**Elizabeth Mulligan, PhD**
**Assessment Work Sample**

**Contextual Statement:** I have chosen to present the assessment case of Mr. X, an 84-year-old, married, Caucasian, non-service connected (NSC) veteran of the Army who was initially referred to the Geriatric Mental Health Clinic by his Geriatrics provider in the context of difficulty adjusting to discontinuing his driving. My work with him has included an initial psychodiagnostic assessment, a brief course of individual therapy after which he transitioned to a support group for veterans with dementia I facilitate, an evaluation of his capacity to discontinue his medications, and a related adult protective filing. For the sake of brevity, I will focus primarily on the capacity evaluation, but I will describe our previous interactions to provide contextual information. I have also included a final individual therapy note/termination summary below for this purpose.

The veteran's wife reported that he was diagnosed with dementia by a non-VA neurologist approximately one year prior to our initial encounter and that he was advised to stop driving at that time. Throughout the course of his 7 sessions of individual therapy, the veteran endorsed adjustment-related concerns regarding his inability to drive as well as to other functional limitations (e.g., the need to use a walker), but he denied significant symptoms of anxiety and depression. His wife's reports were inconsistent with his, as she described him as anhedonic with marked difficulties with initiation and noted that this represented a change from his previous behavior. His mental status in session reflected flat affect as well as difficulties with motivation and initiation. Neither the veteran nor his wife were able to provide additional details about the specific nature of his dementia diagnosis, but he signed a release of information for me to request documentation from his non-VA providers. I was particularly curious about this information because I was unsure regarding his ability to benefit from individual therapy. Program evaluation efforts within the Geriatric Mental Health Clinic indicated that a large proportion of our referrals have dementia (~20%) or milder forms of cognitive impairment (~30%) so this is an issue I often face. My general approach is to assume these patients are able to participate in therapy unless proven otherwise and to gather additional information about the severity and nature of their impairments in order to determine how to tailor the therapy approach (e.g., Would 30 minute sessions be more appropriate?; Would written materials be helpful?).

In Mr. X's case, I had some difficulty contacting his non-VA neurologist, but I was eventually informed that his dementia diagnosis had been based on neuroimaging and a clinical interview. There was no information about the veteran's particular areas of cognitive impairment/strengths or about the type of dementia he likely had. As described in greater detail below, I then spoke with the veteran and his wife about the nature of the difficulties he was having, completed a MoCA (18/30), and referred him for a neuropsychological evaluation. Over time, I found that the veteran's ability to participate actively in therapy was limited, likely due to a combination of his cognitive impairment (e.g., difficulty retaining information from one session to the next; slow processing speed and vague responses at times) and his amotivation (e.g., often hesitant to implement suggestions). In the end, the veteran and I decided that an ongoing, weekly support group I facilitate for veterans with dementia would be the best fit for his needs and he transitioned to this group.

At that time, the veteran's wife also began attending a corresponding support group for caregivers of veterans with dementia facilitated by my colleague, a social worker/Dementia Care Coordinator. I strongly encouraged her to attend given her level of strain. During his therapy, the veteran and I met primarily individually, with Mrs. X joining us at the end for the purpose of treatment planning. I used this approach because of a combination of the veteran's preference, his tendency to defer to his wife when she was in the room, and my concerns for potential abuse. In these interactions, Mrs. X expressed significant caregiver strain and a fair amount of frustration/irritability with her husband. I also witnessed her using a

harsh tone with the veteran on multiple occasions when she believed he was not trying hard enough to ambulate. I felt some comfort when Mrs. X told me she was participating in mental health treatment with her own providers, but I also regularly consulted with colleagues from Primary Care Social Work and the Dementia Care Coordination regarding providing her with additional support and psychoeducation. I also regularly assessed risk with the veteran. He noted he and his wife had disagreements at times, but he consistently denied any physical altercations or concerns for his safety. Several months after she began attending the caregiver support group, Mrs. X reported to that group's facilitator that her husband had "hit her again," and my colleague filed an Adult Protective Services (APS) report at that time given concerns for both the veteran's and his wife's safety (she is also an older adult).

