Appendix 1: Capacity Assessment Algorithm for Lawyers

Are there any observational signs of diminished capacity?

If No, Proceed with transaction.

If Yes, Are there any mitigating factors that explain observational signs?

If No, Address mitigating factors. Re-evaluate later.

If Yes, Perform Legal Analysis

1. Consider legal elements of capacity for transaction at hand.
2. Weigh abilities in view of factors such as consistency with values and commitments, fairness of decision, irreversibility of decision.

Categorize legal judgment

- Intact: Proceed with transaction.
- Mild Problems: Proceed with transaction OR Consider medical referral, clinical consultation, or evaluation.
- More Than Mild Problems: Proceed with transaction with caution OR Consider medical referral, clinical consultation, or evaluation.
- Severe Problems: Do not proceed with transaction.

Summarize observations, and, if appropriate, legal analysis and decision, and actions to be taken in a file note.
Appendix 2: Case Examples

Introduction to Case Examples

In writing this handbook, the working group considered four possible types of case examples: (a) a case of an older adult with intact cognition and judgment, with no evidence of incapacity, who is asking for assistance with a legal transaction; (b) a case of an older adult with mild problems with capacity but where the attorney proceeds with the transaction either because the risk and complexity of the transaction are low, or after informal consultation and clarification with a clinician; (c) a case of an older adult with more than mild problems with capacity and where the lawyer seeks formal assessment; (d) a case of an older adult where the capacity problems are severe and rather obvious and the lawyer cannot proceed even to representation.

The first type of case, with intact capacity, would represent the majority of a lawyer’s older adult caseload. We decided that it would likely be most helpful to include examples of cases with more than mild problems, and where the lawyer does seek formal assessment, in order to illustrate the type of case where this might occur, provide examples of good quality assessment reports, and describe how the lawyer used such reports to guide follow-up action. In contrast, we presumed that lawyers would not find it necessary to review case examples where capacity or incapacity were obvious. As such, the following two examples illustrate situations with more than mild capacity problems and where an attorney sought formal assessment. In the following case examples, the formal assessments were written by psychologists. As noted in the handbook, the style of the report received will vary depending on the discipline of the assessor. These reports are more typical of what a lawyer would receive from a psychologist rather than a physician or psychiatrist.

CASE EXAMPLE #1: Contract, Will, and Finances

A. Example of Attorney Model Referral Letter

RE: Referral of Mr. Patient for Mental Health Assessment

Dear _________:

As we discussed by telephone, I am writing to make a referral of Mr. Patient for a neuropsychological assessment, with emphasis on his capacity: (1) to contract, (2) to make a will, and (3) to manage his business and financial affairs, as well as (4) his vulnerability to undue influence.

Background

I represented Mr. Patient and his now deceased wife several years ago in preparing their estate plan. Recently, Mr. Patient requested that I redraft a will for him and also prepare a buy/sell agreement for him with respect to his company Happy Valley Construction, which he owns with his brother James. Mr. Patient is 76 years old, was born and raised in Columbus, Georgia, and lives alone in his home of 34 years, although he receives home care services every day. His wife of 40 years died in 1990. He has two married daughters and one disabled single son. His daughter, Mrs. Daughter, is the only one who lives close by. She regularly helps him with shopping, paying bills, cooking, and light housekeeping. She is also named as his agent on his general durable power of attorney for financial affairs. However, she has not yet assumed the role of acting as his agent or attorney-in-fact.

As a result of my preliminary information gathering of his business and personal financial circumstances, as well as direct observations of Mr. Patient, I recommended to him that he undergo this formal evaluation. He consented to undergo the assessment, to have the results of the assessment released to me (release attached), and to pay the cost of the assessment. He should be billed directly by you. He has also consented to your contacting his daughter for additional background information.
Appendix 2: Case Examples

Triggering Issue

Mr. Patient’s daughter, Mrs. Daughter, called my office to make an appointment for her father to review a contract (a buy-sell agreement) that Mr. Patient’s brother asked him to sign. She also said that her father wanted to discuss rewriting his will.

I met with Mr. Patient on x/xx/xx for part of the time in private and for part of the time with his daughter present. While he appeared well-groomed and dressed appropriately and was able to describe the purpose of his visit, he showed considerable difficulty understanding the contents of the contract his brother asked him to sign. The buy-sell contract would give his brother a first option to acquire his interest in their closely-held family company (Happy Valley Construction) on very favorable terms. But it also goes a significant step further in vesting the entire company in his brother upon Mr. Patient’s death and forgiving several unspecified loans made by Mr. Patient to the company. The daughter expressed concern that her uncle is taking advantage of her father’s diminished health in urging him to sign such a one-sided agreement.

As to his will, he urgently wants to redo it, now that his wife has died (although her death is now several years passed). I had prepared his current will when his wife was still alive. Under his current will, his disabled son would receive half the estate in trust, while the two daughters would each get one-quarter of the estate. He states that he now wants everything to go equally to his three children, but he appears to be confused about the nature and extent of property in his estate and about the terms of his present will.

His daughter also reports high levels of forgetfulness, confusion, and poor judgments, especially around financial transactions. She is concerned that he is unable to handle neither his business nor personal financial affairs, and she currently does most of his personal bill paying for him.

Relevant Legal Standards

**Contractual capacity.** In this state, the test of whether party has sufficient mental capacity to execute a valid contract is whether he is possessed of sufficient mind and reason for a full and clear understanding of the nature and consequences of making the contract. A more complicated contract calls for a higher level of capacity than a simple one. While a buy-sell agreement is not unusually complex, the proposed agreement in this case goes well beyond the usual buy-sell terms, and would in effect be a will substitute for a major part of his estate, as well as forgiving several loans (the number or amount of which I have not yet verified).

**Testamentary capacity.** In this state, the capacity to make a will is defined as requiring: (1) an understanding that a will is a disposition of property to take effect after death, (2) a general understanding of the property subject to the will, (3) a knowledge of the persons related to him by ties of blood and of affection who would be the usual beneficiaries of a will, and (4) an ability to conceive and express by words, written or spoken, or by signs, or by both, any intelligible scheme of disposition. It is possible for one to have testamentary capacity but not contractual capacity.

**Legal incapacity to manage one’s property.** This is the standard used to determine the need for a court-appointed guardian in this state: a court may appoint a guardian for a person who is: (1) incapacitated by reason of mental illness, mental retardation, mental disability, physical illness or disability, chronic use of drugs or alcohol, detention by a foreign power, disappearance, or other cause; and (2) as a result of such condition, incapable of managing his or her estate, and (3) the appointment is necessary either because the property will be wasted or dissipated unless proper management is provided or because the property is needed for the support, care, or well-being of such person or those entitled to be supported by such person.

**Undue influence.** “Undue influence” is influence that amounts either to deception or to force and coercion which destroys free agency. It is recognized that lesser amount of influence may be necessary to dominate a mind that is impaired by age or disease. However, honest persuasion or argument does not constitute undue influence in the absence of fraud or duress when the individual in question has the mental capacity to choose between his original intention and the wishes of the other person.
Medical/Social/Functional Information

Mr. Patient reports that he is on medication for diabetes and heart problems. His daughter reports that he had bypass surgery in 1989 or 1990 and that he had surgery on his lungs in 2000. His personal physician is Dr. Medical, at (address and phone). My contacts with Mr. Patient go back 15 years, and he was always quite knowledgeable in business affairs, very caring of his family, and active. My own observations are that he is now clearly quite frail and variable in his level of understanding, alertness, and confusion. Only his daughter appears to have regular contact with him. She is very concerned about his welfare and very distrustful of her uncle. The uncle essentially runs the business alone now, but maintains contact with Mr. Patient. Mr. Patient appears to have great trust in his brother.

In summary, I request an evaluation for the purposes described above. Please include the following in your assessment report if possible:

- Mental health diagnosis
- Tests conducted
- Analysis of test results
- Applicability to situation at hand
- Specific assessment of the ability of Mr. Patient to:
  - execute a contract (the buy-sell agreement described above)
  - make a will
  - manage his business and financial affairs
- Assessment of his vulnerability to undue influence
- Suggestions for improving his capacity or accommodating his deficiencies, if any.

I understand that the evaluation and report can be completed by x/xx/xx. If that time frame changes, please let me know. Please send your report to me at my Columbus office address. I appreciate your help with the case and look forward to working with you in the future.

Sincerely,
I. BACKGROUND INFORMATION

Mr. Patient was referred as an outpatient to the Neuropsychology Clinic by his attorney, Mr. Legal, Esq., for evaluation of the patient’s cognitive and emotional status, and capacities to contract (execute a buy/sell agreement), manage his overall business and financial affairs, and make a will.

History of Present Illness: Mr. Patient reportedly has a 3- to 5-year history of memory problems, which reportedly developed insidiously and have gotten progressively worse over time. He reportedly has not been previously evaluated for these problems.

In interview, Mr. Patient stated that he does not have any problems with his memory. He also generally denied any other cognitive or functional problems. He stated that he does not have any help at home, but that his daughter comes by sometimes to help him pay bills or to bring him groceries. He denied problems with his driving. Regarding mood or personality changes, he reported that he is “doing fine” and denied any symptoms of depression or anxiety. Upon inquiry by the examiner, he expressed only a vague knowledge of a buy-sell agreement regarding his business that has reportedly been prepared by his brother.

