Kate L. M. Hinrichs, PhD
Assessment Example

Contextual Statement:

I am presenting the case of Mr. J, an 81-year-old, White, never-married, post-Korean era Army veteran who was referred for evaluation of decision-making capacity regarding discharge planning in the context of possible elder neglect/abuse in his group home environment. He was referred to our sub-acute rehab unit for strengthening following a fall at his group home. He had a medical history that included: Type II Diabetes, Hyperlipidemia, COPD, Peripheral Neuropathy, amputation of big toe last year, and Chronic Schizophrenia. While in our care several incidents raised concerns about Mr. J returning to his previous living environment where he has been a resident for 25 years.

This veteran had been followed for years by an outpatient psychiatrist who became concerned for his well-being and filed an elder at risk report three months prior. She indicated the veteran had missed almost all of his follow up appointments after his toe amputation, had lost significant weight, and was showing up to their appointments wearing dirty and ill-fitting clothes. While in our care the veteran's caregiver, Mrs. P was observed visiting frequently and she herself was often disheveled. One day Mrs. P also brought along two of her group home residents who were observed to be incontinent of urine and malodorous. Further, Mrs. P frequently asked the physician when Mr. J could come home, sharing that she relied on his rent money to get by. Thus, the team became concerned and requested an assessment of his capacity to choose to return to his previous home. Since his VA psychiatrist had already reported concerns about neglect and potential financial exploitation, my assessment focused on the issue of capacity. Of note, I was also able to contact elder protective services, who confirmed that this case had been forwarded to the district attorney's office for review

My approach to capacity assessment is based on the framework in the ABA-APA Capacity Handbook for Psychologists (2008). This typically begins with in-depth review of a comprehensive electronic medical record and interview with family members or providers who know the patient well. Fortunately Mr. J had received all of his care in the VA so his records were robust, and his outpatient psychiatrist was very willing to discuss the case. The battery I used in this assessment included clinical interview and a screening of cognitive functioning (MoCA).

This evaluation was completed on the unit and was scheduled for a time when Mrs. P would not be present as she had proved to be quite intrusive with other disciplines and in my initial meeting with Mr. J to schedule the assessment. Regarding the cognitive screening, Mr. J had not had previous cognitive assessment, but had been previously screened by his psychiatrist using the MMSE (last score was 20/30 about one month prior). Given the recency of this screen, I opted to re-screen using the MoCA on which he scored 12/30 (11+1 for low educational attainment) showing evidence of global cognitive deficits. The goal of the screening was not to clarify his diagnosis but rather to better understand how his cognitive functioning might impact his capacity. If we had further diagnostic questions I may have referred him for comprehensive neuropsychological testing, but this was not a clinical priority given that he was already living in a supervised environment.

To evaluate his decision-making capacity, I utilized interview questions focused on four elements: his understanding, appreciation, reasoning, and ability to express a choice. In this situation, his understanding of his current medical needs was quite limited, as was his understanding of why anyone might be concerned about his current living environment. His appreciation of his current circumstances was very poor as he did not seem aware of having missed multiple medical appointments and could not appreciate that others had been worried about his living status or why they might be. His judgment and reasoning were poor as he was not able to weigh risks and benefits of the situation he was presently in since he could cite no risks whatsoever. However, Mr. J was able to clearly and consistently express the choice to return to his group home and to the care of Mrs. P. He was found to lack capacity to make decisions regarding discharge.

The ethical issues in this situation are significant. Most notably is the precarious balance of the individual's autonomy with protecting them from harm (non-malfeasance). In this case Mr. J could communicate that he wanted to remain in his group home, which had been his only home for the last 25 years. However, it seemed likely that Mrs. P was no longer able to meet her resident's needs and Mr. J was thus being neglected. Further, I could not rule out potential financial exploitation as Mrs. P had indicated to our physician that she was dependent on Mr. J's rent money, and Mr. J had virtually no knowledge of how his money was spent each month. If at all possible I wanted to balance his preference for remaining at home while ensuring that he was safe, well-cared for, and was properly informed of alternate options for housing, care, and financial management.

Since Mr. J was clearly unable to weigh such information, I recommended involving his next-of-kin (since no health care proxy had been identified). Unfortunately, Mr. J's NOK was an elderly brother who was unable to come in and who deferred to the VA to decide what was best for his brother. Elder Protective Services was already involved in this case and simply asked to be informed if Mr. J was going to return to living with Mrs. P. Given the lack of an adequate decision-maker, I recommended our team consult the Ethics Committee to help guide us in planning a discharge for Mr. J.

