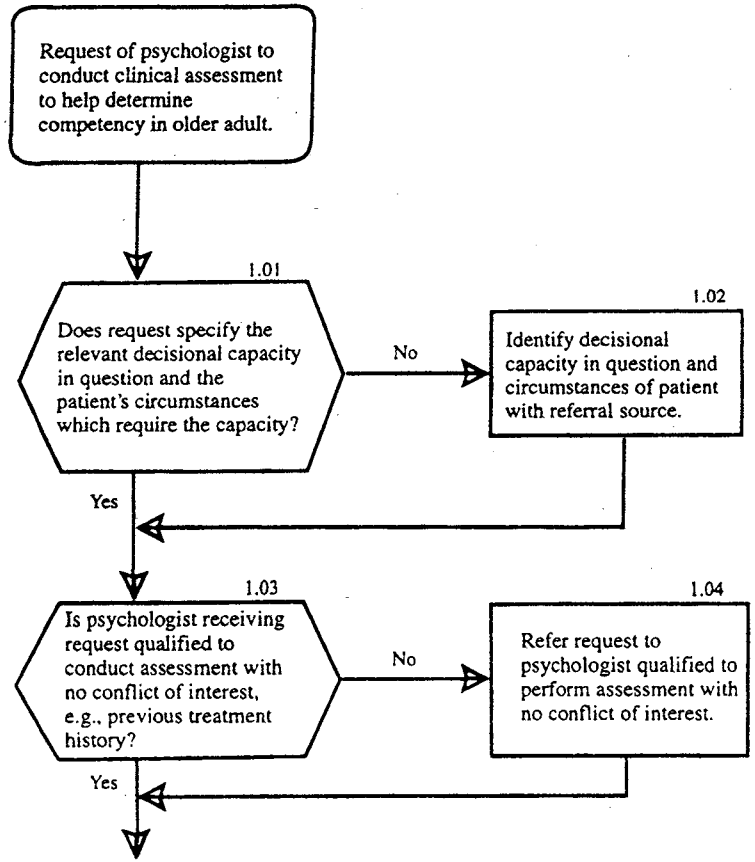
The actual assessment activity comprises the third step in the process. In addition to a clinical interview to collect data on the patient's values, goals, and preferences, a performance-based evaluation of cognition, mental health functioning, and specific capacities under question is recommended.

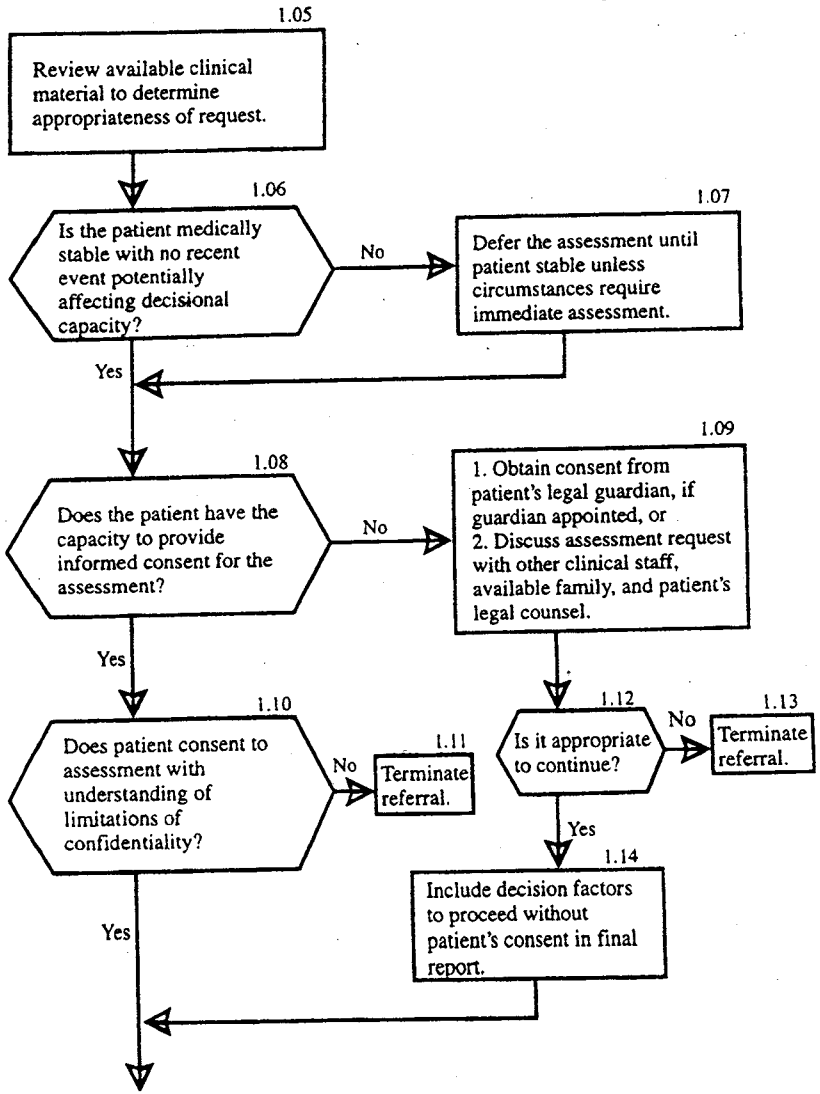
The fourth step of the assessment process involves the synthesis of the data and the communication of the findings of the assessment. The written report must synthesize assessment data and conditions bearing upon the specific capacities in question. Any recommendations must be fully justified. Limitations of the findings are to be included along with any data on the potential temporary nature of any deficits noted. If applicable, it is suggested that the report note ways that the patient's behavior or the treatment environment could be better managed to compensate for any identified deficits. In addition to the written report, feedback on the assessment should be discussed with the patient and relevant family members.

As a fifth step, consideration should be given to recommending or planning any follow-up evaluation. Such planning is especially appropriate for conditions affecting specific capacities believed temporary in nature or amenable to treatment or environmental management.

The assessment process is additionally summarized in the algorithm in Figure 2. The algorithm depicts key decision points in conducting the assessment of specific capacities to be used in support of competency determinations.

Figure 2. Algorithm for assessment of competency and capacity of the older adult: A practice guideline for psychologists.