Mr. Patient’s daughter, Ms. Daughter, described a much more serious situation. Ms. Daughter said that her father has had memory problems for at least 5 years, and that his memory has become noticeably worse over the past 3 years. She said that she first noticed something was different when she left her accounting job in the family business in 1998 over some disagreements with her uncle James, who co-owns the business with her father. She said that her father did not seem to be taking up for her, which was uncharacteristic of him. She said that she later realized that her father was forgetting about these disagreements and his role in resolving them. Ms. Daughter reported that he currently asks the same question repeatedly, forgets conversations, and constantly misplaces items. She said that he has more trouble remembering people’s names. She said that he has comprehension problems, but pretends to understand people when they talk to him. She reported that when they go to restaurants, he gets lost on his way back from the restroom. She reported that he has not driven since July 2000 when he had lung surgery. She said that just prior to that, he complained to her about getting lost while driving in a familiar area.

Regarding functional changes, Ms. Daughter reported that her father has no meaningful activities around the home. He has had full-time caregivers since July 2000. She noted that he still cannot remember their names. She reported that prior to these home health care arrangements, her father was not bathing and was wearing the same clothes every day. She reported that she has handled all of her father’s bill paying since October 2000. She said that she also tries to supervise his business transactions. Ms. Daughter reported that her father co-owns an excavation business Happy Valley Construction, with his brother James. The business is located in Columbus, Georgia.

Mr. Patient reportedly has a separate business where he also buys, develops, and sells real estate. Ms. Daughter stated that her father has agreed on several occasions to consult her before signing any business documents, but then forgets to do this.

Ms. Daughter reported several poor business decisions her father has made recently. She said that in the past year he sold a piece of real estate for $10,000 that was worth $100,000. She also reported that he has made almost $500,000 in loans to the family business over the past 2 years, and that these loans have not been repaid. She reported that her father initially loaned $200,000 to Happy Valley in 1998, $90,000 of which went to his nephew, who also works for the company. She stated that there does not appear to be a note for the loan to his nephew. She reported that the remaining $300,000 was loaned out in October 2000.

Ms. Daughter also expressed concern about a proposed buy-sell agreement that was presented to her father by his brother while she was out of town. This agreement reportedly presents terms that are very favorable to the brother. It apparently states that if her father dies, the company will go to her uncle James and the money owed by the
company to her father will be forgiven. She noted that in this buy/sell agreement, some property that belongs to her father is listed instead as company property. Upon learning of this agreement, Ms. Daughter encouraged her father to contact his attorney Mr. Legal to discuss this.

Finally, Ms. Daughter expressed concern about whether her father may have recently signed a new will. Although he has no recollection of signing a new will, she indicated that he had stated that his brother had recently mentioned the “need” for a new will.

Regarding mood or personality changes, Ms. Daughter reported that her father is more laid back and even indifferent. She said that he used to be very focused on and concerned about his business affairs, but now seems often indifferent to them. She denied symptoms of anxiety or depression, but noted that he naps a lot during the day. She also stated that he always wants to eat because he forgets that he has already eaten.

Social/Academic/Occupational History: Mr. Patient reportedly was born and raised in Columbus, Georgia. He reportedly has 4 brothers and sisters. The patient’s father was a farmer and iron smith. The patient was reportedly married for 40 years when his wife died in 1990. He reported that he has two daughters and one son with a disability. He currently lives alone.

Mr. Patient reportedly completed 6 years of education. He reportedly buys and sells real estate and co-owns an excavation business called Happy Valley Construction Company, Inc. Mr. Patient reportedly started the excavation business and then brought his brothers into the business at a later time.

Prior Medical History: Mr. Patient’s medical history reportedly is significant for diabetes and history of blood clots. Surgical history reportedly includes four-way coronary artery bypass graft (1989) and partial lung resection (2000). The patient reportedly does not drink alcohol and does not smoke. There reportedly is no history of alcohol or other substance abuse.

Family medical history is reportedly positive for myocardial infarction in his brother, stomach cancer in his sister, skin cancer in his sister, and possible AD in his mother.

Psychiatric History: Mr. Patient reportedly has no history of mental health treatment. As noted above, he reportedly has had no prior evaluations for his memory problems.

Medications: Coumadin, Exelon, Prevacid, Tenormin, ginkgo biloba, Ambien, Detrol, Claritin.

II. BEHAVIORAL OBSERVATIONS

Mr. Patient presented as a well-groomed, nicely dressed 76 year-old Caucasian man. He was accompanied to the evaluation by his daughter, Ms. Daughter.

In interview, the patient’s speech was fluent and reasonably goal-directed but lacked spontaneity. Responses were terse and impoverished. Comprehension appeared generally intact. Affect was mildly constricted, and mood was pleasant but irritable. Insight was judged to be very poor. There was no indication or report of formal hallucinations or delusions, or of a thought or perceptual disorder. There was no indication or report of suicidal ideation, plan, or intent.

During testing, Mr. Patient was alert and pleasant but would quickly become irritable and uncooperative with testing. He exhibited mild performance anxiety. He displayed task frustration by abandoning or avoiding tasks. He showed no response to encouragement from the psychometric technician. He displayed inability to complete some tasks due to comprehension problems. He made a few perseverative and intrusion errors. He required constant redirection to task. He showed a complete lack of test-taking strategies.

At one point, he refused to continue testing and started to leave, but was persuaded by his daughter to continue. Because of his reluctance to participate, and the examiner’s concern that he would prematurely terminate the testing, only an abbreviated test battery could be administered. Nevertheless, sufficient information was obtained to respond fully to the referral questions. Overall, the patient appeared to put forth variable but acceptable effort during the testing. Much of his reluctance to participate related to tasks that he appeared unable to perform. Overall, the current test results are an accurate representation of Mr. Patient’s current levels of cognitive and emotional functioning, and of his current financial abilities.

III. TESTS ADMINISTERED

California Verbal Learning Test - II (CVLT-II)
Clinical Interview
Cognitive Competency
Executive Clock Drawing Task (CLOX)
Financial Capacity Instrument (FCI)\(^4\)
Geriatric Depression Scale (GDS)
IV. SUMMARY OF RESULTS

Please see attachment.

V. IMPRESSIONS AND SUMMARY

Neuropsychological Findings:

1. Probable dementia, currently moderate (DRS=89/144, CDR= 2.0).

The neuropsychological test results were consistent with probable moderate dementia. Evidence for this impression included severe impairment on a dementia screening instrument and impairments in high-load verbal learning, recall, and recognition memory (severe to profound), simple short-term verbal recall (severe), orientation to time (severe), orientation to place (severe), simple auditory comprehension (severe), reading abilities (moderate), visuospatial construction of a clock drawing (mild), simple visuomotor tracking (mild), propositional auditory comprehension (moderate), and spontaneous construction of a clock drawing (severe). The patient was unable to complete a measure of visuomotor tracking/set flexibility. In addition, the patient’s daughter reported that he has had progressive memory and other cognitive problems for as long as five years.

Functional testing and interview data were also consistent with moderate dementia. Mr. Patient was severely impaired on a cognitive measure of everyday problem solving abilities. On a functional measure of financial capacity, the patient showed intact performance only on simple tasks of naming coins/currency, coin/currency relationships, and single and multi-item grocery purchases. He demonstrated significant impairment on tests of counting coins/currency, understanding financial concepts, making change for a vending machine, tipping, conceptual understanding of a checkbook/register, pragmatic use of a checkbook/register, conceptual understanding of a bank statement, use of a bank statement, detection of telephone fraud, conceptual understanding of bills, identifying and prioritizing bills, and knowledge of his personal financial assets and activities. In addition, the patient’s daughter indicated that he has home health care aides around the clock. She reported that prior to these arrangements, the patient was not bathing and wore the same clothes every day. She said that he currently has no meaningful activities around the home.

As discussed above, due to the patient’s reluctance to participate fully in the testing, only an abbreviated test battery was administered. Some cognitive domains were not assessed (e.g., expressive language, general intellectual abilities), and other domains were not assessed as comprehensively as they normally would be.

2. Possible Alzheimer’s disease.

Mr. Patient’s neuropsychological profile was consistent with possible AD. High-load verbal learning, recall, and recognition memory were moderately to severely impaired and he was unable to benefit from semantic or recognition cueing. He showed 0% recall after a short delay, which is consistent with the rapid decay of information over delay seen in AD. In addition, he had 0% short-term recall of verbal items from the memory subtest of the DRS. Mr. Patient demonstrated characteristic impairments on measures of executive function (simple visuomotor tracking, propositional auditory comprehension, and spontaneous construction of a clock drawing) and inability to complete a measure of visuomotor tracking/set flexibility.

Clinical course was consistent with AD. Mr. Patient’s cognitive difficulties reportedly have been slowly progressive over the past 5 years. He also has a family history of possible AD.

In the examiner’s judgment, it is highly probable that Mr. Patient has AD. However, he needs a neurological work-up for dementia before the clinical diagnosis can be established conclusively.

Capacity Findings:

1. Probable current incapacity to enter into contracts. This incapacity would include loan agreements, real estate contracts, and corporate buy/sell agreements.

The history, interview information, and test data indicated that Mr. Patient is probably incapable currently of entering into contracts such as the proposed buy-sell agreement. Ms. Daughter reported that her father has recently
sold some real estate at a fraction of what it is worth. She said that he has also made several large loans to his business recently, but seems generally unaware of these loans and the fact that they are not being repaid. He had very little specific knowledge regarding the proposed buy-sell agreement and seemed confused about its purpose.

Contractual capacity is a higher order legal competency which draws upon a variety of cognitive abilities, including memory, conceptual knowledge, reading ability, mental flexibility/executive function, and judgment. As discussed above, Mr. Patient is suffering from a moderate progressive dementia, probably of the Alzheimer’s type, and he currently demonstrates significant deficits in all cognitive domains tested, including attention, memory, comprehension, and executive function. Screening for reading abilities revealed that Mr. Patient currently reads at the 2nd grade level (2%ile for age), which reflects a decline from estimated premorbid levels.