In the weeks after my evaluation, Mr. J was seen jointly with Mrs. P by the Ethics Committee, who determined it was in Mr. J's best interest to return to living in a familiar environment with the caregiver he considers his 'family'. However, they did recommend that in order for him to return to the home Mrs. P would have to agree to a home safety evaluation, increased aid/services in the home such as home-maker/home health-aid to assist Mrs. P in caring for Mr. J, and she would need to allow for regular monitoring via a VA case-manager. It was recommended that if Mr. J's needs could not be safely met in the group home with added supports, placement would be in order. Ultimately Mrs. P and Mr. J agreed to these conditions, services were arranged, and Mr. J returned to living under Mrs. P's care in the group home.

Informed Consent: My setting does not utilize specific written consent for psychological services. I obtain informed consent verbally, and if the person cannot provide consent, I seek their assent to participate. In this instance, the veteran did appear to have the ability to provide informed consent for the cognitive screening and did so. However, he was unable to understand the risks, benefits, or potential outcomes of the capacity interview and thus provided assent for that portion of the evaluation.

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.

Evaluation (including History and Psychological Test Data):

LOCAL TITLE: MH CAPACITY EVALUATION
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: SEP 13, 2013@14:37 ENTRY DATE: SEP 13, 2013@14:37:34
AUTHOR: HINRICHS,KATE MARTI EXP COSIGNER:
URGENCY: STATUS: COMPLETED

SESSION TYPE: Initial Clinical Interview
DURATION: 45 minutes

REFERRAL INFORMATION: Per CLC physician's consult request "Please assess capacity for veteran to understand going back to P homestead versus alternate living arrangement (see elder abuse alert)."

CONSULTATIONS: discussed with MD, SW, PT, OT, nursing, and OP psychiatrist

INFORMED CONSENT: The purpose of the current evaluation was explained to Mr. J and he readily agreed to participate. He expressed limited understanding of the impact of this evaluation. He did seem to understand that his memory would be assessed, but it is unclear if he fully comprehended the potential outcomes of this assessment. He provided consent for cognitive screen and assent for capacity assessment.

PRESENTING PROBLEM AND HISTORY OF PRESENTING PROBLEM:
Mr. J J was admitted to the BR VA TCU on 9/4/13 for rehabilitation. He came from the WX VA WXR where he was admitted on 8/29/2013 for falling at home. He was previously a patient in the TCU last October after a toe amputation. He is now referred to MH for an assessment of his capacity to make decisions related to discharge as there have apparently been concerns about the quality of care he receives at his group home.

It seems Mr. J lives in a former CRC home that has since been decertified by the VA (P Homestead). He has lived there since 1989. This year Mr. J's outpatient Psychiatrist, Dr. C, became concerned and filed an Elder at Risk report. See her 6/7/13 Elder Abuse/CWN note stating the following:

Begin excerpt---
Elder lives in a private home for disabled veterans run by Mary P (same phone number). Mrs. P is responsible for arranging medical appointments and travel to these appointments. Mr. J had an

amputation of his great toe in October 2012, raising concerns about insufficient care and supervision at home. He has missed (no show or cancel) 5 appointments with podiatrist and primary care physician at VA since his amputation - appointments arranged to follow up on proper wound healing, ongoing medical care, etc.
End excerpt---

A 7/2/13 addendum to this report states:
"Voice mail message from case worker, Old Colony Elder Services. She reports "a lot of concerns" based on her home visit to veteran's home. Visit triggered by my report of suspected Elder Neglect. She reports "deplorable conditions" and a "horrible odor" at the facility."

A 7/18/13 addendum to Dr. C's 7/5/13 note states:
"Voice mail message from case worker, Old Colony Elder Services. States she is referring her findings regarding conditions at veteran's residence to the district attorney's office. Her contact information:."

It should also be noted that a consult was placed to Short-term case management, which was closed on 5/22/13 with the following information:
"Received 5 voicemails messages from veteran's caregiver Mrs. P 5/22/13 during the morning. Mrs. P stated the same thing on each message that she 'takes care of the men in the house, does all the meds, and gets them to their appointments. I don't need a social worker. there is no need for them to be calling you or you coming here.' Writer returned Mrs. P's call to clarify and discuss short-term case mgmt. support for veteran. Again, Mrs. P made the same comments and asked this writer not to call again. STCM declined. No additional follow-up planned."

MD note from 9/6/13 states:
"Caregiver in with patient: "I take good care of him"; "I need him to come to the house; I cannot afford to pay the bills if he does not come to the house"."

Multiple recent notes and consultation with staff reveal that Mrs. P visits Mr. J often and that she is constantly asking when he can come home. She apparently comes to the unit looking disheveled, and on 9/10/13 the brought two of her house residents with her to the unit who were both observed to be incontinent and malodorous.

BACKGROUND INFORMATION: The following information was obtained from the clinical interview and a review of the electronic medical record.