Less than one week after this first APS report was filed, my colleague had a phone conversation with Mrs. X in which she stated that her husband had decided to discontinue all of his medications with the exception of an over-the-counter pain pill. She stated that she was respecting her husband's wishes and was expecting a home visit from a hospice agency. I was very concerned about this turn of events due to their conflictual relationship and wondered if the veteran had the capacity to make this decision. I was also aware that even if he did not have capacity, he had appointed his wife as his healthcare proxy. With my colleagues' assistance, I spoke with the veteran and his wife over the phone and confirmed that he had discontinued these medications, consulted with his Primary Care provider to make sure there was no imminent risk, and requested that the veteran come in early for an evaluation prior to our next group.

In general, I would not advocate for this dual role of group therapy provider and assessor of capacity. However, I recognized the potential risks of delaying the evaluation by placing a referral for someone else to complete it. I consulted with other members of the Geriatric Mental Health Clinic team and ultimately decided it was best for me to complete the evaluation. I also knew from prior experience that if I ended up filing an Adult Protective report regarding this issue, then one of the first questions they would ask would be "Does the patient have the capacity to make decisions regarding his medication?".

My approach to capacity assessment is guided by the framework delineated in the ABA-APA Capacity Handbook for Psychologists (2008). Although normally I would complete a comprehensive chart review and gather information from all of the relevant stakeholders, in this case much of this work was already done given my prior interactions with the veteran and his wife. I also typically utilize a combination of structured and interview-based assessment. I did not complete any additional cognitive assessment since the veteran had participated in neuropsychological evaluation several weeks earlier that was consistent with Major Neurocognitive Disorder Due to Multiple Etiologies. It provided me with sufficient information regarding how the veteran's cognitive functioning might affect his capacity. I therefore focused primarily on a clinical interview with the veteran with questions covering the core concepts of understanding, appreciation, reasoning, and expressing a choice as well as the veteran's healthcare values. I wanted to make sure that the veteran's performance was not entirely determined by his impairments in memory so I provided him with plenty of cues and external support regarding the purpose of his various medications.

I determined that the veteran did not have the capacity to make decisions regarding discontinuing his medications at the time of our evaluation. Although he was able to express some desire to eliminate unnecessary medications, his understanding of the purpose of most of his medications was quite limited even with additional support and cueing. He also lacked full appreciation of the potential risks of discontinuing various medications and was unable to provide a clear explanation regarding how he might go about determining which medications are necessary. I also determined that he did retain the capacity to appoint a healthcare proxy. He had already appointed his wife on a previous occasion, but in this interaction he expressed a preference for his wife and his children to collaborate on decision-making.

In terms of ethical issues, this case represents the delicate balance of respecting the veteran's dignity and autonomy with nonmaleficence given his limited abilities to understand, appreciate, and reason regarding the potential risks of discontinuing his medications. My colleague called APS to report this additional information given that there was already an open case involving the veteran, but they requested I file a separate report, which I have included below. I considered this to be a case of potential neglect given that the veteran did not have the capacity to make the decision to discontinue his medications, but his wife was still honoring this decision. I also worried about the potential for undue influence from the veteran's wife given her level of caregiver strain and their conflictual relationship. I tried to make practical recommendations regarding involving the veteran's children in decision making and providing his wife with additional supports in the community. I also made sure to speak with the case manager directly to explain some of the details about the veteran's relationship with his wife that may not be fully represented in the written report. Ultimately, APS followed the veteran on an ongoing basis, he resumed his medications, and he was determined by the hospice agency to not be appropriate for their services at that time. Unfortunately, the veteran and his wife stopped attending their support groups shortly after this report was filed. I spoke with both Mr. and Mrs. X over the phone to encourage them to attend and they repeatedly stated they would come in, but they never did. I made the APS case worker and the veteran's other VA providers aware of this development. He continues to attend other appointments at the VA.

Informed Consent: The outpatient Geriatric Mental Health Clinic does not utilize a specific written consent for psychological services. As described below, I seek to obtain informed consent verbally. If a patient is unable to provide consent, I seek their assent. In this case, the veteran did seem to have the ability to provide informed consent. Although he required some repetition and written information, he demonstrated good understanding of the potential risks and benefits of this evaluation and he agreed to participate.