In the examiner’s opinion, Mr. Patient no longer possesses the abilities to read and comprehend contractual documents, to recall essential information and details about contractual matters, to have the mental flexibility and judgment to negotiate effectively, or to make such business decisions in his best interest. In summary, he is no longer capable of entering into contracts, and it is likely that he has lacked this capacity for several years.

2. **Probable current incapacity to make a new will.**

Interview and test data indicated that Mr. Patient is probably incapable currently of making a new will. Mr. Patient was unable to provide an adequate description of a will, stating only “It’s where you put stuff in different people’s names.” He was also unable to set forth the nature and extent of his property to be listed within a will, describing his assets initially only as “farmland.” When specifically prompted about items of property including his business, home, bank accounts, and stocks, he stated that he wanted these things to go to his children. When asked about debts owed to him, he stated that no one owed him any money. When reminded that he had loaned money to his business, and that repayment of these loans could be made to his estate after his death, he acknowledged that these debts were still outstanding. However, he could not recall the exact amount of the loans. Mr. Patient’s lack of knowledge of assets/property to be passed in his will was also reflected in his poor performance on Domain 8 of the FCI, which tests general knowledge of personal assets and estate arrangements.

Mr. Patient did know the objects of his bounty and did indicate a general plan of distribution, stating that he would want his property to pass to his children equally. However, on testing Mr. Patient indicated that he had not yet made a will, whereas his daughter reported that he has a current will.

It is the examiner’s judgment that Mr. Patient currently lacks testamentary capacity.

3. **Probable current incapacity to manage business-related and everyday financial affairs.**

History, interview, and test data indicated that Mr. Patient is also currently incapable of managing his overall financial affairs and making business-related decisions. In interview, Mr. Patient demonstrated inaccurate knowledge of his financial and business affairs. For example, the patient indicated that he goes into work at his excavation business every day, even occasionally running construction equipment, whereas the patient’s daughter reported that he is retired and that his brother operates and manages the business on his own. She reported that her father continues to manage his own finances, but makes poor business decisions (e.g., recently sold some property for 10% of what it was worth). She reported that her father has agreed several times not to sign anything without letting her review it first, but then forgets to consult her.

Functional testing of financial abilities revealed overall severe impairment in financial capacity. On testing, Mr. Patient demonstrated intact performance on tasks of naming coins/currency, coin/currency relationships, and single and multi-item cash purchases. However, he was impaired on tests of counting coins/currency, understanding financial concepts, making change for a vending machine, tipping, conceptual understanding of a checkbook, use of a checkbook, conceptual understanding of a bank statement, use of a bank statement, detection of telephone fraud, conceptual understanding of bills, identifying and prioritizing bills, and knowledge of personal financial activities. Taken together, these findings indicate that he is no longer capable of managing any aspect of his business and financial affairs.

4. **Probable vulnerability to undue influence.**

In addition to his capacity impairment, it is very likely that Mr. Patient is currently vulnerable to undue influence in his business and other activities. Early on in their disease course, as their short-term memory and comprehension abilities erode, patients with AD become increasingly vulnerable to the influence of others. It is likely that Mr. Patient’s reported recent poor business decisions may reflect such a vulnerability. For example, during testing Mr. Patient failed to detect a telephone credit card scam situation and agreed to provide his credit card number over the phone to an unknown caller.
VI. RECOMMENDATIONS

1. We recommend that Mr. Patient be referred to the UAB Memory Disorders Clinic for a full neurological and dementia evaluation.

2. Continued pharmacotherapy with cholinesterase inhibitors appears to be appropriate.

3. Mr. Patient and his family should consider legally securing his business, financial, and personal affairs as soon as possible. Mr. Patient could potentially benefit from formal guardianship and conservatorship.

4. Mr. Patient’s cognitive and emotional status should continue to be closely monitored. This evaluation would provide a useful baseline if follow-up testing were indicated.

*The results of this evaluation are confidential.*

C. Note on Post-Assessment Action by the Attorney

Based on this assessment, Mr. Patient’s attorney concluded that she should not proceed in doing Mr. Patient’s will, nor with execution of the buy-sell agreement. The attorney informed Mr. Patient of the assessment results and provided a copy to Mr. Patient and, with his permission, to his daughter. (However, if Mr. Patient had not given permission, the attorney would have to determine whether disclosure might be a necessary action to protect the legal interests of his client under Model Rule 1.14.)

The attorney advised Mr. Patient and his daughter that it is time for his daughter to handle his financial affairs as his legal agent. The attorney provided the daughter with a background brochure explaining the responsibilities and tips for carrying out the responsibilities of a fiduciary under a durable power of attorney. Finally, the attorney reinforced the assessor’s recommendation for referral to the UAB Memory Disorders Clinic.
## Attachment—Test Scores

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<th>Scaled/Index</th>
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CASE EXAMPLE #2: Guardianship

A. Example of Attorney Model Referral Letter

RE: Referral of Mr. Doe for Mental Health Assessment

Dear __________:

As we discussed by telephone, I am writing to make a referral of Mr. Doe for a mental health assessment, with primary emphasis on financial management abilities and, to a lesser extent, health care decision-making capacity. I am representing Mr. Conservator, who is the court-appointed conservator for Mr. Doe. Mr. Doe has consented to the assessment and either he or Mr. Conservator will contact you to arrange an appointment. Mr. Doe also has consented to release of the assessment results to Mr. Conservator, as well as to me as counsel for Mr. Conservator (see attached release). Mr. Doe has consented to your contacting his son for additional information. Mr. Conservator has agreed to payment for the proposed assessment from the funds of Mr. Doe, but will need a statement of the procedure’s cost in advance. Below is background information that may be of help in conducting the assessment and preparing the report.

Background: According to Mr. Conservator, Mr. Doe is a Korean War veteran, age 72, a widower with four adult children. He has multiple chronic medical conditions as detailed in his records (attached), as well as a history of alcohol problems, various mental problems, and possibly some degree of dementia. Mr. Conservator reports that Mr. Doe shows some degree of confusion, yet still seems to have some understanding of his financial situation. Mr. Conservator was appointed by the County Probate Court to serve as conservator in 1995. In that capacity, he manages all of the income of Mr. Doe (military benefits, Social Security, small pension). Mr. Doe has no substantial assets and lives with his son. Mr. Conservator provides Mr. Doe with a stipend of $600 per month for food, gas, and other spending. Mr. Conservator reports that he was selected as conservator due to evidence of quarrels among Mr. Doe’s children. Mr. Doe has expressed confidence in his son. However, the son has medical and neurological problems of his own due to an auto accident.

Triggering Issue: Recently, Mr. Doe has had specific needs for larger amounts of cash, and has expressed frustration to Mr. Conservator that he lacks control of his income and must make requests in order to use it. Mr. Doe states that he has the capacity to manage his own funds, but that if he cannot do so, he would like his son to be the conservator. Mr. Conservator as court-appointed fiduciary understands that he is under a duty to seek the least restrictive alternative and maximize the autonomy of the conservatee. He needs professional advice on evaluating the specific abilities of Mr. Doe to manage money and avoid undue influence before taking any action before the court.

In addition, Mr. Conservator noted that Mr. Doe has discussed the importance of making his own health care decisions, and Mr. Conservator inquired about the possibility of having Mr. Doe execute an advance directive. Please include in the assessment an evaluation of Mr. Doe’s capacity to make health care decisions and to appoint a health care agent.

Relevant State Law Provisions: In this state, a court may appoint a conservator if an individual is “incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to manage property or financial affairs or provide for his or her support or for the support of his legal dependents without the assistance of a conservator. A finding that the individual displays poor judgment, alone, shall not be considered sufficient evidence that the individual needs a conservator.” [citation] A conservator has broad financial powers, unless limited by the court (in an order appointing a “limited conservator”), including the power to make gifts, convey property, engage in estate planning or create a trust, but must make decisions based on the values and preferences, as well as the best interests of the protected individual.

In this state, capacity to make health care decisions is based on the ability of an individual to “understand the significant benefits, risks, and alternatives to proposed health care” [citation]. Capacity to appoint a health care agent is
based on a person’s ability to “understand the nature and effect” of such an appointment [citation]. The level of capac-
ity needed to appoint an agent is generally lower than that needed to make complex health care decisions or to give
instructions about such decisions in advance.

Specific Assessment Request: Mr. Conservator requests that the following information be included in your
assessment report:

- Mental health diagnosis
- Tests conducted
- Analysis of test results
- Applicability of results to situation at hand
- Specific assessment of the ability of Mr. Doe to –
  - Understand basic financial concepts
  - Understand the sources and amounts of his income
  - Make financial judgments
  - Pay bills
  - Make monetary calculations, including making change on a transaction
  - Contract for goods or services
  - Avoid exploitation or undue influence
- Assessment of Mr. Doe’s capacity to execute an advance directive for health care.

Please send your report and invoice to Mr. Conservator at [address], with a copy of the report to me at this office,
and a copy to Mr. Doe at [address]. I appreciate your help with this case and look forward to working with you in the
future.

B. Example of Psychological Report

REASON FOR REQUEST:
Mr. Doe was referred from Mr. ——, representing Mr. Doe’s conservator, for neuropsychological and functional test-
ing. Mr. Doe is expressing dissatisfaction in his current conservator (known to Mr. Doe as his “guardian” and refer-
cenced as guardian in this report) and a question as to whether he still needs to have a guardian. Given his current
cognitive status, there is also a question regarding his capacity to complete an advance directive and capacity to make
treatment decisions.