Psychiatric History:
- Chart is + for: Schizophrenia NOS, Chronic and Anxiety State NOS
- OP MH prescriber/MHTC is Barbara C, MD (last seen 8/26/13)
- Current Psych Meds:
  OLANZAPINE*ATYPICAL-2ND LINE*TAB 10MG PO QDAILY schizophrenia

Medical History: per admission note
- DM
- Acute renal failure 9/2013, resolved
- hx of Toe amputation site ulcer
- hyperlipidemia
- COPD, stable
- Schizophrenia:
- peripheral neuropathy

Military History:
Period of Service: POST-KOREAN
Branch of Service: ARMY 08/13/1951 TO 05/13/1952
Combat: NO POW: NO
Eligibility: AID & ATTENDANCE Status: VERIFIED
NSC, VA PENSION

Social/Family History:
Never-married; no children. Has a brother (Billy J/NOK) who lives in Weymouth and a sister in Nevada. He says he is in contact with his brother. Education- completed 8th grade at age 16. Records indicate a history of special education and needing to repeat grades. Veteran currently lives in a group home (former CLC home now decertified by the VA) in Brockton. He has resided there since 1989. The home includes: the owner Mrs. P (caregiver), and the patients: Mr. P, Mr. J, and one other man.

MSE/BEHAVIORAL OBSERVATIONS:
Appearance: elderly man, wearing VA pajamas
Attitude: fairly cooperative
Behavior: found asleep, but he agreed to meet and sat at eob, limited EC
Speech: low spontaneous output, dysarthric
Mood: "when am I getting out of here?"
Affect: restricted
Thought Content: nonbizarre; no report/evidence of SI/HI
Thought Form/Process: basically goal-directed, responded to direct questions
Perceptual Disturbances: none noted or observed
Cognitive Examination: see MoCA below
Orientation: []Time [X]Person [X]Place [X]Situation
Attention: grossly intact
Abstraction: impaired
Memory: impaired
Insight/Judgment: impaired

Cognitive Screen:
Previously the MMSE has been used to screen Mr. J' cognitive functioning. Per Dr. C's notes on 8/26/13 he scored 20/30 on this measure. Prior to that he scored 21/30 on 4/11/12. These scores are consistent with cognitive impairment.

Today the Montreal Cognitive Assessment (MoCA) was administered. The MoCA was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses various cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculation, and orientation. The total score is 30 points; a score of 26 or above is considered normal.

Mr. J scored 12/30 (11+1 for low educational attainment), which is significantly below the normal cut-off score of 26. This score is consistent with the presence of severe cognitive impairment.

His performance was as follows:
- Visuospatial ->
  - Mini Trails (0/1), did not understand instructions and quickly lost set
  - Cube Copy (0/1), incomplete design missing several features
  - Clock (1/3), contour was good, only included the numbers 12, 3, 6, 9, 10 and hands were drawn to originate from the 12 rather than the center of the clock face.
- Confrontation Naming (2/3), called the rhinoceros a "buffalo"
- Immediate Verbal Recall (not scored); 3/5 (trial 1), 3/5 on (trial 2)
- Attention ->
  - Digit Span (2/2)
  - Letter List (0/1), started out ok, but then stopped tapping at all
  - Serial 7s (2/3), stated 100-93-87-73, with cuing to continue throughout so had 3 subtractions correct with cuing to continue subtractions
- Language ->
  - Repetition (1/2), error of omission on second sentence
  - Fluency (0/1), 4 F words in 60 seconds, gave up after 30 seconds stating "that's it" and "I can't think of anymore"
- Abstraction (0/2), gave concrete responses only
- Delayed Verbal Recall (0/5), 0-free recall, 0-category cues, 1-multiple choice cues
- Orientation (4/6), said it was Thursday Sept 12, 2008 (on Friday 9/13/13), had location and city correct

Capacity Interview:
Veteran began interview by asking when he could leave. When informed that there have been concerns about his home situation he said repeatedly "they take good care of me". When asked what they do for him Mr. J initially said "nothing, I take care of myself". However, when queried about specific tasks, he admitted that Mrs. P cooks, cleans, manages his medications, keeps track of his medical appointments, and provides transportation to his appointments.

Mr. J reported his monthly income is a "VA check" that totals about $1800/mo and it is direct deposited into an account. He says his only monthly bill is his rent, which is $1000, and he pays this in cash

directly to Mrs. P. When asked about other expenses he notes he likes to go to the movies, and sometimes goes out to eat. With prompting he shares he buys his own clothes and shoes, however it does not appear this has occurred recently. He is unable to describe how he spends the rest of his "spending money" each month, but seemed to indicate that he was not accumulating money in the bank. He seems to have a somewhat limited understanding of his current financial situation.