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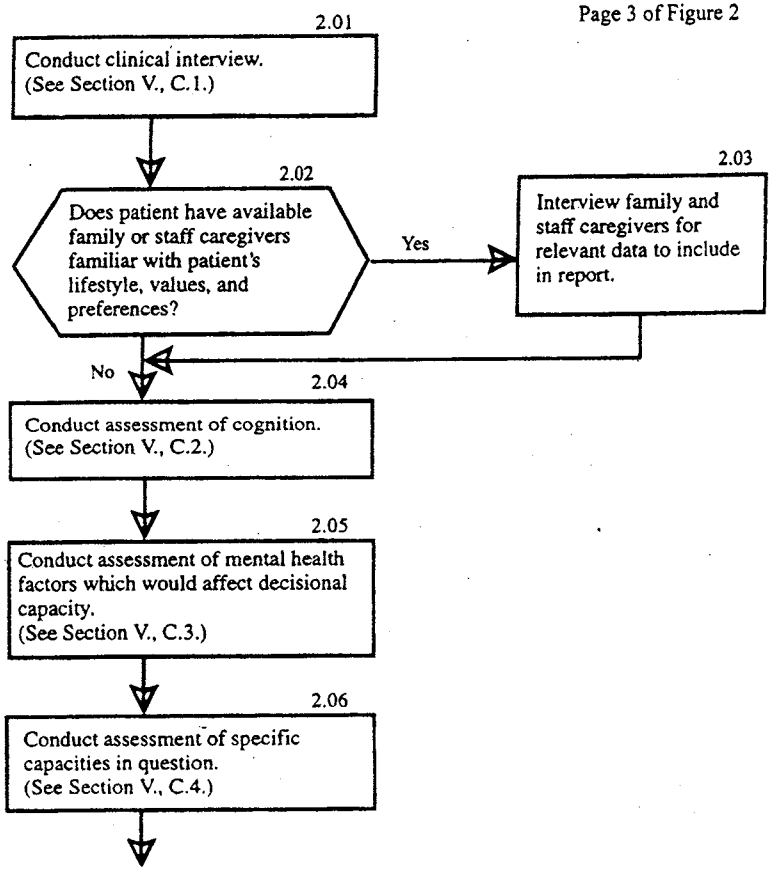

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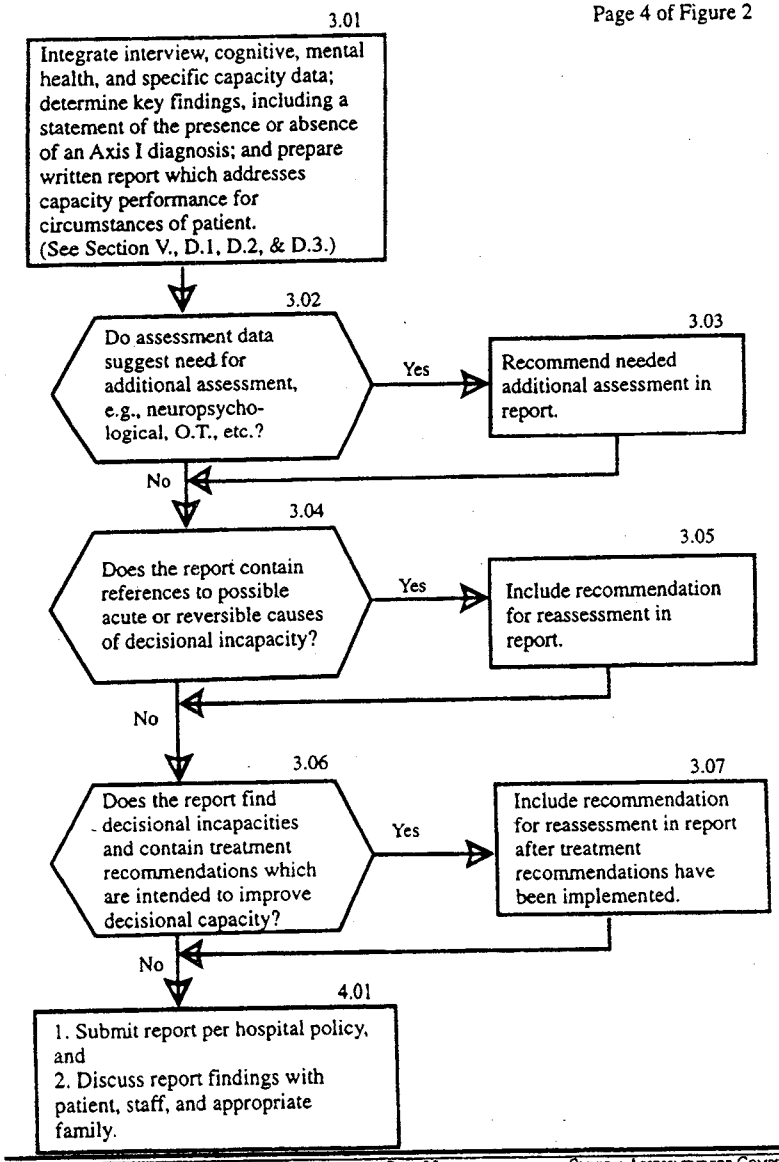

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APPENDIX A

THE LEGAL CONTEXT FOR COMPETENCY ASSESSMENTS

As noted in this Guideline, clinical assessments of competency do not determine a patient's legal status as competent or incompetent. This determination must be made by the court. Nevertheless, the clinician must be aware of the legal criteria that courts are required to apply when making judgments about legal competency. This maximizes the likelihood that the clinician will construct an assessment that obtains legally relevant data and will communicate it in a way that is useful to the court.

Statutes and Cases

All states have statutory definitions of incompetency, and some states have landmark legal cases (heard on appeal by a state's highest court) that have interpreted those definitions. It is important for the clinician to obtain the relevant statutory (or legal case) definition of incompetency, to cite it in the report of the competency assessment, and to be able to explain how the clinical data within the assessment are related to the various parts of the legal definition of competency.

The specific content of competency definitions varies from one state to another. Moreover, many states have several definitions of legal incompetency: for example, one for persons needing a guardian for decisions about the patient's general welfare, and another specifically for competence to accept or refuse medical treatment. Assistance from a legal professional may be necessary in order to assure that the clinician fully understands the applicable definition.

Competency as a Legal Construct

Although specific definitions of legal competency vary, reviewers (Anderer, 1990; Brakel, Parry, & Weiner, 1985; Grisso, 1994) have found that the construct has certain features that are relatively consistent across jurisdictions. The modern legal concept of competency has evolved only within the past three decades.