References:

American Bar Association Commission on Law and Aging, & American Psychological Association. (2008). Assessment of older adults with diminished capacity: A handbook for psychologists. Washington, DC.

**Final Individual Therapy Note and Termination Summary:**

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Individual psychotherapy with this provider began on October 30, 2013. We
decided to meet for ~6 biweekly individual sessions, with a possible transition
to the dementia support group. We re-evaluated the PSA today, and the veteran
was in agreement with a plan to terminate individual therapy and attend the
weekly men's group. His wife will attend the corresponding group for caregivers.

GERIATRIC MENTAL HEALTH CLINIC

SESSION TYPE: Individual Psychotherapy
DURATION:  45 minutes (~25 minutes with veteran alone; 20 minutes with veteran
and his wife).

PURPOSE: The veteran identified the following treatment goals: (1) processing
his thoughts and feelings about his dementia diagnosis and related functional
limitations; (2) improving his relationship with his wife. As today was a
termination session, we focused on reviewing individual treatment and discussing
plans for ongoing treatment.

BACKGROUND:  Mr. A X is an 84-year-old, married, Caucasian, NSC,
non-combat veteran of the Army who was referred for an evaluation in the
Geriatric Mental Health Clinic following a Primary Care-Geriatrics appointment
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with his PCP. Records indicate that the veteran was diagnosed with dementia at a non-VA hospital last year. His medical history is also significant for NPH s/p VP shunt 12/2012; ?CVA 1/2013, ? Parkinson's, BPH, incontinence, HTN, HL, peripheral neuropathy, and s/p CABG 1997. On intake, the veteran denied most symptoms of depression and anxiety, but he did endorse adjustment concerns related to declines in his functional abilities, especially discontinuing driving. The veteran receives VNA/VHA and he has begun attending ADHC at Sinai 3 days a week (Mondays, Tuesday, and Thursdays). His wife assists with many tasks related to the veteran's care and managing the household, and she has reported caregiving strain.

The veteran's wife reported noticing the following changes in her husband's memory and thinking that have progressively declined over the past 1-2 years: diminished short-term memory, amotivation/poor initiation, word finding difficulty, a tendency to get lost prior to when the veteran stopped driving, and declines in independent functioning (including incontinence with indwelling catheter). I completed a brief cognitive screen at our 10/30 session, which was consistent with probable cognitive impairment (MoCA = 18/30 with one point added for 12th grade education). The veteran lost points on items related to executive functioning, visuoconstruction, naming, attention/working memory, phonemic fluency, abstraction, and delayed recall. He has been referred for a neuropsychological evaluation.

PROBLEM 1: Cognitive and functional limitations in the context of dementia
OBJECTIVES: (1) The veteran will gain a better understanding of his thoughts and feelings about his dementia diagnosis. (2) The veteran will reflect on personal strengths and resilience factors from past challenging situations.

PROBLEM 2: Adjustment disorder with mixed anxiety and depressed mood.
OBJECTIVES: (1) Veteran will report an increase in activity level and enhanced motivation, including more pleasant events and greater social interaction.
(2) Veteran will report improvements in his relationship with his wife.

PROGRESS/SESSION CONTENT: At a previous session, the veteran reported that it was "easy to talk," but he probably "doesn't need" individual meetings and we discussed the benefits of transitioning to the group (e.g., receiving support from other veteran who have similar problems with their memory and thinking). He and his wife agreed to think about the dementia and caregiver support groups would fit into their schedule. Today the veteran and his wife both agreed to a plan to transition to these groups and to terminate individual therapy.

During our one-on-one time, I provided the veteran with a handout delineating his treatment goals and ways he can help himself, and we reviewed this handout in session. Provided the veteran with the opportunity to ask questions and to make changes to this handout, but he declined. He did report that he often feels "I am not in charge anymore," which contributes to his low motivation.

The veteran's wife continued to express strain and frustration regarding the veteran's limited motivation/initiation and support and psychoeducation were provided. She expressed appreciation for her interactions with various VA providers.