INFORMED CONSENT:
Prior to the interview and testing, the nature and purpose of this evaluation was explained. The patient was told that
the findings would be provided in a written report to the referring attorney as requested by his guardian; that testing
would evaluate his thinking, memory, and problem-solving related to his need for a guardian; that the results of the
testing could support his desire not to have a guardian (benefit from his perspective), or the testing could indicate that
he does need a guardian (risk from his perspective). Mr. Doe appeared to understand the nature, purpose, risks and
benefits of the evaluation. Mr. Doe stated that he understood the testing was to re-evaluate his cognition, and to com-
pare to previous test performance, with a focus on financial decision-making and, to a lessor extent, medical deci-
sion-making. He consented to the interview and testing.

PRESENTING PROBLEM AND HISTORY:
Mr. Doe is a 72-year-old male. He worked as a truck driver, tile worker, and mason. He currently lives with a son who
is disabled from a car accident (reportedly with memory problems and gait problems). He has another son and two
daughters.
Mr. Doe is a Korean war veteran (served 1950-1954) who receives a 100% service-connected disability for “psychosis,” and 10% for superficial scars and ear infection.

Psychiatric history includes alcohol abuse (6-8 beers per night plus valium), sober 15 years. History of schizophrenia is unclear; more recent diagnoses for Mr. Doe are dementia due to multiple etiologies (alcohol abuse, head injury) and mood disorder secondary to general medical condition, with psychotic features. He has had four psychiatric hospitalizations beginning in 1956.

Medical history is taken from medical records provided by Mr. ———. Medical history includes recurrent cancer (lung, throat). Mr. Doe is still smoking and is followed privately for medical problems. He is also noted to be s/p gun shot wound to head (no information but apparently superficial), history of GI problems, and history of seizures.

Mr. Doe was appointed a guardian for finances while living in Louisiana, for money management problems related reportedly to alcohol abuse. He was appointed a guardian for finances (conservator) in this state after he moved back here in 1995. He has expressed recent frustration that he is only paid $600 per month (from which he buys food, gas, and for spending money for himself and his son). He desires more control over his finances. For example, he was upset that his lawyer requested receipts prior to releasing money for his daughter’s wedding. He expresses a desire for control over his money and states his son at home could help with paying bills. He would like to have $2,000 to take a vacation trip through ME and NH. He cannot identify any benefits to himself with having a guardian.

MEDICATIONS include Codeine 30mg, Acetaminophen 300mg T1 every 6 hours prn, Phenobarbital 30mg t1 qhd, Oxybutynin 5mg t1 bid, Phenytoin 100mg t1 tid, Citalopram 40mg t 1/2 qd, Paroxetine 20mg t1 qd, Olanzapine 7.5mg t1 qhs, Thioridazine 100mg t1 bid, Trazodone 50mg t2 qhs.

NEUROPSYCHOLOGICAL TESTING has been done in the past in 1996 and 1998, as well as 1970 and 1972. Recent testing found significant deficits in memory and planning/organization, moderate deficits in verbal skills, relative strengths (low average performance) for visual skills. Early testing found low average IQ.

CT SCAN OF HEAD completed 7/30/99 found no lesions, but moderate dilation of lateral ventricles raising a suspicion for early normal pressure hydrocephalus.

COLLATERAL INTERVIEW:
With the guardian’s and the patient’s consent, the patient’s son, with whom he lives, was contacted. His son said that he has lived with his father since his father’s return in 1995. He said that his father (the patient) has had problems “thinking straight” for most of his life. He noted that he feels these problems have gotten worse in the past two years. He said that he helps his father to take care of the house and to make meals. The son acknowledged that his father has been a poor manager of money in the past, particularly when drinking. He said that earlier in his life, when his father drank more actively, the family had to struggle to pay for meals and bills. He said that he is reluctant to help his father manage his money as money has been a source of conflict between them in the past. He also acknowledges that he (the son) is having some difficulties organizing his affairs since his car accident; and confirmed some ongoing differences with his siblings, including differences in matters concerning his father.

DATA:
Medical Record Review
Clinical interview + Financial & Health care interview
Wechsler Adult Intelligence Scale III (WAIS)—subtests
Wechsler Memory Scale III (WMS)—subtests
Controlled Oral Word Association Test “FAS”
Boston Naming Test (BNT)
Geriatric Depression Scale (GDS)
Independent Living Scales—Money Management and Health and Safety scales

MENTAL STATUS:
Mr. Doe missed his first scheduled appointment, having confused it with another canceled appointment, but, with a reminder call, arrived 20 minutes early for his next appointment. He was neatly groomed, thin, elderly male. He presented as mildly anxious, eager to please, and concerned about his test performance. There was no evidence of active depression or psychosis, but he complained of fears and concerns about mental breakdown and suicidality (although he was not actively suicidal at the time of the interview). He was oriented to person, place, and near time (thought it was 8/30 rather than 8/31).

TESTING:
ATTENTION as measured by digits forward was in the average range for his age (5 digits forward), while CONCENTRATION as measured by digits backward was in the low average range for his age (3 digits backward). He also evidenced problems with sustained attention during testing, having trouble focusing on instructions and problems for an extended period of time.

VERBAL AND VISUAL MEMORY were severely impaired, consistent with previous test performance. Immediate recall of stories was in the borderline-defective range (a decline from 96, 98 testing) and 30-minute delayed recall of stories was in the borderline-defective range (about the same as before) with 32% of the material remembered at delay from the initial presentation. Immediate recall of designs was in the borderline range, while delayed recall of designs was in the borderline-defective range (both about the same as before) with 6% of the material remembered at delay from the initial presentation.

VERBAL SKILLS on the WAIS-III were in the borderline to borderline-defective range. Word knowledge (Vocabulary) was borderline-defective (a decline from previous testing). Abstract reasoning (Similarities) was in the borderline-defective range (about the same as before) and Everyday reasoning (Comprehension) was in the borderline range (a decline from before). Confrontation naming (BNT) was in the defective range with anomia evidenced during testing.

VISUAL SPATIAL SKILLS on the WAIS III were in the low average to defective range. Attention to visual detail (Picture Completion) was in the defective range. Visual-problem solving (Matrix Reasoning) was in the low average range.

EXECUTIVE FUNCTION on the FAS was in the low average to borderline range. Also, test performance was consistently impulsive (didn’t wait to hear instructions before answering), gave up easily—for this reason on many of the tests he was given additional instruction and many opportunities to expand on his first answer or to think about it more/again to maximize his performance. Also, he was slightly disinhibited.

DEPRESSION screening with the GDS indicated mild depression (14/30), but in fact most of the responses seemed related to his intrusive thoughts and concerns about his thinking, rather than depression.

FINANCIAL DECISION-MAKING on the ILS was in the low/dependent range. He knew some basic financial concepts (Social Security, home insurance, health insurance) but could not say when income tax was due. His procedur-
al skills were quite limited. He counted out some basic change, but could not calculate change due from a $5 bill or co-payment due on a bill. Also, he was unable to write checks to pay bills. His financial judgment was marginal. He has some sensitivity to reasons it was important to pay bills and ways to avoid getting cheated out of his money, but could not give well elaborated reasons on this. In interview he was unable to estimate the sources of his income, the size of his savings account. He noted he likes to give gifts but tries to avoid giving gifts to friends.

HEALTH CARE MANAGEMENT on the ILS was in the low/dependent range, although a bit better than his financial management skills. He was able to give accurate responses for a number of emergency medical and safety situations although some of his explanations about his current health situation were vague—he had trouble describing his current state of health, the importance of bathing (although noted he showers every day), a plan for managing his medications. In interview he had some definite ideas about managing his health care. He very much wants to make his own decisions regarding his health care. If he was unable to make decisions he’d like his son (who lives with him) to do so. He feels knowing his children and granddaughter is what “makes life worth living” for him and that he values continued living highly, i.e., states he would like to continue to live even with disabilities in walking, talking, and thinking. These views are informed in part by his religious beliefs.

SUMMARY AND CONCLUSIONS:
Mr. Doe is a 72-year-old male with a current diagnosis of dementia due to multiple etiologies and mood disorder secondary to general medical condition. He has a guardian for finances and is expressing displeasure at the controls (wants more money per month, wants to be able to have larger sums for trips and presents). There is also a question of medical decision-making and capacity to name a health care proxy.

Results of Cognitive Testing:
Neuropsychological testing finds intact simple attention, relative strengths in visual problem solving and verbal fluency. Otherwise, there are severe deficits in concentration and working memory, delayed memory, verbal problem solving. He was very pleasant and cooperative during testing, but was consistently impulsive in his test responses. Results and history are consistent with the following diagnoses.

I. Clinical Disorders and Other Conditions that may be a focus of clinical attention:
   Dementia due to multiple etiologies
   Mood disorder related to General Medical Condition
   Alcohol Dependence in sustained full remission
II. Personality Disorders and Mental Retardation:
   None
III. General Medical Conditions:
   History of cancer; history of gun shot wound to head; question of NPH
IV. Psychosocial and Environmental Problems: Problems related to guardian, family conflict
V. Global Assessment of Functioning: 38 (current)

Results of Functional Testing/Capacity Findings:
1. Understanding of basic financial concepts:
   Mr. Doe has very limited knowledge of his own finances or important financial concepts.

2. Understanding of sources and amount of income:
   Mr. Doe was not able to state the sources and amount of his current income.

3. Making financial judgments:
   Results of both the cognitive and functional testing indicate that his ability to make financial judgments is poor.
4. Paying bills:
During testing, Mr. Doe was unable to understand a bill statement or appropriately write checks in response to the statement.

5. Making monetary calculations, including making change on a transaction:
Mr. Doe has good social skills and is able to count some change, however, he was unable to determine the amount owed to him as a result of a financial transaction.

6. Contracting for goods or services:
Results of both the cognitive and functional testing indicate that Mr. Doe lacks the ability to contract for goods or services.