Legal incompetency was once synonymous with serious mental disorder. In contrast, while recognizing that the risk of deficits in decision-making abilities is greater among persons with mental disorders, modern law does not consider the mere presence of mental disorder as warranting a determination of incompetency. Mental disorder is necessary, but not sufficient, for a finding of incompetency. If mental disorder is present, the question of competency then rests on whether the disorder impairs the person's actual abilities to make relevant decisions and, if it does, the degree of that impairment. Thus persons with serious mental disorders are sometimes considered legally competent. By implication, this means that the clinician must assess not only mental disorder, but also its functional consequences for the individual's decision-making capacity.

Legal incompetency was once considered to be an all-or-none condition; one was either competent or incompetent to make all types of decisions affecting one's life. In contrast, the modern legal concept of competency has evolved to favor allowing individuals to retain as much decision-making autonomy as possible. Thus most states' statutes recognize the concept of specific competencies. This means that courts may determine that individuals are incompetent to make decisions in certain

domains of life while allowing them to retain the right to make decisions in all other areas. Similarly, limited guardianship is often assigned by courts, narrowing the guardian's decision-making role to just those areas of life for which the individual's decision-making abilities are not sufficient. This aspect of the legal definition of competency means that clinicians must assess the individual's decision-making capacity in relation to specific domains of life (e.g., financial decisions, treatment decisions), not merely as a general capacity.

A corollary of the legal notion of specific competency is the fairly recent evolution of legal competency as a person-environment concept. Many courts no longer consider legal incompetency as merely a function of the individual's abilities. It depends also on the nature of the specific decisions that the individual must make. Thus whether or not an individual is considered incompetent will require comparing the degree of the individual's decisional abilities to the demands of the individual's specific situation. Less demanding decisional tasks (e.g., understanding a relatively simple and low-risk treatment in an informed consent procedure) require less ability, which lowers the threshold required to find the individual competent in that instance for that specific purpose. Similarly, less ability may be required if the individual has the assistance of a trusted relative in making important decisions. For the clinician, this suggests the importance of assessing not only the individual's abilities, but also the nature and social context of the decisions that the individual must make.

Finally, legal incompetency used to be considered a static, relatively enduring condition. Consistent with recent trends in U.S. law toward maximizing individual autonomy, modern law recognizes incompetency as a current condition that potentially can change. Part of the clinician's assessment, therefore, should be directed toward informing the court of the likelihood of future change in the individual's condition and the potential need for future reassessment.

The Structure of Legal Definitions of Incompetency

Although competency statutes vary across states, they tend to have certain elements in common (Grisso, 1986). In general, they include the following components.

1. Functional component

Most statutes make reference to deficits in certain functional abilities on which the question of competency will focus. These are stated as things that individuals can or cannot do (or for which they manifest relative deficits) pertaining to decision making and judgment. Comprehensive reviews of states' competency laws (e.g., Appelbaum & Grisso, 1988) have found frequent reference to three types of abilities:

- *Understanding*: the ability to comprehend and retain relevant information for a decision.

- *Appreciation*: the ability to recognize, without distortion by patently false beliefs (e.g., psychotic delusions), the relevance of information for one's own situation.

- *Reasoning*: the ability to manipulate information in a problem-solving process (e.g., to weigh alternatives and their consequences).

Not all states' legal definitions of competency refer to all three of these functional abilities. Clinicians should be prepared to describe individuals' abilities of the type that are clearly specified by statute in their own states. The mere fact that one of these abilities is not included by name in a state's definition, however, does not mean that it should be ignored. Most states' definitions, and many courts interpretations of them, are sufficiently broad to find room for all of these potential types of functional deficits, since they are all logically related to decision making.

2. Causal Component

For a finding of incompetency, most statutes require evidence of a clinical condition that accounts for deficits in the individual's functional abilities relevant for decision making. Often this is expressed in general terms (e.g., mental illness or mental retardation), and sometimes the terms used in legal definitions have no clinical synonym (e.g., insanity). Clinicians should make some effort to learn the relation between these terms and specific clinical diagnostic entities, as interpreted in their own states. For example, not all DSM-IV mental disorders constitute mental illness for various legal purposes. Nevertheless, the legal relevance of the clinician's competency assessment will always depend on the ability to identify and explain how a clinical condition (e.g., psychosis, dementia, or depression) may account for the deficits in relevant functional abilities that the clinician has observed.

3. Interactive Component

Statutes often make reference to the decisional context within which the individual's abilities must be considered. Often this takes the form of specific situations or affairs of life about which the individual must make decisions. For example, when statutes refer to "making financial decisions," courts will interpret this as referring to the financial decisions and circumstances of the individual being evaluated. The individual's abilities, therefore, must be weighed in interaction with the demands of the individual's own financial responsibilities. Clearly this requires that clinicians must be aware of these circumstances as part of their competency assessment.

4. Consequential Component

Some statutes specify that the court must determine whether certain consequences, or decision outcomes, are likely to occur if the individual is allowed to make his or her own decisions. Examples include the likelihood that the individual will "dissipate property," will "injure self or others," or is likely to "be deceived by artful and designing persons."

Clinicians are not required to make precise predictions that such outcomes will or will not occur. If they appear in one's statutes, however, they form a legal context that may raise questions for which the clinician should be prepared. For example, the clinician may be able to offer an opinion about the relative degree of risk of such negative consequences. Ultimately, however, the court must decide whether that level of risk is enough to tip the scales in favor of protection of the individual (at the expense of the individual's right to autonomous choice).

Legal Issues in the Evaluation Process

Assessments performed to assist legal determinations of competency require special attention to the rights of examinees and the needs of lawyers and the courts. The following are some of the more

important considerations. Many of them are consistent with ethics in the practice of psychology even if they are not specifically defined by law in one's own state. Additional guidance can be found in the "Specialty Guidelines for Forensic Psychologists" (Committee on Ethical Guidelines for Forensic Psychologists, 1991).

1. When clinicians receive a request to perform a competency assessment, they are obligated to consider whether they are competent to perform it. Failure to do so may raise questions later, when the court is asked to qualify the clinician as an expert for purposes of receiving his or her opinions based on the competency assessment. Professional competence does not necessarily require a high degree of specialization in competency assessments. The main issue is whether the clinician is prepared, by training and experience, to perform assessments and form diagnostic opinions regarding persons like the one who is assessed: for example, the clinician's familiarity with assessment and diagnostic issues associated with older persons.