ASESSSMENT/MENTAL STATUS: The veteran's records indicate that he was diagnosed with Dementia NOS at a non-VA facility and his performance on a brief cognitive screen on 10/30 consistent with such (MoCA = 18/30 on 10/30/13). He also endorsed adjustment-related concerns related to declines in his functional abilities including an inability to drive, but repeatedly denied most depressive symptoms with the exception of amotivation, some loss of interest, and occasional irritability (Geriatric Depression Scale = 1/15 on 12/11/13). Today the veteran was fully oriented, but he appeared more tired, likely related to his recent illness. He has some difficulty recalling information across our biweekly sessions, but seems to somewhat benefit from cueing. His affect was

generally flat, although he smiled at times. His processing speed/rate of speech were both slow. He typically ambulates slowly with the assistance of a walker and require assistance from his wife to lift himself up from the chair, but today he used a wheelchair. Whenever his wife is in the room, he looks to her to respond to questions, but he is able to provide some responses on his own.

DIAGNOSES (The following diagnoses are based on DSM 5 criteria)
Mental Health Diagnoses: Unspecified Major Neurocognitive Disorder per record, Adjustment Disorder with mixed anxiety and depressed mood
R/O Depressive Disorder Due to Another Medical Condition

Relevant Medical Conditions: NPH s/p VP shunt 12/2012; ?CVA 1/2013, ? Parkinson's, BPH incontinence, HTN, HL, s/p CABG 1997

Significant Psychosocial and Contextual Factors: No longer able to drive, limited social support

PLAN:
-Individual treatment is terminated at this time. The veteran was in agreement with a plan to attend a support group for veteran's with dementia and his wife will attend a corresponding support group for caregivers.
- Continued psychiatric medication management and counseling with Susan Rouse, CNS.
- A referral for a neuropsychological evaluation has been placed. Will pass along the records from his non-VA neurologist (Dr. JG) prior to this evaluation.
- A referral to Dementia Care Coordination is not needed at this time because the veteran and his wife have already worked with his primary care social worker, on multiple occasions.

BRIEF TREATMENT SUMMARY: The veteran participated in 1 evaluation session and 7 sessions of psychotherapy with this provider. Primary presenting issues were adjustment disorder with mixed anxiety/depression stemming from the veteran's dementia diagnosis and related functional limitations (e.g., inability to drive). Interventions included processing thoughts and feelings related to this diagnosis, problem solving regarding enjoyable activities that the veteran may still be able to participate in (e.g., becoming more involved at his wife's temple since he was no longer able to drive to his temple), focusing on enjoyable and productive tasks the veteran can still engage (e.g., setting the table), and improving communication his wife. The veteran's ability to participate actively in therapy was limited, likely due to a combination of his cognitive impairment (e.g., difficulty retaining information from one session to the next; slow processing speed and vague responses at times) and his amotivation (e.g., often hesitant to implement suggestions such as asking his wife for a ride).

Throughout treatment, the veteran denied most depressive symptoms with the exception of some loss of interest, frustration with functional limitations, and occasional irritability. However, his presentation in sessions (fairly flat affect) and his wife's report of anhedonia, low verbal output, and poor initiation indicated a possible depressive episode, and I subsequently referred the veteran for a psychiatric evaluation. I also wondered about the severity of the veteran's dementia and therefore completed a cognitive screen (MocA = 18/30 on 10/30/13; see more details in the Background section above) and requested remote records from his non-VA Neurology provider. Based on a review of these records and my conversations with the veteran and his wife, he has not previously had a neuropsychological evaluation and a consult was placed.

For most sessions, I primarily met with the veteran and his wife joined for 5-10 minutes at the end. However, for a couple sessions, Mrs. X joined for longer and expressed caregiver strain related to the veteran's limited motivation/initiation as well the need for her to assist with many IADLs and ADLs (e.g., veteran's incontinence). Support and psychoeducation related to the

veteran's areas of cognitive impairment and the potential benefits of various interventions (e.g., caregiver and dementia support groups; a neuropsychological evaluation) were provided. Ms. X also benefitted from social work interventions provided by his primary care social worker (e.g., respite).

During our one-on-one time, the veteran reported that he and his wife sometimes have disagreements, but denied that they ever escalate to physical altercations.

Ultimately, the veteran and his wife were in an agreement with a plan to transition to the dementia support group and the corresponding group for caregivers. I think these groups will be a better fit for their ongoing needs than my therapy sessions with the veteran.