7. Avoiding exploitation or undue influence:
Due to Mr. Doe’s problems with reasoning and executive functioning, he is at high risk for exploitation and undue influence. Whether his son could fill the role of conservator is uncertain without more formal assessment of the son—but it appears that there is a history of family conflict about finances and this would not be the optimal situation even if the son was more able to manage money himself. For now I would recommend working with Mr. Doe to keep the conservator in place.

8. Making medical decisions and appointing a health care proxy:
In terms of medical decision-making, testing and interview suggests he holds strong values and beliefs about his health and care decisions, and can understand basic aspects of his health and health care. This combined with results of neuropsychological testing suggests that he would be capable of completing an advance directive although may need extra attention and careful explanation in educating about the process and options. He can likely make simple medical decisions but as the decision in question is more difficult, this may tax his ability to remember basic information about the risks and benefits of treatments, and thus he may for those decisions utilize the input of a health care proxy or concerned family member.

Clinical Interventions Recommended:
Mr. Doe’s clinical status may be improved with the following interventions.

1. Medication review by a primary care doctor, geriatrician, or neurologist to consider whether it is possible that any of his current medications may be contributing to decreased ability to process information and concentrate.

2. Referral to neurology to follow up on possible Normal Pressure Hydrocephalus (NPH) given CT findings and evidence of probable decline in cognition.

3. If significant medication changes are made to reduce their potential impact on cognition, and/or if Mr. Doe is diagnosed with and treated for NPH, it would be important to re-assess his cognition to determine if his functioning has improved.

4. Given Mr. Doe’s strong desire for more autonomy, it might be worth working with Mr. Doe to improve avenues for his autonomy, and increased financial freedom in context of conservatorship. For example, can he be given a sum of money for a trip or a present as a trial (with request to return receipts later).

Thank you for this referral.
C. Note on Post-Assessment Action by Attorney

Based on this assessment, the attorney advised that the conservatorship should remain in place at the present time, but that Mr. Conservator should make efforts to expand Mr. Doe’s financial decision-making authority. The attorney recommended that Mr. Doe be allowed a specified amount of funds in addition to his regular allowance, with the understanding that Mr. Doe would report back to the conservator on expenditures and provide receipts. The attorney also supported the recommendation in the assessment report for a medication review and a referral to a neurologist concerning NPH diagnosis and treatment. If changes in medication and/or NPH treatment result in cognitive improvements, and if Mr. Doe appears able to manage the extra funds provided him, some modification of the scope of the conservatorship might be discussed in the future. The attorney also advised that Mr. Conservator appears to be the most appropriate fiduciary, even though Mr. Doe may want his son to fill this role, due to uncertainty about the son’s financial management capabilities and the son’s conflicts with his siblings. However, with Mr. Doe’s permission, Mr. Conservator should increase his contacts with the son and with Mr. Doe’s other children.

The attorney advised the conservator that Mr. Doe appears to have the capacity to appoint a health care agent, and to indicate basic health care preferences in an advance directive. Further investigation might be necessary to determine whether the son could serve as the agent. Mr. Doe should seek counsel for the preparation of an advance directive. The attorney noted that the local legal services program has a lawyer who specializes in aging issues including advance directives, and that Mr. Doe appears to qualify for such assistance. The attorney gave Mr. Conservator a brochure about health care decision-making for discussion with Mr. Doe.
Appendix 3: Brief Guide to Psychological and Neuropsychological Instruments

For the purposes of this fact sheet, psychological tests are described in four categories: (1) tests used to evaluate and document symptoms of cognitive impairment; (2) tests used to rate the type and severity of emotional or personality disorder; (3) tests used to detect unusual response styles, or the validity of test taking; and (4) tests used to evaluate specific functional capacities or abilities. A brief guide to cognitive screening instruments is provided at the end of this appendix.

This listing is not meant as an exhaustive or definitive list, but provides an overview of some of the more commonly assessed domains and tests. The number of tests can be somewhat overwhelming; added to this is that evaluators may refer to tests by shortened names or abbreviations. For more information on specific tests, please refer to the reference books noted at the end of this chapter.

A. Tests for Evaluating Cognitive Impairment

A comprehensive psychological or neuropsychological evaluation would typically assess the domains of appearance and motor activity, mood, level of consciousness, attention, memory, language, visual-spatial or constructional ability, reasoning, fund of information, and calculations. Some of these areas are assessed through observation of the client’s presentation and communication during a clinical interview. Other areas can be assessed through standardized, norm-referenced tests.

1. Appearance, Orientation, and Motor Activity

**Definition**: Although typically assessed through observation, not testing, an important part of a comprehensive evaluation is examination of appearance, grooming, weight, motor activity (active, agitated, slowed), and orientation to person, place, time, and current events.

2. Level of consciousness

**Definition**: Although also typically assessed through observation, not testing, the evaluator will also observe the degree of alertness and general mental confusion, rating as alert, lethargic, or stupor. Additional assessment with basic measure of attention may be necessary.

3. Attention

**Definition**: Attention concerns the basic ability to attend to a stimulus; also the ability to sustain attention over time, as well as freedom from distractibility.

**Tests**:
- Digit Span Forward/Digit Span Backward from the Wechsler Adult Intelligence Scale–III (WAIS-III) or the Wechsler Memory Scale–III (WMS-III)
- Working Memory (from the WMS-III)
- Paced Auditory Serial Attention Test (PASAT)
- Visual Search and Attention Test (VSAT)
- Visual Attention (from the Dementia Rating Scale (DRS))
- Trails A of the Trail Making Test

4. Memory and Learning

**Definition**: Memory assessment involves evaluation of the system by which individuals register, store, retain, and retrieve information in verbal and visual domains.

**Tests**
- Memory Assessment Batteries (from the WMS-III or the Memory Assessment Scales (MAS))
Appendix 3: Brief Guide to Psychological and Neuropsychological Instruments

- Auditory Verbal Learning Test
- Recall and Recognition (from the DRS)
- Fuld Object Memory Evaluation
- California Verbal Learning Test (CVLT)
- Hopkins Verbal Learning Test (HVLT)

5. Language

*Definition:* Language includes a number of abilities such as spontaneous speech, the fluency of speech, repetition of speech, naming or word finding, reading, writing, comprehension. The presence of aphasia (difficulty receiving or expressing speech) and thought disordered speech is also noted.

*Tests:*
- Boston Naming Test (BNT)
- Controlled Oral Word Association Test (commonly called the “FAS”)
- Boston Diagnostic Aphasia Examination (BDAE)
- Token Test

6. Executive Function

*Definition:* The assessment of executive functions concern planning, judgment, purposeful and effective action, concept formation, and volition. This area is often an extremely important aspect of capacity.

*Tests:*
- Similarities (from the WAIS-III)
- Trails B of the Trail Making Test (TMT)
- Wisconsin Card Sorting Test
- Stroop Color Word Test
- Delis-Kaplan Executive Function System (DKEFS)
- Malloy
- Mazes

7. Visual-Spatial and Visuo-Constructional Reasoning and Abilities

*Definition:* Visual spatial assessment involves evaluation of visual-spatial perception, problem solving, reasoning, and construction or motor performance involving visual-spatial skills.

*Tests:*
- Performance subtests from WAIS-III, such as Block Design, Object Assembly, Matrix Reasoning
- Hooper Visual Organization Test
- Visual Form Discrimination Test
- Clock Drawing
- Rey-Osterrieth Complex Figure
- Line Bisection

8. Verbal Reasoning and Abilities

*Definition:* The assessment of verbal reasoning involves evaluation of logical thinking, practical judgments, and comprehension of relationships. Related abilities are fund of knowledge, which is the extent of information known and retained, and calculation concerning arithmetic skills.

*Tests:*
- Verbal subtests from the WAIS-III, such as Similarities, Comprehension, Information, Arithmetic
- Proverbs
9. Motor Functions

Definition: Tests of motor function provide basic ability about praxis or motor skills in each hand, which are important for distinguishing observed deficits on tasks involving motor performance from primary (motor) or secondary (central nervous system) deficits.

Tests:
- Finger Tapping
- Grooved Pegboard

B. Tests for Emotional and Personality Functioning

Tests of emotional and personality functioning can provide a more objective means to assess the range and severity of emotional or personal dysfunction.

1. Mood and Symptoms of Depression, Anxiety, and Psychoses

Definition: These scales assess the individual’s degree of depressed or anxious mood, and associated symptoms such as insomnia, fatigue, low energy, low appetite, loss of interest or pleasure, irritability, feelings of helplessness, worthlessness, hopelessness, or suicidal ideation. Some scales will also assess the degree of hallucinations, delusions, suspicious or hostile thought processes.

Tests:
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia
- Dementia Mood Assessment Scale (DMAS)
- Beck Depression Inventory (BDI)
- Beck Anxiety Inventory (BAI)
- Brief Symptom Inventory (BSI)

2. Personality

Definition: Personality inventories are occasionally used in capacity assessment to explore unusual ways of interacting with others and looking at reality that may be impacting sound decision-making. Projective personality tests are relatively less structured and allow the patient open-ended responses. Objective tests in contrast typically provide a question and ask the patient to choose one answer (e.g., “yes” or “no”).

Tests:
- Rorschach
- Minnesota Multiphasic Personality Inventory–2 (MMPI)
- Profile of Mood States (POMS)

C. Tests of Effort, Motivation, or Response Style

These measures, also referred to as validity tests, are structured in such a way to detect inconsistent or unlikely response patterns indicative of attempts to exaggerate cognitive problems. They serve as one type of evidence permitting the clinician to judge the validity of the overall cognitive testing. Generally they detect test-taking response patterns that deviate from chance responding or from norms for established cognitively impaired clinical populations like AD. If the tests are positive, they suggest an intentional (or in some cases subconscious) test-taking approach to exaggerate deficits. It remains a clinical judgment as to how to interpret the clinical meaning of the test-taking bias/exaggeration. In some cases, they may reflect malingering for monetary secondary gain, whereas in others they may indicate a factitious disorder or sometimes a somatoform disorder. Tests of validity may be used when the examiner is concerned that the individual has a reason to gain from “faking bad” on the test, such as in disability claims. Older adults who are receiving capacity evaluation are most likely to be giving maximal effort to perform at their highest level, in which case formal tests of validity are probably not indicated.
1. **Validity**

**Definition:** Validity tests are structured in such a way to detect inconsistent or unlikely response patterns indicative of attempts to exaggerate cognitive dysfunction.

