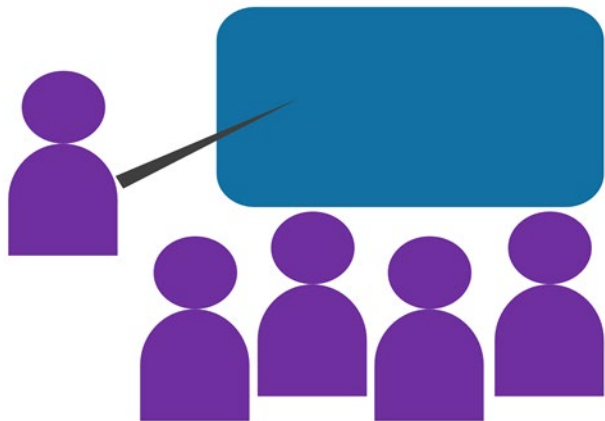


Capacity Screening in Adult Protective Services: Guidance and Resources



Introduction

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

APS caseworkers do not perform clinical health or capacity assessments unless specifically qualified or authorized by state law. They may perform an initial capacity screening or assessment when they suspect that an older person or person with disabilities suffers from impaired decision making. The needs/risk assessment process outlined in the Final National Voluntary Consensus Guidelines for State Adult Protective Services Systems, published by the Administration for Community Living in 2016, identifies several domains that could help APS caseworkers screen for indications of cognitive

impairment. When concerns are identified, APS can refer the client to qualified professionals such as physicians, geriatricians, psychologists, or psychiatrists to administer professional, comprehensive capacity evaluations. Screening tools, in general, are helpful in determining whether clients have the ability to make informed decisions, to give or deny consent for APS services and/or to meaningfully participate in care planning (Falk & Hoffman, 2014).

A comprehensive capacity evaluation should include:

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

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

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

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

Part I: Understanding Capacity Terminology

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

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

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

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

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

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

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

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

Incapacity – The inability to receive and evaluate information or to make or communicate decisions to such an extent that an individual is unable to meet essential requirements for: physical health, safety, or self-care, even with the appropriate technological assistance. Clinical incapacity is a judgment about one’s functional abilities (National Center on Elder Abuse, 2015).

What is Capacity?

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

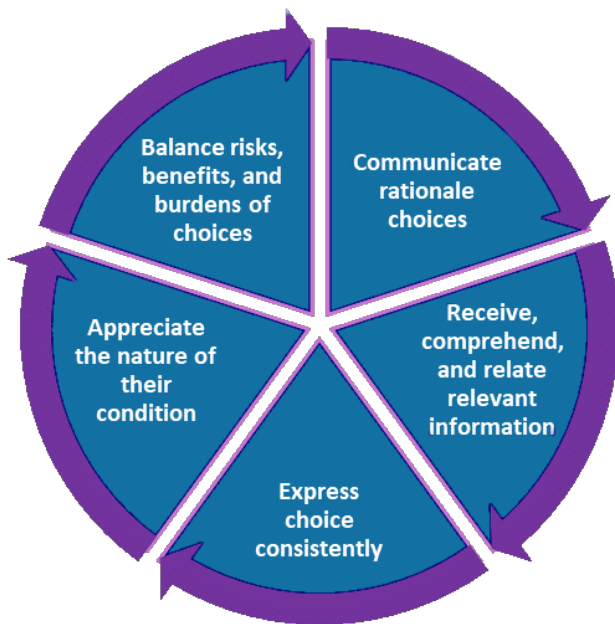
- memory and logic,
- behavioral and physical functioning that people use in everyday life,
- a continuum of decision-making abilities,

- contextual, and varies by the complexity of the task or the decision,
 - an element that should always be evaluated in relation to the particular act that is at issue (e.g., signing over a home, creating a will, marrying, testifying about abuse).”
- (Judicial Council of California & Mosqueda, 2012)

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

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

Attributes of Capacity



An individual’s decision-making abilities may vary as a result of physical or mental stress, the complexity of the decision, and can vary from day to day or

from morning to evening. Differentiating a physical disability, such as stroke-related aphasia, from decisional incapacity is critical (Ramsey-Klawnsnik, *The Complexities of Cognitive Capacity*, 2014). Medications, medication interactions and sensory deficits can also play a role.

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

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

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

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

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

(Ganzini, Volicer, & Fox, 2004)

Civil Capacities - Capacity to Do What?

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

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

medications is strongly linked to the capacity to live independently.

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

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

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

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

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

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

Testamentary Capacity – Criteria for testamentary capacity vary across states but according to the ABA & APA Assessment of Older Adults With Diminished Capacity (2008), there are generally four criteria identified including “a testator must have (1) knowledge of what a will is; (2) knowledge of that class of individuals that represents the testator’s potential heirs (“natural objects of one’s bounty”); (3) knowledge of the nature and extent of one’s assets; and (4) a general plan of distribution of assets to heirs.” It is important to note that the functional elements of testamentary capacity are

almost completely cognitive and to “exercise this capacity, a client must communicate and work with an attorney, which introduces a professional relationship and some element of social discourse into the exercise of this capacity” (American Bar Association Commission on Law and Aging & American Psychological Association, 2008).