Treatment Summary (provided the veteran with a copy)
Goals for treatment:
1. To discuss your thoughts and feelings about your problems with memory and thinking and on how they have affected your life (for example, not being able to drive).
2. To get along well with your wife.

Methods for helping yourself:
1. Engaging in activities that you enjoy and/or that make you feel productive is one of the best things you can do if you are feeling depressed. Some activities that you used to enjoy are more difficult for you to do since you are unable to drive (for example, going to the temple). However, there may be ways for you to do more of these things (for example, asking your wife for a ride or becoming involved at her temple).
2. Do not be afraid to ask for help when you need it. Remember that your family cares about you and wants to help.
3. Be nice to yourself rather than critical. Try to focus on what you are doing and can do versus what is hard for you.
4. Continue to spend time with other people rather than isolating yourself. The adult activity center you attend is one way of making sure you are spending time with others.
5. You recognize that your wife appreciates when you help around the house. Although you may not be able to help with everything you used to because of your problems with memory and thinking, focus on the things that you can do (for example, setting the table).

Next step:
- Support group for veterans with dementia on Mondays from 11-noon. A group for caregivers meets at the same time. The couple is planning to begin on Monday, March 10, assuming they can switch his ADHC day by that time.
- An evaluation of your memory and thinking, also known as a neuropsychological evaluation.

Contact information: Beth Mulligan, PhD

## Evaluation of Capacity to Discontinue Medications:

LOCAL TITLE: MH CAPACITY EVALUATION
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: JUL 14, 2014@17:21 ENTRY DATE: JUL 14, 2014@17:21:32
AUTHOR: MULLIGAN,ELIZABETH EXP COSIGNER:
URGENCY: STATUS: COMPLETED

SESSION TYPE: Evaluation of capacity to discontinue medications
DURATION: 25 minutes
SUPERVISOR: Elizabeth Mulligan, Ph.D.

BRIEF BACKGROUND: Mr. A X is an 84-year-old veteran with Major Neurocognitive Disorder Due to Multiple Etiologies (see evaluation dated 4/16/14 by <Psychology Fellow>, for additional information). The veteran and his wife are followed in the Memory and Health support group for veterans with dementia facilitated by this provider and the corresponding Caregiver Support group facilitated by Dementia Care Coordinator. In phone conversations with both DCC and this provider, Mrs. X reported that her husband decided to discontinue all of his medications at this time with the exception of OTC pain medications and that they were planning to meet with a local hospice agency.

Per Pharmacy records, the veteran's current medications include:

| DRUG | STATUS | SIG |
|---|---|---|
| BAG,URINARY DRAINAGE 2000CC | ACTIVE | |
| SIG: USE BAG(2000 ML) TO SKIN AS DIRECTED BY PROVIDER | | |
| TRAZODONE HCL 50MG TAB | ACTIVE | |
| SIG: TAKE ONE AND ONE-HALF TABLETS BY MOUTH EVERY DAY FOR DEPRESSION/MOOD/SLEEP | | |
| FLUOXETINE HCL 10MG CAP | ACTIVE | |
| SIG: TAKE THREE CAPSULES BY MOUTH EVERY MORNING FOR DEPRESSION AND ANXIETY | | |
| ATENOLOL 25MG TAB | ACTIVE | |
| SIG: TAKE ONE TABLET BY MOUTH EVERY DAY | | |
| FINASTERIDE 5MG TAB | ACTIVE | |
| SIG: TAKE ONE TABLET BY MOUTH EVERY DAY FOR PROSTATE | | |
| ATTENDS PLUS BRIEF PULL-ON LARGE | ACTIVE | |
| SIG: USE BRIEF PLUS (LARGE) TO SKIN TWICE A DAY | | |
| SIMVASTATIN 40MG TAB | ACTIVE | |
| SIG: TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME FOR REDUCING CHOLESTEROL | | |
| GLOVE VINYL LARGE NONSTERILE | ACTIVE | |
| SIG: USE AS DIRECTED TO SKIN AS DIRECTED BY PROVIDER | | |
| ASPIRIN 81MG EC TAB | ACTIVE | |
| SIG: TAKE (DO NOT CRUSH) ONE TABLET BY MOUTH EVERY DAY TO PREVENT STROKE/HEART ATTACK | | |
| DONEPEZIL HCL 5MG TAB | ACTIVE | |
| SIG: TAKE ONE TABLET BY MOUTH AT BEDTIME | | |
| MULTIVITS W/MINERALS TAB/CAP (NO VIT K) | ACTIVE | |
| SIG: TAKE 1 TABLET BY MOUTH EVERY DAY TO PREVENT VITAMIN DEFICIENCY | | |