2. Clinicians also should consider whether their performance of the competency assessment conflicts with their other professional roles. For example, many clinicians do not perform assessments for legal purposes involving individuals for whom they have treatment responsibilities. Mixing the treatment and assessment roles sometimes jeopardizes one's impartiality, as well the patient's trust in the treatment relationship.

3. The clinician should be aware of the specific purpose for which the assessment is to be performed (e.g., the type of legal competency in question). Consultation should be sought prior to the assessment when this is unclear.

4. Typically, legal counsel for the individual should be informed before the assessment is undertaken. This provides an opportunity for consultation between the individual and his or her attorney.

5. Laws often require that individuals whose competency is to be assessed must first be informed of the nature, purpose, uses, and potential consequences of the evaluation. They may also have the right to refuse to participate in the evaluation. When an individual does refuse to participate, the clinician may wish to discuss the refusal with the individual's legal counsel, who in turn might be of assistance in advising his or her client of the value of participation (if legal counsel believes that an evaluation is in the individual's best interest).

Patients will sometimes appear to be so confused or demented that they cannot provide meaningful, informed consent to their participation in the evaluation, even if they seem willing to participate. In these situations, the clinician may need to inform a court of the clinical condition of the individual and seek authorization to proceed with the competency evaluation. In some jurisdictions, approval by the individual's legal counsel to proceed will constitute proper authorization.

In any circumstance of this type, the clinician's report of the competency evaluation should specifically and clearly describe the individual's apparent incapacity to have understood the nature of the evaluation and doubtful competency to have provided informed consent to participate. This allows a court to determine whether to admit the report as evidence in a legal competency proceeding, and it fulfills the clinician's obligation to protect the individual's rights.

6. Assessments for legal purposes require that one adhere to the highest clinical standard of documentation of the process. This pertains, for example, to the careful recording of data one obtains, and the restriction of access to the data by persons not specifically authorized to obtain it as defined by law.

7. Clinicians should remember that reports intended for use by courts cannot be written like reports intended for use by other clinicians. Technical terms should be avoided or, if used, should be defined. Diagnostic labels are helpful only for identifying the disorder; one should not presume that they have any meaning to the reader without further description of them. The clinician should spell out in detail all logical inferences and interpretations (e.g., why it is believed that a particular disorder is responsible for the individual's functional deficits in decision making), many of which might not require explanation in usual discourse with other clinicians.

8. The report should be well organized and complete, including everything that is needed in order to explain one's professional opinion. A clear and comprehensive report often results in fewer complications during expert testimony in court, and sometimes it results in an agreement between parties without the need for lengthy testimony.

9. Courts sometimes expect clinicians to offer an opinion about the ultimate legal question: whether the individual is competent or incompetent. Other courts, however, specifically prohibit this. They ask the clinician only to provide clinical opinions about functional deficits, mental disorders causing those deficits, the potential consequences of the individual's decision-making incapacities, and potential remediation. For the latter courts, whether these facts are sufficient to require a finding of incompetency is not a question for clinical experts. It is a matter for moral judgment by the court concerning the competing values of autonomy and beneficence, given all of the clinical information that has been provided. Clinicians should be aware of the expectancies of the court in their jurisdiction so as to be prepared to deal with these questions about opinions on the ultimate legal question.

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APPENDIX B

ECOLOGICAL VALIDITY

Definition of Ecological Validity

Clinical evaluations for the determination of legal competencies in older adults must be ecologically valid. Here, ecological validity refers to the extent to which the evaluation describes and predicts performance on the specific task in question in the context of specific environmental demands and resources. This appendix focuses on this definition of ecological validity as evidenced in tests of cognition and tests of specific capacities. The appendix reiterates and expands upon several key concepts presented in this guideline and in Appendix A, and provides a brief literature review for interested readers.

Ecological validity in specificity of task and environment

One important element of ecological validity in clinical evaluations for legal competencies is specificity. Just as most state laws are moving from general guardianship determinations to decision-specific or situation-specific guardianships, so must clinical evaluations become more focused on specific decisions and situations. As noted in the guideline, if the referral is not specific, the onus is on the psychologist to determine what is the specific decision or task in question, and, in what situations and under what environmental demands and resources will the decision be made or task be performed. Mediating variables which enhance or diminish performance in the environment must be considered. Psychologists are sensitive to the manner in which behavioral outcomes and level of risk are multi-determined, including the impact of social support, other psychosocial issues, and the environmental context.

Ecological Validity in Decisional and Executional Aspects of Task Performance

It is important to appreciate that evaluations for competency focus on performance that involves decisional and executional abilities (Callopy, 1990). That is, most competency related tasks involve decisional autonomy (judgment, reasoning, planning; such as making decisions about spending) and many involve executional autonomy (behavior to carry out decisions; such as paying bills and handling money).

Measuring Decisional and Executional Abilities

This practice guideline recommends that a clinical interview be augmented by instruments to assess mental health as well as tests of cognition and tests of specific capacities. As noted in Figure 1 on Page 12, tests of cognition and tests of specific capacities often complement each other in providing information about everyday functioning and in this way maximize ecological validity. Ecological validity in tests of cognition and tests of specific capacities is further delineated in Table B-1 (on the following page).

Tests of cognition often provide important information about decisional aspects of everyday functioning and competency issues, or whether the person has the requisite attention, memory, reasoning, and problem solving to think and decide about specific issues or tasks. As such, tests of cognition often have important predictive value for assessing everyday functioning and legal competencies. Empirical investigation of the ecological validity of cognitive tests often relies upon the predictive validity of tests.

TableB-1	
Tests of Cognition	Tests of Specific Capacities
Useful in predicting everyday functioning.	Useful in describing everyday functioning.
Focuses on decisional aspects of everyday functioning.	Focuses on executional aspects of everyday functioning.
Often concerned with predictive validity.	Often concerned with content validity.

Tests of specific capacities often provide important information about executional aspects of everyday functioning and competency issues, or whether the person can carry out the decision or task in question. As such, tests of specific capacity often have important descriptive value for assessing everyday functioning and legal competencies. Empirical confirmation of the ecological validity of tests of specific capacities usually concerns the content validity of the tests; does the test adequately sample the domain of behaviors in question. This distinction is somewhat blurred in that the specific capacity or legal competency in question may be medical decision making capacities. Still, general cognitive abilities, measured by tests of cognition, and decision making abilities, measured by test of specific decision making capacities, can be used together in the determination of legal competency for medical decision making.