**Tests:**
- Test of Memory Malingering (TOMM)
- 21 Item Test
- 15 Item Test
- CVLT-II Forced Choice

D. **Tests for Evaluating Specific Capacities or Abilities**

When capacity or competency is specifically in question, a comprehensive evaluation would include direct assessment of the area in question. We include here instruments designed for clinical (not research) use. As these tests are more recently developed, we include a more detailed description of the instruments. Specific information on reliability and validity relevant to the Daubert standard of scientific admissibility can be found in the test manuals and is also summarized in several chapters.55

1. **Adult Functional Adaptive Behavior Scale (AFABS)**


**Area Assessed:** Functional Abilities for Independent Living

**Description:** The Adult Functional Adaptive Behavior Scale (AFABS) was developed to assist in the assessment of ADL and IADL functions in the elderly to evaluate their capacity for personal responsibility and the matching of a client to a placement setting. The AFABS consists of 14 items. Six items rate ADLs: eating, ambulation, toileting, dressing, grooming, and managing (keeping clean) personal area. Two items tap IADLs: managing money and managing health needs. Six items tap cognitive and social functioning: socialization, environmental orientation (ranging from able to locate room up through able to travel independently in the community), reality orientation (aware of person, place, time, and current events), receptive speech communication, expressive communication, and memory. Items are rated on four levels: 0.0 representing a lack of the capacity, 0.5 representing some capacity with assistance, 1.0 representing some capacity without assistance, and 1.5 representing independent functioning in that area. Individual scores are summed to receive a total score in adaptive functioning. The AFABS assesses adaptive functioning through interviewing an informant well-acquainted with the functioning of the individual in question. The informant data is combined with the examiner’s observation of and interaction with the client to arrive at final ratings. The AFABS is designed for relatively easy and brief administration (approximately 15 minutes). The author recommends it be administered only by professionals experienced in psychological and functional assessment, specifically a psychologist, occupational therapist, or psychometrician, although research with the AFABS has also utilized psychiatric nurses and social workers trained in its administration.

2. **Aid to Capacity Evaluation (ACE)**

**Primary Reference:** Edward Etchells et al., Assessment of Patients Capacity to Consent to Treatment, 14 J. Gen. Internal Med. 27-34 (1990).

**Area Assessed:** Medical Decision-Making

**Description:** The ACE is a semi-structured assessment interview that addresses seven facets of capacity for an actual medical decision (not a standardized vignette): the ability to understand (1) the medical problem, (2) the treatment, (3) the alternatives to treatment, and (4) the option of refusing treatment (5); the ability to perceive consequences of (6a) accepting treatment and (6b) refusing treatment; and (7) the ability to make a decision not substantially based on hallucinations, delusions, or depression. These reflect legal standards in Ontario, Canada but also correspond to U.S. legal standards.
3. **Capacity Assessment Tool (CAT)**


**Area Assessed:** Medical Decision-Making

**Description:** The CAT proposes to evaluate capacity based on six abilities: communication, understanding choices, comprehension of risks and benefits, insight, decision/choice process, and judgment. It uses a structured interview format to assess capacity to choose between two options in an actual treatment situation; as such, it does not use a hypothetical vignette.

4. **Capacity to Consent to Treatment Interview (CCTI)**


**Area Assessed:** Medical Decision-Making

**Description:** The CCTI is based on two clinical vignettes; a neoplasm condition and a cardiac condition. Information about each condition and related treatment alternatives is presented at a fifth to sixth grade reading level with low syntactic complexity. Vignettes are presented orally and in writing; participants are then presented questions to assess their decisional abilities in terms of understanding, appreciation, reasoning, and expression of choice.

5. **Competency Interview Schedule (CIS)**


**Area Assessed:** Medical Decision-Making

**Description:** The CIS is a 15-item interview designed to assess consent capacity for electro-convulsive therapy (ECT). Patients referred for ECT receive information about their diagnosis and treatment alternatives by the treating clinician, and the CIS then assesses decisional abilities based on responses to the 15 items.

6. **Decision Assessment Measure**


**Area Assessed:** Medical Decision-Making

**Description:** Wong et al., working in England, developed a measure that references incapacity criteria in England and Wales (understanding, reasoning, and communicating a choice), based on methodology by Thomas Grisso et al. (*The MacArthur Treatment Competence Study: II. Measures of Abilities Related to Competence to Consent to Treatment*, 19(2) L. & Human Behavior 127-148 (1995)). Their instrument also assesses the ability to retain material because it is one of the legal standards for capacity in England and Wales (though not in the United States). A standardized vignette regarding blood drawing is used to assess paraphrased recall, recognition, and non-verbal demonstration of understanding (pointing to the correct information on a sheet with both correct information and distracter/incorrect information).

7. **Decision-Making Instrument for Guardianship (DIG)**


**Area Assessed:** Self Care, Home Care, Financial, (Guardianship)

**Description:** The Decision-Making Instrument for Guardianship (DIG) was developed to evaluate the abilities of individuals to make decisions in everyday situations often the subject of guardianship proceedings. The instrument consists of eight vignettes describing situations involving problems in eight areas: hygiene, nutrition, health, etc.
care, residence, property acquisition, routine money management in property acquisition, major expenses in property acquisition, and property disposition. Examinees are read a brief vignette describing these situations in the second person. Detailed scoring criteria are used to assign points for aspects of problem solving including defining the problem, generating alternatives, consequential thinking, and complex/comparative thinking. The DIG is carefully standardized. Standard instructions, vignettes, questions, and prompts are provided in the manual. In addition, detailed scoring criteria are provided. Sheets with simplified lists of salient points of each vignette, provided in large type, help to standardize vignette administration and emphasize the assessment of problem solving and not reading comprehension or memory. Vignettes are kept simple, easy to understand, and are brief.

8. Direct Assessment of Functional Status (DAFS)


Area Assessed: Functional Abilities for Independent Living

Description: The Direct Assessment of Functional Status (DAFS) was designed to assess functional abilities in individuals with dementing illnesses. The scale assesses seven areas: time orientation (16 points), communication abilities (including telephone and mail; 17 points), transportation (requiring reading of road signs; 13 points), financial skills (including identifying and counting currency, writing a check and balancing a checkbook; 21 points), shopping skills (involving grocery shopping; 16 points), eating skills (10 points), dressing and grooming skills (13 points). The composite functional score has a maximum of 93 points, exclusive of the driving subscale, which is considered optional. The DAFS requires that the patient attempt to actually perform each item (e.g., is given a telephone and asked to dial the operator). The entire assessment is estimated to require 30-35 minutes to complete. Any psychometrically trained administrator can administer the scale. The DAFS has been used for staging functional impairment in dementia, from one to three, in a group of 205 individuals with probable Alzheimer’s disease.


Area Assessed: Financial

Description: The Financial Capacity Instrument (FCI) was designed to assess everyday financial activities and abilities. The instrument assesses six domains of financial activity: basic monetary skills, financial conceptual knowledge, cash transactions, checkbook management, bank statement management, and financial judgment. The FCI is reported to require between 30-50 minutes to administer, depending on the cognitive level of the examinee. The FCI uses an explicit protocol for administration and scoring.

10. Hopemont Capacity Assessment Interview (HCAI)


Area Assessed: Financial, Medical Decision-Making

Description: The Hopemont Capacity Assessment Interview (HCAI) is a semi-structured interview in two sections. The first section is for assessing capacity to make medical decisions. The second section is for assessing capacity to make financial decisions and will be discussed here. In the interview the examinee is first presented with concepts of choice, cost, and benefits and these concepts are reviewed with the examinee through questions and answers. The examinee is then presented medical or financial scenarios. For each scenario the individual is asked basic questions about what he or she has heard, and then asked to explain costs and benefits, to make a
choice, and to explain the reasoning behind that choice. The HCAI uses a semi-structured format. General instructions are provided. Specific standardized introductions, scenarios, and follow-up questions are on the rating form.

11. Independent Living Scales (ILS)


Areas Assessed: Care of Home, Health Care, Financial (Guardianship)

Description: The Independent Living Scales (ILS) is an individually administered instrument developed to assess abilities of the elderly associated with caring for oneself and/or for one’s property. The early version of the ILS was called the Community Competence Scale (CCS). The CCS was constructed specifically to be consistent with legal definitions, objectives, and uses, in order to enhance its value for expert testimony about capacities of the elderly in legal guardianship cases. The ILS consists of 70 items in five subscales: Memory/Orientation, Managing Money, Managing Home and Transportation, Health and Safety, and Social Adjustment. The five subscales may be summed to obtain an overall score, which is meant to reflect the individual’s capacity to function independently overall. Two factors may be derived from items across the five subscales: Problem Solving and Performance/Information. The ILS has extensive information on norms, reliability, and validity.