PURPOSE: The purpose of this evaluation was to assess the veteran's decision-making capacity regarding discontinuing his medications.

INFORMED CONSENT: This writer reviewed the purpose of the evaluation and discussed the potential risks and benefits with the veteran using simple and concrete language. The veteran required some repetition of this information, but he demonstrated good understanding of the potential risks and benefits of this evaluation and agreed to participate.

CLINICAL INTERVIEW:
The veteran was asked to describe recent decisions regarding his medication and he reported "We (my wife and I) eliminated ones that are not necessary". When asked whose idea it was to discontinue some medications, the veteran noted that he was unsure. When asked to describe his criteria for determining a necessary medication, the veteran noted that he his wife decided and that he trusts her given her experience as a nurse. He was unable to spontaneously recall any of his medications and stated "I guess I take 6 right now". With some cueing, he noted that he continues to take a sleeping pill on a nightly basis and Tylenol as needed and that he utilizes a catheter. His responses to other questions regarding his medications were quite vague even with additional support and cueing. For example, when asked if he has ever taken medication for mood/anxiety, the veteran reported "It's possible.". Additionally, this provider

described the role of simvastatin as a medication for cholesterol. When asked if he had ever taken this type of medication, the veteran reported "I don't think so". He had difficulty describing the purpose of this medication and what would happen if he stopped taking it, even with repeated descriptions of the risks by this provider.

We also briefly discussed the purpose of hospice care. The veteran demonstrated some understanding of this information. When asked if he would consider hospice care for himself, he noted that he had "been thinking about it," but "was not sure about it yet". With regard to healthcare values, the veteran identifies "being able to live at home" as very important to him.

The veteran denied major mental health symptoms including depression and anxiety at this time with the exception of some frustration with functional limitations and occasional irritability. However, his affect was flat and his wife reports anhedonia.

MENTAL STATUS: The veteran ambulated slowly with the assistance of a walker. He demonstrated poor initiation. Eye contact was variable. Hearing and vision appeared adequate for this assessment. Speech was notable for slowed rate (likely due to both word finding difficulties and slowed response latencies), low volume, and paucity of content. He was oriented to person and time, but not place (said he was at the Quincy Medical Center). He denied depressive symptoms but his affect was quite flat and restricted and his wife reports anhedonia. He denied SI and did not report HI.

DIAGNOSES (The following diagnoses are based on DSM 5 criteria):
Mental Health Diagnoses:
Major Neurocognitive Disorder due to Multiple Etiologies (294.10; per 4/16/14 neuropsychological evaluation); R/O Depressive Disorder Due to Another Medical Condition

Relevant Medical Conditions:
Hx of normal pressure hydrocephalus (s/p lp, shunt), chronic ischemic heart disease (s/p CABG 1997), hyperlipidemia, HTN, benign neoplasm of colon, BPH, OSA

Significant Psychosocial and Contextual Factors:
Ongoing adjustment to driving cessation, limited social support

CONCLUSIONS:
It is the opinion of this provider that the veteran does not currently retain the capacity to make decisions regarding discontinuing his medications. Although he was able to express some desire to eliminate unnecessary medications, he was unable to recall most of his medications. Additionally, his understanding of the purpose of most of his medications was quite limited even with additional support and cueing. He also lacked full appreciation of the potential risks of discontinuing various medications and was unable to provide a clear explanation regarding how he might go about determining which medications are necessary.