Some psychologists may be most familiar with tests of cognition and concepts of predictive validity. As such, utilization of tests of specific capacities may require a shift in thinking and greater attention to the relationship between tests of cognition and everyday functioning.

Prediction of Everyday Functioning from Tests of Cognition

There is an extensive literature on the prediction of brain function from tests of cognition. The literature regarding the prediction of everyday function from tests of cognition is more limited. A brief review of this literature is provided below.

A growing body of research has documented a central role of cognition in the prediction of performance of ADLs, such as hygiene, dressing, eating, transferring, and toileting. In a series of studies (Lichtenberg et al., 1994; Moore & Lichtenberg, 1995) the Dementia Rating Scale (DRS) predicted initial and discharge ADLs, even after demographic and medical variables were considered. In an earlier study (McCue, Rogers, & Goldstein, 1990), 45% of the total variance associated with cognitively oriented self-care tasks and 29% of the total variance associated with physically oriented self care tasks was accounted for by neuropsychological variables among elderly psychiatric patients. In another study (Searight et al., 1989), 33% of the variance associated with ratings of everyday function was accounted for by selected neuropsychological variables among geriatric patients. Specific ADLs such as upper extremity hygiene and eating have been correlated with neuropsychological test performance (Titus, Gall, Yerxa, Roberson, & Mack, 1991; Nadler et al., 1993).

Similarly, a growing body of research has demonstrated the role of cognition in predicting IADLs, or the more advanced tasks necessary for independent living such as using the telephone, shopping, meal preparation, cleaning, laundry, use of transportation, handling finances, and medication adherence (Lawton & Brody, 1969). The degree of cognitive impairment has been found to be the best predictor of return to independent living among patients with severe impairment (MacNeill & Lichtenberg, 1996). Specific IADLs have been correlated with specific neuropsychological tests, especially visuospatial problem solving, memory, and measures of global functioning, as follows.

Medication Compliance: Several studies have found a relationship between visuospatial problem solving, memory, and medication management. Richardson, Nadler and Malloy (1995) found visuospatial problem solving (Hooper) and memory (WMS-R) tests most correlated with medication administration. In another study, (Palmer & Dobson, 1994) independence with medication, as measured by the ability to ask for medication and to comply with a 24 hour supply of medication was best accounted for by performance on visuospatial problem solving (Block Design), memory (CVLT), and self-rated memory ability. In a third study (Isaac & Tamblyn, 1993) visuospatial attention (Letter Cancellation) and visual memory (WMS) was associated with accurate medication compliance.

Driving: Two studies have found a relationship between visuospatial skills, general cognition, and driving. In one study (Odenheimer et al., 1994) driving skills assessed in a road test were correlated with general cognition (MMSE), visual attention (Trails A), memory (WMS-R), and complex reaction time. In another study (Owsley et al., 1991) accident frequency was associated with useful field of view and general cognition (Mattis Organic Mental Status Syndrome Examination).

Money Management and Other IADLs: Several studies have demonstrated a relationship between visuospatial problem solving, general cognition, and money management as well as other IADLs. Visuospatial problem solving (Hooper) and memory (WMS-R) were correlated with money management, and overall safety and community utilization in older psychogeriatric patients (Richardson et al., 1995). General cognition as measured by DRS or MMSE has been related to money management and other IADLs in several studies (Caron & Lichtenberg, 1996; Lowenstein et al., 1992; Nadler et al., 1993).

In summary, in recent years, a modest but growing line of research has found that cognition is predictive in the performance of ADLs and IADLs. Tests of visual-spatial and memory abilities may have an important role in the prediction of specific functions such as hygiene, dressing, medication compliance, money management, and driving. The reasons underlying the predictive value of these tests remains to be clarified, and likely involves latent demands shared between the tasks, such as fluid abilities related to problem solving in novel situations. Shortcomings of some studies include the appropriate measurement of everyday functioning, small samples, failure to measure potential mediator variables such as age and education, and lack of multi-variate analyses. In addition, much of the data has been collected on psychogeriatric patients or community volunteers, and cannot be generalized to other samples, such as adults with low levels of education or ethnic minorities.

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APPENDIX C

EXAMPLES OF GUIDELINE APPLICATIONS*

Example 1: Decision Not to Conduct an Evaluation

Mr. A, an 84 year old patient in a VA Nursing Home Care Unit has a brother who asserts that he is no longer competent to manage funds. The brother asks the treatment team to conduct a competency assessment for purposes of appointing the brother a guardian of Mr. A's funds. The physician on the team asks the psychologist whether such an evaluation is indicated.

In a review of the medical chart, the psychologist notes that Mr. A requires assistance in ambulation due to a hip joint placement for which he is receiving physical rehabilitation, and that he also requires assistance in eating due to a severe arthritic condition in his hands. The psychologist further notes that Mr. A is on self-medication orders and reliably follows that schedule. Nursing staff also indicate that Mr. A is a regular participant in unit activities with no need to remind him of schedules for eating and other activities. One nursing staff notes that he particularly enjoys attendance at hospital Bingo games and is a frequent winner.

In an interview with Mr. A by the psychologist, Mr. A indicates that his brother has been trying to get control of his funds for 10 years and is not surprised by the brother's request. He suggests that the psychologist contact the patient's sister for more information on the family conflicts (which are also described in the patient's medical record by a previous social worker contact with the sister.)

The psychologist enters a note regarding the brother's request in Mr. A's medical record and notes that the ADL deficits responsible for his need for nursing home care at this time are not related to the capacity for managing funds. The psychologist further notes that Mr. A's behavior on the unit suggests no memory problems nor other evidence for problems in judgment which would affect money management problems and recommends that a formal competency assessment not be conducted at this time.

Example 2: Decision to Delay Assessment

Mr. B is a 70 year-old widowed male with two prior admissions for alcohol detoxification who was admitted to a geropsychiatric unit one week ago because of inappropriate behavior and confusion related to drinking and not taking proper care of himself. His house was filthy and roach-infested. Since his wife died one year ago, Mr. B has been living alone, his drinking has increased, and his memory has gotten worse. He severed contact with his two children years ago and has no other social support except for an older sister. She has been trying to help him as best she can, but says she can no longer visit him daily due to her own recent medical problems. She desires that he be placed in a nursing home, but he has consistently refused to agree to placement. The nursing home will only admit him if he has a guardian to sign him in. The psychiatrist requests a psychological evaluation of competency.