When discussing medical issues, Mr. J has a hard time explaining his medical conditions. He says he is in the hospital because of a sore foot. When asked about his toe amputation last year he says he does not remember what led to that. He says "that was a long time ago" and "it might have been infected". When asked why he missed his follow up medical appointments for his amputation he said "I forgot". But when reminded that it was Mrs. P who was in charge of getting him there he became somewhat upset and said loudly "it's my fault, not hers!" When asked about weight loss (~50lbs over 2yrs) he says "I walk a lot" (which seems doubtful given his amputation last year as well as COPD and peripheral neuropathy) and he says "I was too fat anyways".

In discussing the concerns about the care he has received, Mr. J again became somewhat upset. He denies any knowledge that anyone has ever been worried about his home situation, and denies any concerns about it himself. He repeatedly stated his desire to return to living in the P home saying "I like it there." When asked what is good about the home he says Mrs. P is a good cook, they watch TV together, and sometimes go to movies or out to eat. When asked if there was anything he did not like about the home he said "no". He has no worries about his care there. Was quite concrete and was unable to discuss hypothetical situations (e.g. what if the care weren't good? who could you call?).

DSM-IV-TR Multi-Axial Assessment:
Axis I: Cognitive Disorder NOS (vs. Dementia NOS)
Schizophrenia, Chronic
history of learning disorder vs. borderline intellectual functioning
Axis II: deferred
Axis III: see medical history above
Axis IV: limited social supports
Axis V: GAF = 45

ASSESSMENT:
Mr. J J is an 81yo, white, male, never-married, NSC, post-Korean era, Army veteran who is admitted to the BR VA TCU for rehab s/p falls at home. He is referred to MH for an assessment of decision-making capacity in the context of suspected elder neglect/abuse at his group home. Mr. J has a history of low educational attainment (completed 8th grade at age 16, with history of special education) that may indicate either a history of learning disability and/or baseline borderline intellectual functioning.

Cognitive screening today showed severe and global cognitive deficits. Regarding memory, he had some trouble with encoding, and was totally unable to recall information later, even when given multiple choice cues. Abstract thinking was absent and he was quite concrete in his thinking and responses. Executive functioning also appear impaired with particular difficulty in sequencing and planning. His level of impairment would be very concerning if he were driving or living independently as he would be unable to plan a route, manage his own medications, remember appointments, etc.

The capacity interview is further revealing of impaired cognitive functioning. Mr. J is consistently able to state a choice (to return to living at the P Homestead), and he is able to cite the benefits of living there (Mrs. P is a good cook, and he enjoys watching TV or going to the movies with her). However, he is unable to cite any negatives of living there and was not accepting of any of the reported concerns regarding his care there. He maintains that it is "his fault" that he missed several necessary appointments (despite the fact that Mrs. P manages his appointments and his transportation). Mr. J has very limited understanding of his own medical conditions, his medical needs, or why it is so important to receive follow up medical care. He lacks an appreciation for the gravity of his situation and the fact that poor medical follow up could lead to poor medical outcomes. He shows limited reasoning ability for his decision to return to this home beyond saying he "likes it there". Mr. J has impaired insight and judgment.

At this time Mr. J lacks capacity to make decisions about where he lives. Although he can state a choice and list some benefits of that choice, Mr. J is unable to cite any risks, lacks appreciation of his situation and shows limited reasoning abilities. Further, given the apparent risk of neglect at this previous home, the threshold for capacity would be quite high. Even with a low threshold, Mr. J would not have the requisite capability to make complex decisions. At this time he requires assistance in making decisions. As he has no HCP, his NOK is the default decision-maker for VA purposes. The NOK should be contacted and involved as soon as possible.

RECOMMENDATIONS/PLAN:
1) Mr. J lacks decision-making capacity regarding d/c planning. Since he has no documented HCP, his NOK is the default decision-maker for VA purposes. The NOK is Mr. J’s brother Billy in Weymouth, MA.

2) Once NOK is involved a family meeting should be held to discuss concerns about Mr. J preferred d/c plan and to go over alternate housing and care options for Mr. J.

3) Although he lacks capacity for this major decision, Mr. J should still be involved to the extent he is able in planning for his care, and his values and wishes should be considered as much as possible.

4) Given his cognitive impairment, Mr. J may benefit from a rep-payee, or other service, to manage his money for him.

5) Mr. J retains capacity for day-to-day decisions such as medication refusal, how to use his pocket money, etc.

6) It may be useful for Mr. J's current care team to contact Old Colony Elder Services (case worker) to report any new concerns and/or to follow up on the status of this case.

7) Co-signing Mr. J's MHTC/psychiatrist for continuity of care purposes.

/es/ KATE MARTIN HINRICHS PHD
PSYCHOLOGIST
Signed: 09/16/2013 09:47