PLAN/RECOMMENDATIONS:
- It is recommended that the veteran's healthcare proxy be activated for decisions regarding his medications. Of note, when asked who he would like to make decisions on his behalf if he were unable to, the veteran stated "my wife in discussions with my kids". Would strongly recommend his son G X and his daughter D L be involved in decision-making if possible given the veteran's stated preference and his wife's current level of caregiver strain.
- Will also talk with the veteran regarding if he wants to update his advance directive since his son is not currently listed in any capacity.
- An Adult Protective report has already been filed by DCC, and the agency has been alerted to the veteran discontinuing his medications. Have discussed these results with members of the Geriatric Mental Health Clinic team and DCC has agreed to pass them along to his case manager at Old Colony Elder Services.

**Report Submitted to Adult Protective Services:**

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LOCAL TITLE: Elder Abuse/CWN
STANDARD TITLE: CLINICAL WARNING
DATE OF NOTE: JUL 16, 2014@10:43     ENTRY DATE: JUL 16, 2014@10:43:56
      AUTHOR: MULLIGAN,ELIZABETH   EXP COSIGNER:
     URGENCY:                           STATUS: COMPLETED

   *** Elder Abuse/CWN Has ADDENDA ***

Dear Mandated Reporter:

The Elder Abuse Mandated Reporter Form should be used by mandated
reporters to report suspected elder abuse or neglect. Mandated reporters
who suspect that an elderly person is suffering from abuse or neglect
should immediately make a verbal report to a local designated protective
service agency or the Elder Abuse Hotline. The elder abuse
hotline can direct you to the designated protective service agency in the
patient's area.

Print off this report, sign it where it says "Signature of the reporter",
and fax it to the designated protective service agency after making an
oral report.

EXECUTIVE OFFICE OF ELDER AFFAIRS
COMMONWEALTH OF MASSACHUSETTS

ELDER ABUSE MANDATED REPORTER FORM

This form should be returned within 48 hours of the oral report,
to the Designated Protective Service Agency:

XXXX Elder Services
_____________________________________________________________________
Reporter Information:

Name:       Elizabeth Mulligan, PhD
Occupation: Staff Psychologist
Agency:     VA Boston Healthcare System
Address:    940 Belmont Street, Brockton MA 02301
Tel. #:

Information about Elder Being Allegedly Abused/Neglected:

Name:    A X
Address: Permanent: X
   Temporary:

Tel. #: X

Approximate Age: 84     Sex: MALE
Preferred Language: English

Is the elder aware a report is being made? No- he has been informed in general
about the limits of confidentiality, but he likely has difficulty retaining this
information due to dementia

Is English spoken?  Yes
_____________________________________________________________________

Description of alleged abuse incidents and/or condition of neglect:
Include name, dates, times, and specific facts and any information
regarding prior incidents of abuse/neglect.
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The concern is primarily for potential neglect:

Mr. A X is an 84-year-old veteran with dementia (Major Neurocognitive Disorder Due to Multiple Etiologies). The veteran and his wife B X are followed in the Memory and Health support group for veterans with dementia facilitated by this provider and the corresponding Caregiver Support group facilitated by Dementia Care Coordinator. In phone conversations with both DCC and this provider, Mrs. X reported that her husband decided to discontinue all of his medications at this time with the exception of OTC pain medications and that she is following his wishes. I completed a capacity evaluation with the veteran and concluded that he does not currently retain the capacity to make decisions regarding discontinuing his medications and that his healthcare proxy (his wife) should be consulted for such decisions. In consultations with the Geriatric Mental Health Clinic team, this report is being filed given concerns that the veteran's wife may have difficulty with this role as his healthcare agent given her high level of caregiver strain/feeling overwhelmed. The veteran does retain the capacity to appoint a healthcare proxy and requested that his wife make decisions on his behalf in consultation with his children (G X and D L; contact information unknown). Additional complicating factors include discrepancies between the report of the veteran and the report of his wife and it is hard to determine if this is related to his dementia or to some other issue. For example, in the capacity evaluation with the veteran, he reported that he believes he has only discontinued several of his medications while he continues to take several of them that are "necessary". He was unable to identify which medications he was taking even with additional support and cueing with the exception of a "sleeping pill" and also noted that he determined which medications are necessary by deferring to his wife since he trusts her medical knowledge (she was a nurse). The veteran denied that discontinuing his medications is a way of ending his life.