The psychologist peruses his chart and finds that the admitting diagnosis is delirium due to alcohol and a rule-out of vascular dementia. There is evidence on the CAT scan and MRI consistent with heavy alcohol

**These examples are solely intended to illustrate key concepts in the use of the guidelines. Because specific data may vary from case to case, these examples should not be used alone to make decisions on individual cases.*

usage and multi-infarcts. In addition, he has hypertension, stomach ulcers, and early stage cirrhosis. However, the nurses report that Mr. B has become more alert by the end of the first week in the hospital and has begun to feed and dress himself, although he continues to have some difficulties following directions and remembering recent events. He now admits that drinking is a problem, but says that he doesn't want to stop completely.

This is a common and appropriate referral for psychologists providing services on a geropsychiatric inpatient unit. Given the patient's recent heavy drinking and significant physical problems requiring acute treatment, the psychologist decided to proceed cautiously and administered the Mini-Mental State Exam (MMSE) and the Dementia Rating Scale (DRS). Mr. B received a score of 15 on the MMSE and 100 on the DRS, both falling within the significantly impaired range of cognitive functioning. However, he showed significant variability on the DRS subtest scores, with the Attention and Initiation/Perseveration subtests particularly impaired. A qualitative analysis revealed that he answered some of the more difficult items correctly but failed relatively simple questions. For example, on the MMSE, he knew the day and the month but missed the year. At this point the psychologist deemed it advisable to defer further testing until his medical condition stabilized and his mental status cleared.

Although the neuroradiological findings are positive, it would have been an error to hastily conclude that Mr. B was incompetent due to the possibility that the initial psychological testing results reflected an acute rather than chronic condition, and the frequent lack of clear association between neuroanatomical findings and functional behavior. If psychological testing proceeds just prior to discharge after Mr. B has further cleared, and the results suggest cognitive deterioration severe enough to warrant a recommendation of incompetence and nursing home placement, then re-testing should be strongly considered in at least six months. This will help determine if the routine structured nursing home environment has gradually improved his physical and mental functioning enough for him to become competent. Re-testing should be considered even if he still maintains that he will drink again after he is discharged, because many young adults hold the same view without ageist accusations of incompetence.

Example 3: Decision in Support of Decisional Capacity

A psychologist received a request to "evaluate competence" of Mr. C--a 69 year old male patient, from a psychiatrist on an acute psychiatry unit where she consults. She asked the psychiatrist to clarify in writing the nature of his concerns and she also spoke with him about his concerns. He noted that Mr. C's son had spoken of selling the home in which he and his father lived prior to the father's admission for increased insomnia and agitation. The psychiatrist was concerned about Mr. C's abilities to consent to this decision at this point in time, and whether the team should intervene to avoid the possibility of exploitation. Two months ago he had an acute medical condition which resulted in some decline in cognition, and also has had long-standing psychiatric difficulties characterized as atypical depression and anxiety. The psychiatrist was concerned about the possible effects of either cognitive or psychiatric dysfunction on Mr. C's capacity to consent.

The psychologist reviewed Mr. C's medical record to gain information about his medical and psychosocial history and his current medication regimen, to begin planning for the evaluation, and to insure she was qualified to perform an evaluation of his mental status and abilities relevant to the competency concern. The patient was new to the psychologist; she had not had a previous psychotherapeutic or professional relationship with him or his family. The psychologist, who carries hospital privileges in neuropsychology and medical psychology, determined she was qualified to perform the evaluation, but first gained more information about the acute medical condition resulting in the cognitive decline through request and review of old records and consultation with another staff member expert in the medical condition.

After deciding to proceed with the evaluation, the psychologist interviewed a number of unit staff, including the charge nurse, nursing assistants, and the occupational therapist, to gain more information about Mr. C's function on a daily basis. In particular she asked about potential fluctuations in mental status throughout the course of the day and his interactions with others. She then approached him to gain his consent for the evaluation. She explained the nature of the evaluation, what would be involved, and what the purpose was, and how the report would be used, asking specific questions about his understanding of the plans to sell his home. On the morning of the evaluation she again spoke with unit staff, reviewed recent progress notes, and spoke with Mr. C to determine that he was clinically stable to undergo the evaluation.

The evaluation consisted of a comprehensive clinical interview which included an assessment of Mr. C's current psychiatric symptoms, substance use, psychosocial history, and values and preferences regarding his relationship with his family, the management of his assets, and his goals for the future. He was then assessed with cognitive tests consisting of subtests from the WAIS-R, WMS-R, and brief executive function screening tools. Finally, he was assessed with subscales of the Independent Living Scales to gain more information about specific capacities relevant to financial management and home care management.

The evaluation found that Mr. C was more clinically stable now, and that his difficulties with agitation and insomnia which had resulted in his admission, had remitted with hospitalization and medication. In reviewing the history in the medical record and with the patient, he appeared to struggle with anxiety and be at risk for escalation to delusional thinking, although he did not currently meet criteria for an Axis I disorder. He had a history of alcohol dependence, which was in sustained full remission for more than eight years. Cognitive testing found intact memory, and mild to moderate deficits in abstract and integrative problem solving, which appeared to be consistent with life long learning patterns and educational achievement rather than a new onset neuropsychiatric disorder. Cognitive testing was compared to previous testing and scores had improved since the acute medical episode. Specific capacity testing found he had a concrete approach to managing his assets and home, and that his explanations of reasoning underlying related decisions and social situations were vague, although not clearly impaired. His family had been providing care for him for a number of years and the consideration of selling the home was related to concerns about the appropriateness of the size of the home for Mr. C's needs and the difficulty in maintaining upkeep on the home given his age and medical status. The patient and family reported there was not a financial gain to be made in selling the home.

The psychologist concluded that Mr. C did display some mild degree of difficulty in problem solving typified by a concrete and acquiescent approach, but that the impairments were not significant enough to recommend adjudication, nor did there appear to be significant risk for exploitation. The psychologist described the results of the evaluation in a written report, including diagnostic impressions and functional implications. She recommended continuing diagnostic clarification, work with the family to monitor the situation, and interventions to increase Mr. C's opportunities for socialization which he desired. She informed the clinical staff when the report was filed, and stated her availability to discuss the report. The psychiatrist responded after the team had reviewed the report, and stated that the written report had clarified the issue and resolved the team's concerns.