12. MacArthur Competence Assessment Tool - Treatment (MACCAT-T)


Area Assessed: Medical Decision-Making

Description: The MacCAT-T utilizes a semi-structured interview to guide the clinician through an assessment of the capacity to make an actual treatment decision. It does not use a standardized vignette. Patients receive information about their condition, including the name of the disorder, its features and course, then are asked to “Please describe to me your understanding of what I just said.” Incorrect or omitted information is cued with a prompt (e.g., “What is the condition called?”), and if still incorrect or omitted, presented again. A similar disclosure occurs for the treatments, including the risks and benefits of each treatment alternative. Next, patients are asked if they have any reason to doubt the information and to describe that. They are then asked to express a choice and to answer several questions that explicate their reasoning process, including comparative and consequential reasoning and logical consistency.

13. Multidimensional Functional Assessment Questionnaire (MFAQ)


Area Assessed: Functional Abilities for Independent Living

Description: The Multidimensional Functional Assessment Questionnaire (MFAQ) was developed to provide a reliable and valid method for characterizing elder individuals and for describing elderly populations. The MFAQ supersedes the nearly identical Community Survey Questionnaire (CSQ, a predecessor which also was developed by the Duke Center). Both instruments frequently have been called the “OARS,” in reference to the program that developed the instrument throughout the 1970s. The MFAQ or the CSQ was already in use by well over 50 service centers, researchers, or practitioners nationally when the MFAQ was published (1978). Part A provides information in five areas of functioning, including activities of daily living. The Activities of Daily Living (ADL) dimension assesses 14 functions including both instrumental and physical ADLs. Instrumental ADLs are: use telephone, use transportation, shopping, prepare meals, do housework, take medicine, handle money. Physical ADLs are: eat, dress oneself, care for own appearance, walk, get in/out of bed, bath, getting to bathroom, continence. Part B of the MFAQ assesses the individual’s utilization of services, that is, whether and to what extent the examinee has received assistance from various community programs, agencies, relatives, or friends, especially within the latest six months. Questioning also includes the examinee’s perceived need for the various services.
14. Philadelphia Geriatric Center Multilevel Assessment Inventory (MAI)


Area Assessed: Functional Abilities for Independent Living

Description: The Philadelphia Geriatric Center Multilevel Assessment Inventory (MAI) was designed to assess characteristics of the elderly relevant for determining their needs for services and placement in residential settings. The MAI is a structured interview procedure that obtains descriptive information about an elderly respondent related to seven domains. Each of the domains (except one) is sampled by interview questions in two or more subclasses, which the authors call sub-indexes. The full-length MAI consists of 165 items; the middle length MAI has 38 items, and the short-form has 24 items. The domains assessed are physical health, cognitive, activities of daily living, time use, personal adjustment, social interaction, and perceived environment. The MAI manual provides considerable structure for the process of the interview, sequence and content of questions, and scoring. It describes criteria for 1 to 5 rating of each of the domains, but these criteria are not tied specifically to item scores. The manual discusses general considerations for interviewing elderly individuals and dealing with special problems of test administration with this population (e.g., dealing with limited hearing or vision).

E. Cognitive Screening Tests

Cognitive screening tests are useful for giving a general level of overall cognitive impairment, but they are notoriously insensitive to deficits in single domains. They may be used as an overall screening to determine whether additional testing is needed. They may also be used for individuals with more severe levels of impairment who cannot complete other tests.

1. Blessed Information-Memory-Concentration Test (BIMC): The BIMC is a 33-point scale with subtests of orientation, personal information, current events, recall, and concentration. There is a short version with six items. It has adequate test-retest reliability and correlation with other measures of cognitive impairment.

2. Mental Status Questionnaire (MSQ): The MSQ is a 10-item, 10-point scale assessing orientation to place, time, person, and current events. It has low to modest sensitivity for detecting neurological illness.

3. Mini Mental State Examination (MMSE): The MMSE is a 30-point screening instrument that assesses orientation, immediate registration of three words, attention and calculation, short-term recall of three words, language, and visual construction. The MMSE is widely used and has adequate reliability and validity. Positive findings require more in-depth evaluation. Limitations of the MMSE, discussed in Chapter IV, include the potential for false positives or false negatives, and the association of MMSE scores with age, education, and ethnicity. Longer versions and telephone versions of the MMSE are available.

4. The Seven Minute Screen (7MS): This screening instrument consists of four subtests: recall, verbal fluency, orientation, and clock drawing. It has adequate test-retest reliability and inter-rater reliability.

5. Short Portable Mental Status Questionnaire (SPMSQ): The SPMSQ is scored as a sum of errors on subtests of orientation, location, personal information, current events, and counting backwards. Race and age corrections to scores are available.

F. Key Test Reference Books

Thomas Grisso et al., Evaluating Competencies: Forensic Assessments and Instruments (2d ed. 2002).
Asenath LaRue, Aging and Neuropsychological Assessment (1992).
Muriel D. Lezak, Neuropsychological Assessment (3d ed. 1995).
Appendix 4: Dementia Overview

What is dementia?
Dementia is a syndrome characterized by decline in memory in association with either decline in other cognitive abilities, e.g., judgment and abstract thinking, or personality change. The resulting impairment must be severe enough to interfere with work or usual social activities or relationships. The requirement for decline distinguishes dementia from life-long mental retardation, although a person with mental retardation can develop dementia if his or her cognitive abilities decline from a previous level. The requirement also means that a person with high previous intelligence can have dementia if his or her cognitive abilities decline to average levels, and this decline interferes with work or usual social activities or relationships.

Outdated terms: terms that were used in the past, such as senility, chronic brain syndrome, and hardening of the arteries, are rarely used now because they are imprecise and inaccurate.

What causes dementia?
Dementia can be caused by more than 70 diseases and conditions. The most common cause is Alzheimer’s disease, which is present in 60 percent to 75 percent of dementia cases in the United States. The second most common cause is vascular or multi-infarct disease, which is present in 10 percent to 20 percent of cases. Alzheimer’s disease and multi-infarct disease often co-exist in a condition referred to as mixed dementia. Other diseases and conditions that can cause dementia include Lewy body disease, fronto-temporal disease (including Pick’s disease), Creutzfeld-Jacob disease, Parkinson’s disease, Huntington’s disease, amyotrophic lateral sclerosis (Lou Gehrig’s disease), and AIDS.

Reversible dementia. In a small minority of people with dementia, the condition may be partially or completely reversible with treatment of underlying causes, such as chronic infections, thyroid disease, and normal-pressure hydrocephalus. Unfortunately, these situations are rare.

How common is dementia?
The total number of people with dementia in the United States is not known. That is because most people with dementia do not have a diagnosis, and no study with a nationally representative sample and procedures for diagnosing dementia has been completed.

Estimates of the number of people with Alzheimer’s disease come from studies of smaller community samples. Results of two widely cited studies indicate that 2 percent of people age 65 to 74 have Alzheimer’s disease, with the proportion increasing to 8 percent to 19 percent of people age 75 to 84, and 29 percent to 42 percent of people age 85 and over. Combining these proportions and U.S. Census data indicates that 2.6 million to 4.5 million people age 65 and over (7 percent to 13 percent of all people age 65 and over) had Alzheimer’s disease in 2000. Since prevalence rises rapidly with age, the total number of people with Alzheimer’s disease will increase greatly as the age groups 75 to 84 and 85+ grow in coming decades. Alzheimer’s disease occurs in a small proportion (probably less than one percent) of people under age 65. That proportion may increase in the future as the disease is recognized earlier.

Assuming that Alzheimer’s disease is present in 60 percent to 75 percent of all cases of dementia in the U.S. and that it affected 2.6 to 4.5 million people age 65 and over in 2000, one could estimate that 3.4 to 7.5 million people age 65 and over had dementia in 2000. Preliminary data from the Health and Retirement Survey indicate that there may be 400,000 people under age 65 with dementia, for a total of 3.9 to 8 million people with dementia in all age groups in 2000.

What are the symptoms of dementia?
As noted above, dementia is characterized by decline in memory associated with decline in other cognitive abilities or personality change. Many descriptions of the symptoms of dementia focus primarily on symptoms of Alzheimer’s disease. Symptoms of other dementing diseases and conditions are often described...
only as they differ from the symptoms of Alzheimer’s disease.

**Alzheimer’s disease** generally begins gradually. Its causes are not known, but much has been learned in recent years about the risk factors, biology, and course of the disease (see *Unraveling the Mystery*). The earliest symptoms of Alzheimer’s disease are usually memory problems, especially problems with learning and recall of new information. Other early symptoms include difficulty with language (e.g., word-finding) and disturbances in visuospatial skills that can result in getting lost in a familiar setting. Deficits in executive functions (e.g., planning, organization, and judgment) are also common. These cognitive changes limit the person’s ability to work and carry out activities that are needed for independent living, e.g., driving, shopping, cooking, and managing finances. The person may or may not be aware of, and be disturbed by, these changes.

Alzheimer’s disease is progressive. Over time, the person’s cognitive deficits worsen, and other kinds of symptoms appear. Many people with Alzheimer’s disease are depressed. Some become withdrawn, apathetic, and/or irritable. Agitation is common, and some people with Alzheimer’s disease develop psychiatric and behavioral symptoms, e.g., delusions, aggression, wandering, and inappropriate sexual behaviors. Most people with the disease require 24-hour supervision at least in the middle stage of their illness. Eventually, they become unable to bathe, dress, toilet, and feed themselves. Gait and swallowing difficulties are also common in the late stage of the disease. Death usually occurs sooner than would be predicted on the basis of population data.

**Vascular or multi-infarct dementia** differs from Alzheimer’s dementia in that it generally begins more abruptly and exhibits a step-wise progression of symptoms. This is because the condition is usually caused by a stroke, multiple small strokes, or changes in blood supply to the brain that result in specific brain lesions. A person’s cognitive and other symptoms depend on the type, location, and extent of these lesions; thus, symptoms vary greatly from one person to another.