The Geri MH Clinic team was wondering about referral to Family Caregiver support program, referral to Options Counseling, and additional caregiver support to wife who endorses high caregiver stress and caregiver burden.

Per Pharmacy records, the veteran's current medications include:

| DRUG | STATUS | SIG |
|---|---|---|
| BAG,URINARY DRAINAGE 2000CC | ACTIVE | |
| SIG: USE BAG(2000 ML) TO SKIN AS DIRECTED BY PROVIDER | | |
| TRAZODONE HCL 50MG TAB | ACTIVE | |
| SIG: TAKE ONE AND ONE-HALF TABLETS BY MOUTH EVERY DAY FOR DEPRESSION/MOOD/SLEEP | | |
| FLUOXETINE HCL 10MG CAP | ACTIVE | |
| SIG: TAKE THREE CAPSULES BY MOUTH EVERY MORNING FOR DEPRESSION AND ANXIETY | | |
| ATENOLOL 25MG TAB | ACTIVE | |
| SIG: TAKE ONE TABLET BY MOUTH EVERY DAY | | |
| FINASTERIDE 5MG TAB | ACTIVE | |
| SIG: TAKE ONE TABLET BY MOUTH EVERY DAY FOR PROSTATE | | |
| ATTENDS PLUS BRIEF PULL-ON LARGE | ACTIVE | |
| SIG: USE BRIEF PLUS (LARGE) TO SKIN TWICE A DAY | | |
| SIMVASTATIN 40MG TAB | ACTIVE | |
| SIG: TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME FOR REDUCING CHOLESTEROL | | |
| GLOVE VINYL LARGE NONSTERILE | ACTIVE | |
| SIG: USE AS DIRECTED TO SKIN AS DIRECTED BY PROVIDER | | |
| ASPIRIN 81MG EC TAB | ACTIVE | |
| SIG: TAKE (DO NOT CRUSH) ONE TABLET BY MOUTH EVERY DAY TO PREVENT STROKE/HEART ATTACK | | |
| DONEPEZIL HCL 5MG TAB | ACTIVE | |
| SIG: TAKE ONE TABLET BY MOUTH AT BEDTIME | | |
| MULTIVITS W/MINERALS TAB/CAP (NO VIT K) | ACTIVE | |

SIG: TAKE 1 TABLET BY MOUTH EVERY DAY TO PREVENT VITAMIN DEFICIENCY

Persons or Agencies Involved or Knowledgeable about Elder:

Name
Relationship VA Dementia Care Coordinator & facilitator of caregiver support group
Address

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Is medical treatment required immediately? No - have informed the veteran's VA PCP about this issue. He is a shared care patient who also has a PCP outside of the VA.

Describe treatment needed or already received: Mr. X participates in a weekly support group for veterans with dementia and his wife participates in a corresponding support group for caregivers. She has been provided with much information, education and support around dementia care management for her husband from VA providers.

Does the reporter believe the situation constitutes an emergency? No

Describe the risk of death or immediate and serious harm: Unknown

Additional information or comments:

Any additional assistance from elder services would be appreciated (in terms of assessment and direct interventions & referrals). Would appreciate discussing with assigned worker if case screened in.

Signature of Reporter

Date Jul 16,2014

/es/ ELIZABETH A MULLIGAN
Staff Psychologist
Signed: 07/16/2014 11:57

Receipt Acknowledged By:
07/16/2014 12:18 /es/ Dementia Care Coordinator

07/16/2014 ADDENDUM STATUS: COMPLETED
Received a phone call from Elder Services indicating veteran's case was opened to APS for investigation. Case worker assigned is XXX.

/es/ ELIZABETH A MULLIGAN
Staff Psychologist
Signed: 07/16/2014 15:29

07/23/2014 ADDENDUM STATUS: COMPLETED
Spoke with EPS Case worker further today about this report, including information about the veteran's capacity and his wife's level of caregiver burden. She noted that Mrs. X reported that her husband resumed his medications at this time based on the recommendation of his non-VA PCP and that Elder Services will likely continue to be involved for ~30 days.

/es/ ELIZABETH A MULLIGAN
Staff Psychologist
Signed: 07/23/2014 12:07