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

Part II: The Relationship Between Capacity and Abuse

Why APS Professionals Need to Understand Capacity

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

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

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

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

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

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

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

According to Dr. Holly Ramsey-Klawnsnik, “case planning decisions hinge on capacity and APS caseworkers need to understand what mental

capacity involves, indicators of cognitive loss, effective strategies for gathering and documenting capacity information, and indicated next steps when clients are in danger due to limited capacity. APS workers must also understand how their state law specifically defines capacity and practice accordingly” (Ramsey-Klawnsnik, *The Complexities of Cognitive Capacity*, 2014).

Demographics

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

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

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

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

Client Vulnerabilities

Financial Exploitation – Research has found age-related cognitive impairments such as Alzheimer’s disease are highly correlated with financial exploitation and poorer decision-making abilities. It is important to note that cognitive function is an important predictor of decisional capacity, but other factors may also influence these abilities.

Lichtenberg et al., (2016) point to Boyle’s 2013 work that highlights the fact that financial decision-making capacity differs from executorial capacity. They state, “in nearly 25% of the couples studied, the person with dementia retained decisional capacity, even in the absence of executorial capacity” (Lichtenberg, et al., 2016). This research points to individual differences and the complexities of financial exploitation cases. Thus, to protect the individual’s autonomy, APS should not assume that all older adults are at risk for financial scams and theft.

Undue Influence – Undue influence, generally summarized, occurs “when a fiduciary or confidential relationship exists in which one person substitutes his own will for that of the influenced person’s will” (Quinn M. J., 2018). Some states define the term, some cite it in probate, criminal or other sections of code. For that reason, it is recommended that APS caseworkers be familiar with how the term is applied in their state laws. Though cognitive deficits can make an individual more vulnerable to undue influence, undue influence and incapacity often occur independent of each other. Psychological manipulation over time is the constant in undue influence cases. The

International Psychogeriatric Association Task Force on Testamentary Capacity and Undue Influence, comprised of professionals from the legal, medical and psychological fields identified three areas of risk for undue influence:

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

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

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

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

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

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

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

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

Part III: Capacity Screening – Cognitive Domains and Screening Tools

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

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

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

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

(National Center on Elder Abuse, 2015)

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

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

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

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

Confusion Assessment Method (CAM) – [CAM](#) is a standardized evidence-based tool that enables non-

psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The CAM includes four features found to have the greatest ability to distinguish delirium from other types of cognitive impairment (McCabe, 2019). It can be administered in less than 5 minutes and measure two areas. Part one is an assessment instrument that screens for overall cognitive impairment. Part two includes only those four features that were found to have the greatest ability to distinguish delirium or reversible confusion from other types of cognitive impairment.

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

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

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

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

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

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

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

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

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

The Executive Interview (EXIT25) – The EXIT 25 is a standardized multi-task assessment of executive function comprised of twenty-five tasks that can be administered in APS clients’ homes. It takes 10-15 minutes to administer and does not require

advanced training to score and interpret. According to Schillerstrom et al., “tasks include having the client name as many different words as they can think of that start with the letter “A,” list the months of the year backward starting from January and respond appropriately to a spontaneous clap. Each item challenges the examinee to go against their habits to solve the task at hand” (Schillerstrom, et al., 2013).

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

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

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

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

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

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

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

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

Part IV: Research on Capacity Screening

Executive Function and Recidivism

In a study by the University of Texas Health Science Center at San Antonio (UTHSCSA) and Texas APS, researchers conducted a retrospective medical

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

The authors cited the following observations and APS practice implications:

- There is a disproportionately high prevalence of older adults referred by APS for decision-making capacity assessments with executive function impairments compared to other cognitive domains.
- APS caseworkers appear more sensitive to memory, concentration, and orientation impairments than they are to executive function deficits. Though executive function deficits greatly affect self-care abilities.
- There is a large cost to investigating repeat alleged victims of abuse, neglect, or exploitation. Identifying risk factors for recidivism could significantly decrease caseloads, cost, and suffering.
- Executive function deficits may diminish APS clients' abilities to utilize least restrictive interventions offered by APS, predisposing them to recidivism.
- Identifying risk factors for recidivism, such as executive function impairments, may help target appropriate client interventions and supports to decrease reoccurrences. (Terracina, Aamodt, & Schillerstrom, 2015)

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

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

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

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

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

Conclusion

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

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

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

Training Resources: Adult Protective Services Workforce Innovations (APSWI)

- [APS Core Assessing Client Capacity Instructor-Led Training](#)
- [APS Core Assessing Client Capacity eLearning](#)
- [Undue Influence eLearning Mini-Module](#)
- [Undue Influence Committed by Professionals eLearning](#)

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