Example 4: Decision to Recommend Petition for Guardianship

Mr. D is an 74 year-old married male who was admitted to the VAMC nursing home care unit about a month ago for an extended respite stay while his wife recovered from major surgery. He and his wife live alone in a first floor apartment about two hours away from the medical center. He had a left below the knee

amputation about a year ago. His medical record includes a history of diabetes, peripheral vascular disease, hypertension, coronary artery disease, and new diagnosis of multi-infarct dementia given after a medical work-up. He is totally dependent on a caregiver for assistance with bathing, dressing, transferring. His wife's recovery is proceeding slowly. Even after several more weeks of strengthening, it is unlikely that she will be able to provide the same level of care. Mr. D is at risk of eloping if left unsupervised. Unless there is a 24-hour/day, fully ambulatory caregiver in the home, his home is not a safe place for him to be. His wife has asked that he be transferred to a nursing home in their community. The treatment team doubt that he is aware of his needs and risks. There is no durable power of attorney or other type of advance directive. Mrs. D is willing to pursue guardianship and protective placement. The team has requested a psychological evaluation as a step toward the legal process.

Several attempts were made to secure informed consent from the patient. He was fully alert and did not object, but he was consistently unable to demonstrate an understanding of the purpose of the evaluation. Given the overall circumstance and after consultation with the team and with Mrs. D, it was decided to proceed with the assessment and document the problems with the consent process. The plan was to focus on cognitive function and the ability to participate in health care decision making and to have at least two assessment sessions.

The MMSE had already been administered twice, and both times it was indicative of at least moderate impairment (11/30 and 15/30). Additional testing expanded upon but was consistent with the MMSE. He was oriented only to person. The remainder of his orientation responses were grossly inaccurate. He performed within average range on a digit span task, but all other cognitive measures (including short- and long-term memory) showed moderate to severe impairment. During a structured interview about health care decisions, he was unable to demonstrate any appreciation of the general terms of a relationship between physician and patient or of his own condition, care needs, and limitations.

A report was written in the format and style required by the state for the adjudication process. The effort made to obtain consent from Mr. D was described along with the consultation process that resulted in the decision to go ahead with the evaluation. The report outlined the patient's history, diagnoses, social situation, and current psychological functioning. It concluded with the statement that patient appeared to lack adequate decision making capacity for his own safety regarding his person, estate, and health care, and that it appeared in his best interest that a guardian be appointed. The apparent (irreversible) etiology for this condition was noted. Verbal feedback was given to Mrs. D, and to the treatment team, including some recommendations for improved consistency and structure in his daily routine.

Example 5: Specific Incapacities Due to Depressive Disorder

Mr. E is an 83 year-old widowed male with long-standing cardiovascular and pulmonary disease, who was brought to the clinic by his children as a walk-in, with the complaint that he could no longer care for himself. His son and daughter both live approximately 100 miles away, and were accustomed to visiting him approximately every three months on a rotating basis. When the son came for his visit, he found that Mr. E's house was dirty, and in total disarray. He apparently had been wearing the same clothes for several weeks. His bills had not been paid, and they found one check that had been written for the wrong amount. There was very little food in the house, and he would not be specific about his food intake. He stated that neighbors were bringing him food. Neighbors denied this, reporting that he was staying in his house a lot, and was no longer his usual friendly self. The son expressed his concern, but Mr. E refused to talk about anything, saying that he was all right and didn't need any help. The son then called his sister, who came immediately, and after several failed

attempts to communicate with her father, they decided that he must have had another mild stroke or something and took him to emergency. After a review of his symptoms and current medical status, they called his primary physician. Upon examination, his physician found no marked change in his condition other than a seven-pound weight loss. She administered the MMSE and his score was 20, which was considerably lower than usual. Mr. E was disoriented to time, could do only one of the serial sevens and missed all of the recall items. He was scheduled for a more detailed psychological evaluation by the clinic psychologist, and consults were sent to neurology and nuclear medicine for imaging studies.

Mr. E typically has an appointment at the Geriatric Outpatient Clinic every three months for a routine evaluation of his medical problems, and had been seen approximately two months prior to this walk-in visit. A quick chart review revealed no unusual medical problems. At that time he did relate a disconcerting story about driving his car to San Francisco to take care of a legal matter. He apparently missed a turn, and as a result became confused about his exact location. After driving around for a while, which included turning the wrong way on a busy one-way street, he found a parking place that he thought was close to his destination. However, he was unable to parallel-park, and trusting soul that he is, he asked a stranger to park his car and look after it while he completed business. With the help of the police, he found his car abandoned a few blocks away. After hearing this story, the clinic staff was concerned about his ability to continue driving. A brief neuropsychological examination was competed at that time which revealed his general cognitive functioning to be above normal for his age and education level. Clinic staff admonished him to curtail his driving to places in his local community, and attempted to set up an appointment time for a driving assessment. He stated that he would comply with their request, and therefore, felt that the driving assessment could be postponed until a later date. Mr. E lives alone in cozy bungalow located in a small community approximately 25 miles from San Francisco. On home visits, clinic staff have always found it to be clean and orderly. For the most part, his driving is limited to going to the store, his church and an occasional outing at a friends home nearby.

Mr. E's children talked to his primary care physician and the social worker about future living conditions for him. They discussed the possibility of placement in the VA extended care, or whether they should consider taking him to one of their homes. It was agreed that before any decisions were made, Mr. E should be admitted to the Geriatric Evaluation and Management Unit for further study.

Psychological testing indicated that Mr. E was severely depressed. His score on the Geriatric Depression Scale was 23 out of a possible 30, and his responses on the Schedule for Affective Disorders and Schizophrenia revealed symptoms compatible with a diagnosis of Major Depressive Disorder (Severe), single episode precipitated by realization that he must constrain his driving activities. His level of cognitive function was considerably lower than his expected level corrected for age and education. His performance on tests of abstract functioning and learning and memory were poorer than his performance on tests reflecting highly overlearned skills, but even these were in the moderate to severe range of impairment. A more detailed analysis of his performance revealed that he was inclined to give up easily on difficult items, by saying simply, "I don't know the answers to these questions". His performance on the Logical Memory section of the Wechsler Memory Scale and the Rey Auditory Verbal Learning Test also revealed a pattern of impairment consistent with a diagnosis of severe depression. For example, his immediate recall was in the impaired range, but his 30 minute delayed recall showed 100% retention of immediate recall material. Cued recall improved by 40% and recognition recall by 60%. On the AVLT, he recalled four words on the first trial (the first two and the last two). By trial five he recalled eight words. Thirty minute delay resulted in the loss of only two words (80% delayed recall), and recognition memory yielded three additional words, which is near normal for his age and education level. Based on his overall performance on psychological tests, it was argued that much of his impaired functioning in his home situation might be due to depression, brought on by the stress of required

changes in life style due to self-imposed driving restrictions.