**Lewy body disease** differs from Alzheimer’s disease in that it usually progresses more rapidly. Visual hallucinations, fluctuating cognitive abilities, changing attention and alertness, and motor signs of parkinsonism are also more common.

**Fronto-temporal disease** (including Pick’s disease) differs from Alzheimer’s disease in that learning ability and visuospatial skills are often less affected, and noncognitive symptoms are more common. Patients frequently exhibit profound apathy, distractability, and impulsivity.

**Can stages of dementia be identified?**

Various staging systems have been developed for dementia. These systems are useful because they provide a conceptual framework that often helps families, care providers, and others understand where their relative or client is in the course of his or her illness, and therefore, think about and plan for the person’s current and future care. Some relatively simple staging systems identify only 3 stages (mild, moderate, and severe) and define the stages in very general terms. Other staging systems are more complex and precise. An example of the latter type is the Global Deterioration Scale, a 7-stage system based on the severity of a person’s cognitive and self-care deficits and psychiatric and behavioral symptoms. Despite the usefulness of this and other staging systems, it is important to remember that the progression of dementing diseases and conditions and the timing of particular symptoms vary greatly from one person to another. Thus few patients progress through the stages exactly as they are defined in any system.

**How can cognitive changes that are common in normal aging be distinguished from dementia?**

It is often very difficult to distinguish memory problems and other cognitive changes that are common in normal aging from the early symptoms of dementia, in part because cognitive changes in normal aging are not well understood. In its dementia guideline, the American Medical Association points out that a person with dementia will eventually become unable to maintain independent functioning, whereas independent function-
ing is preserved in normal aging. To distinguish dementia and normal aging without waiting to see whether the person’s functioning worsens, the guideline suggests several comparisons: for example, in dementia, the person’s family is likely to be more concerned about his or her forgetfulness, whereas in normal aging, the person may be more concerned; similarly, in dementia, there is likely to be notable decline in memory for recent events and ability to converse, whereas in normal aging, the person remembers important events and maintains the ability to converse.15 These and other comparisons are helpful but not definitive in distinguishing the two conditions.

Mild Cognitive Impairment is a condition that is receiving increasing attention as researchers attempt to understand the causes of Alzheimer’s disease and find ways to prevent and treat it. For research purposes, it is efficient to study people who are at high risk for the disease, and many elderly people are now enrolled as subjects in observational studies and clinical trials where they are diagnosed as having mild cognitive impairment. An unknown number of elderly people are also being diagnosed with mild cognitive impairment outside of research settings. Many researchers and clinicians believe that all people with mild cognitive impairment will eventually transition to Alzheimer’s disease.16 Reported rates of transition range from 6 percent to 25 percent per year in individuals age 66 to 81 at the start of the study.17 Some clinicians and advocates question the wisdom of diagnosing mild cognitive impairment in people who are quite old at time of diagnosis, may be upset by the diagnosis, may not transition for four or more years, and may be denied insurance and/or admission to certain residential care facilities if the diagnosis is known.

Why is it important to diagnose dementia and the underlying cause of the dementia?

Some physicians are reluctant to diagnose dementia or its underlying cause because they think the conditions are hopeless and are hesitant to call attention to them unless asked by the family.18 Over the past decade, dementia and its causes are being diagnosed more often, primarily because of the availability of medications for Alzheimer’s disease and greater general awareness of Alzheimer’s and dementia. Still many people with dementia have not been diagnosed.19 Physicians may be aware of a patient’s cognitive deficits even if they have not conducted a formal evaluation, but even when a formal diagnosis is made, the patient and family may not be told, and the diagnosis may not be entered into his or her medical record.20

Diagnosis of dementia is important because it allows the person, and perhaps more so his or her family, to understand what is happening to the person and increases the likelihood that they will access available information and supportive services. It also increases the likelihood that physicians will initiate treatments and be alert to limitations in the person’s ability to report symptoms accurately, manage medications safely, and understand and comply with other recommendations. Early diagnosis is important because it gives the person and family time to make financial, legal, and medical decisions while the person is capable.

How can dementia be diagnosed?

Dementia and Alzheimer’s disease can be diagnosed with high accuracy (90 percent or higher) when standardized diagnostic criteria are used.21 Diagnosis of vascular or multi-infarct disease, Lewy body disease, and fronto-temporal disease is often more difficult because many people with these conditions have atypical or nonspecific symptoms.20 The first steps in diagnosis are a focused history and physical, mental status testing, and discussions with the family, if any. Laboratory tests are often used, primarily to rule out reversible or partially reversible causes of dementia. There is disagreement about the value of neuroimaging procedures, but virtually all experts agree that these procedures are useful for younger patients and patients with unusual symptoms.

Delirium and depression can present with symptoms similar to dementia. Recognition and differential diagnosis of these three conditions is important. Delirium is an acute condition that can and should be treated quickly. Depression is also treatable in older people. In addition, however, people with dementia are at increased risk of developing delirium, and many people with dementia also have depression; thus, the three conditions often coexist. Effective treatment of coexisting delirium and/or depression may improve cognitive functioning in a person with dementia, although research suggests that treatment for depression often does not have as much effect as expected on the person’s cognitive functioning.

TREATMENT OF DEMENTIA

Many medical associations and other groups have developed guidelines and consensus statements about treatment of dementia. These documents differ in length, primary focus, and intended audience, but their recommendations are similar. While acknowledging that the effects of available medications for Alzheimer’s disease are often modest, the documents generally recommend an initial trial of the medications. Aggressive treatment of cardiovascular conditions is recommended since these conditions can cause vascular dementia and hasten onset of symptom development in people with Alzheimer’s disease. The guidelines and consensus statements recommend careful evaluation of mood and behavioral symptoms and efforts to manage these symptoms nonpharmacologically, if possible. They also recommend treatment of depression, attention to safety issues (e.g., driving, wandering, and firearms), referrals to community services, and involvement and support of family caregivers.

Coexisting medical conditions in people with dementia

Many people with dementia also have other serious medical conditions. Medicare fee-for-service claims for 1999 show, for example, that 30 percent of beneficiaries with dementia also had coronary heart disease, 28 percent also had congestive heart failure, 21 percent also had diabetes, and 16 percent also had thyroid disease. These medical conditions and the medications and other procedures that are used to treat the conditions can worsen cognitive and other symptoms in a person with dementia. At the same time, dementia clearly complicates the treatment of the other conditions. Families and other informal and paid caregivers of people with dementia and coexisting medical conditions are often coping with extremely difficult care situations.

Where do people with dementia live?

No precise information is available about where people with dementia live, but available data suggest that at any one time, about 20 percent of all people with dementia are in nursing homes; about 10 percent are in assisted living or other residential care facilities; and the remaining 70 percent are at home alone or with a family member or other informal caregiver.

People with dementia who live alone: Studies indicate that about 20 percent of people with dementia live alone. About half of these people have a relative or friend who functions as a caregiver, but the other half have no one. Some of these individuals have mild dementia, but many have moderate to severe dementia. They may come to the attention of attorneys when a landlord, neighbor, or law enforcement official realizes they are unable to care for themselves and may create safety problems for others. Lack of an available surrogate decisionmaker may make them difficult clients.
Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers


2. Id.


4. See Arthur C. Walsh et al., Mental Capacity (2d ed. 1994) for a discussion of the case law concerning the lawyer’s malpractice liability for knowingly allowing an incapacitated person to execute legal documents.


8. Walsh et al., supra note 4, at §2.02; see also, John Parry & F. Phillips Gilliam, Handbook on Mental Disability Law (2002).

9. Walsh et al., supra note 4 at §2.02; Parry & Gilliam, supra note 8, at 147. See also Louis A. Mezzullo & Mark Woolpert, Advising the Elderly Client (2004).


11. Id.

12. Walsh et al., supra note 4, at §2.09; Mezzullo & Woolpert supra note 9, at §32.11.

13. Walsh et al., supra note 4, at §2.10; Mezzullo & Woolpert supra note 9, at §32.12.


18. Benjamin N. Cardozo School of Law, ADA Mediation Guidelines (2000). Also see Erica Wood, Dispute Resolution and Dementia: Seeking Solutions, 35 Georgia Law Review 2, 785 (2001); and http://www.medi-

19. States use differing terms for state intervention in the financial affairs or personal affairs of incapacitated persons. The term “guardianship” is used here to refer to the judicial process for appointing a decision-maker over the personal and/or financial affairs of an incapacitated person, regardless of the particular term or terms used in any specific jurisdiction.


27. Sabatino & Basinger, supra note 20.


32. Patricia Anderten, The Elderly, Incompetency, and Guardianship (1979) (unpublished Masters thesis, St. Louis University, St Louis, Mo.).


34. 62 Fordham L. Rev. 5 (March 1994).

35. Id. at 1073.

36. Id. at 1087.

37. Id. at 1089.


43. Linda F. Smith, Representing the Elderly Client and Addressing the Question of Competence, 14 J. of Contemporary L. 61 at 90 & 92 (1988).

44. Id. at 92-96.

45. Id. at 91 & 93.


47. American Bar Ass’n Ctr. for Professional Responsibility, supra note 39, at Comment [6].

49. American Bar Ass’n Ctr. for Professional Responsibility, supra note 39, at Comment [6].


54. The Financial Capacity Instrument (FCI) is a capacity test developed by Marson and colleagues that directly assesses a patient’s financial management skills across 18 abilities (task level), 9 activities (domain level), and overall (global level). Other capacity measures that include financial test items include the Independent Living Scales (ILS), the Direct Assessment of Functional Skills (DAFS), and the Structured Assessment of Independent Living Skills (SAILS). A description of these tests and their references in the literature may be found in Appendix 3.

55. Barry Reisberg, Senile Dementia, in II The Encyclopedia of Aging 907-915 (G Maddox et al., eds. 2001).