Detailed neurological and neuroimaging studies revealed no evidence of new cerebral damage. Treatment of his depression was implemented in the GEM which included medication and case management for solving life style changes. Initial treatment efforts were successful, and Mr. E is able to continue living in his home. He continues to see a therapist to learn how to overcome life style changes.

Example 6: Including Patient Preferences within Decision of Incapacity

A psychologist was asked by a primary care physician to help with assessment for medical decision-making capacity. Mrs. F, the patient, was a 78 year old woman described as mildly retarded with superimposed dementia, but with no prior formal assessment. She had no known living relatives; a social service agency had been assigned guardianship, but had played no active role. Among her many medical conditions was an inoperable, slow gastrointestinal bleed, which required frequent blood transfusions to sustain life. Mrs. F had recently begun to pull out her IV tubes and show other signs of resistance to medical treatment. The primary care physician was concerned that the non-compliance could be demonstrating a desire to withdraw/withhold treatment. However, he was unable to get verbal confirmation or denial of this from her.

The psychologist met with the primary care physician to clarify the referral question. It was decided that the woman, in all likelihood, was not decisionally capable for health care decisions, based on the fact that she had not shown understanding of her condition, nor the ability to weigh risks and benefits of alternative treatments, nor was she able to verbally communicate her values, goals, or preferences.

However, even in the context of decisional incapacity, the physician still requested help with understanding Mrs. F's preferences. The medical decision-making was delegated largely to him, as the agency guardian passively accepted his recommendations. He had been unable to elicit verbal communication from her. The psychologist conducted the examination at Mrs. F's bedside. The patient made eye contact and appeared to hear, but the psychologist was unable to elicit a verbal response to questions. Finally, after ten minutes of unsuccessful attempts at communicating, the psychologist asked Mrs. F in a loud voice, "Do you want to live or do you want to die?" She sat up in bed and declared in an equally loud voice, "I want to live!"

The psychologist reported this finding to the physician, who then incorporated Mrs. F's preference into a treatment plan of continued transfusions.

The case serves to illustrate the value for both patient and provider of considering patient preferences in decision-making, even when an individual is decisionally incapacitated.

Example 7: Assessment of Elders for Whom English is not the First Language

Mr. G is a 66 year old American citizen of Hispanic origin (he legally immigrated to the United States in 1946 from Mexico, and became a citizen in 1950), who is showing signs of memory loss, cognitive confusion, and poor functioning in his activities of daily living. He had been educated in Mexico where he completed the sixth grade and then became a laborer. He worked on many different jobs requiring manual labor until he came to this country, when he quickly enlisted in the Army to serve in the Korean War. Mr. G was particularly interested in this option since he wanted to obtain a better education and become more proficient in a particular trade through the GI bill benefits. He became a radio communications person in the Army and served on

active duty while in Korea. After an honorable discharge, Mr. G married and was gainfully employed in the communications industry until age 62, when he began showing signs of cognitive slippage.

Mrs. G reported that her husband seemed to lose his way easily, made mistakes handling his money, and became more demanding of attention from her. He neglected his hobby of gardening, and spent more time alone, with little contact with his grandchildren. He also began, over this four year period, to speak more and more Spanish in the home (although English had been the preferred language in his marriage and his dealings with his family, as well as on his job). By the time he was brought for an evaluation of his cognitive and functional capacities, which was requested by his family because of concern that he might spend down his savings and make poor financial decisions), he was speaking almost exclusively in Spanish and seemed quite suspicious of his family members.

Mr. G had never been evaluated for dementia previously, in fact, his family did not come in saying they thought he had Alzheimer's disease and they wanted a confirmation of the diagnosis, rather, they complained to his VA primary care physician that he was "acting strangely" at home. The physician attempted to complete a brief mental status screening (based on the Mini-Mental State Examination), but Mr. G was unable to respond to the questions at all, since they were given in English and he had lost his command of this language. Therefore, he was referred to the staff psychologist for further evaluation based upon his family's report of significant cognitive and functional impairments. However, the psychologist was not bilingual, nor was he familiar with several recent modifications of the MMSE that were developed specifically for Spanish-speaking persons of low literacy level. The psychologist's approach was to attempt to administer a more detailed, multifaceted cognitive screening battery (e.g., the former neurocognitive mental status examination, now called Cognistat). He began by asking questions in English and having Mrs. G translate both his questions and her husband's responses. However, he soon realized this was unsatisfactory because Mrs. G had no training in psychology, seemed very hesitant about her role, and appeared to the examiner to be "correcting" her husband's wrong answers (e.g., on calculation items) and giving her more well reasoned out and correct responses instead. When asked about this directly, Mrs. G agreed that, according to dominant cultural norms in the Hispanic community, Mr. G should not "look bad" to outsiders; therefore, to preserve his dignity and to save face she responded as if there were no memory, concentration, or calculation problems. The psychologist had to explain that the purpose of this evaluation was to determine Mr. G's strengths and weaknesses in terms of everyday functioning, so that appropriate help could be arranged for both of them. Mrs. G then agreed to try to be more accurate in her translations of his responses, but instead, the psychologist requested that a professional interpreter be brought in for the evaluation. This proved to be a much better solution because it allowed for a much more accurate assessment of the patient's capabilities. In fact, there was clear evidence of dementia, along with inability to independently perform most ADLs and IADLs (as verified by the wife, once she realized the importance of being frank about Mr. G's limitations).

Once the diagnosis was confirmed (through additional physical and radiological testing), Mr. G became eligible for several programs (e.g., Alzheimer's day care) at his local VA that were designed to help maintain as much independence and dignity as possible, and his wife began regular attendance at a support group designed to help her understand and cope with this progressive disease.

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