

**CLIENT DECISION-MAKING / CAPACITY FOR
ADULT PROTECTIVE SERVICES &
PUBLIC GUARDIAN**

Participant's Guide





School of Social Work



Department of
SOCIAL SERVICES



This training was developed by the Adult Protective Services (APS) Training Project a program of the Bay Area Academy, San Francisco State University School of Social Work. Funding is provided by the CA Department of Social Services, Adult Services Branch.

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CLIENT DECISION-MAKING/CAPACITY FOR ADULT PROTECTIVE SERVICES & PUBLIC GUARDIAN©

INTRODUCTION

APS TRAINING PROJECT – BAY AREA ACADEMY

We are pleased to welcome you to the Client Decision-Making/Capacity for APS & PG training for APS workers and partners.

The Adult Protective Services (APS) Training Project, a program of the Bay Area Academy/San Francisco State University, works to identify training needs, priorities and emerging issues among county Aging & Adult Services staff - with an emphasis on APS and In-Home Support Services (IHSS) training priorities. The project works in numerous partnerships to develop APS training curriculum and deliver core and specialized training to enhance the skills and knowledge of county social workers who serve vulnerable seniors and adults with disabilities in the State of California.

APS Training Project's overarching goal is to develop and deliver statewide standardized core curricula for new APS/IHSS social workers and to share these trainings on a national scale through our partnership with the National Adult Protective Services Association (NAPSA). Professional training opportunities are a critical step toward ensuring APS social workers have the appropriate tools to serve their clients.

The Project is a founding member of the APS Regional Training Academy Consortium (RTAC) and the National APS Training Partnership. Our partners include:

- Academy for Professional Excellence/Project MASTER, Central California Child Welfare Training Academy and the Northern California Training Academy
- California Department of Social Services, Adult Services Branch
- California State University Sacramento IHSS Training Project
- Protective Services Operations Committee of the California Welfare Director's Association (PSOC)
- California Social Work Education Center Aging Initiative (CalSWEC)
- National Adult Protective Services Association Education Committee (NAPSA)

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Executive Summary

Course Title: *Client Decision-Making/Capacity for Adult Protective Services & Public Guardian*

Outline of Training: A dynamic, multi-disciplinary training on client decision-making/capacity and approaches for more effective interactions and case outcomes. Activities include - straightforward didactic information, lecture, video, and interactive, hands-on individual, small- and large group activities that capitalize on advanced knowledge and skills. This training was developed by the APS Training Project, California Association of PA/PG/PC, Erika Falk, PsyD, Bonnie Olsen, PhD, and Jane Kwon, County Counsel, Los Angeles County .

Trainers: Bonnie Olsen, PhD, Clinical Psychologist - Senior Health Center, UC Irvine (Dr. Olsen will train 2/7, 2/9, 2/10 & 5/3)

Erika Falk, PsyD, Director, Geriatric Assessment & Psychological Services - Institute on Aging, San Francisco (Dr. Falk will train 3/8, 3/9, 4/12, 4/13 & 5/10)

Target Audience: This training will emphasize advanced knowledge and practice skills and is intended for all levels of Adult Protective Services and Public Guardian staff. The intention was to develop a training that looks through a legal and clinical lens, a training that's practical and solution-oriented for both APS and PG. This training that is a very important step in bringing everyone onto the same page with regards to standards and consistency in cases involving issues with client decision-making/capacity.

Outcome Objectives for Participants:

Learning goals – Upon completion of the training, participants will be able to:

1. Identify practical frameworks to use in assessing the decision-making of clients.
2. Identify what level of evidence is needed for cases in which client capacity is in question.
3. Demonstrate ways to gather, structure, and document observations about a client's decision making capacity for various audiences.
4. Describe the assets and limitations of various solutions/resources for clients with diminished capacity.

Transfer of Learning: *Ways supervisors can support the transfer of learning from the training room to on the job.*

BEFORE the training

Supervisors can encourage line staff to attend the training, to identify challenging situations APS and Public Guardian staff encounter in cases where client decision-making/capacity is at question. Identify current practices for dealing with issues that involve the client, family members and other agencies the APS and Public Guardian workers must contend with.

AFTER the training

Supervisors can have one or more participants present an overview of what was learned to other staff members; can provide weekly or monthly reflections of specific challenging situations and the approaches learned from the training that worked and did not work; and how are outcomes changed with partner agencies, physicians and collaterals after participating in the training.

COURSE OUTLINE

Content	Total Time	Activities	Handouts
Welcome & Overview & Introductions	15 min		
Legal Frameworks for Capacity	70 min	<ul style="list-style-type: none"> Capacity Declaration 	1-5 HIPAA Handout
BREAK	10 min.		
Clinical Frameworks for Capacity	60 min	<ul style="list-style-type: none"> Vignette – Wanda Jones 	6
Interviewing to Assess Cognitive Functioning	30 min		7-9
LUNCH	45 min.		
Interviewing to Assess Cognitive Functioning (cont)	30 min	<ul style="list-style-type: none"> Video – Mrs. B 	7-9
Documentation – Brief Review	15 min	<ul style="list-style-type: none"> T, F or Q – Mrs. Zachariah 	
Making the Case...	40 min		10, 11
BREAK 1:50 pm – 2:05 pm	10 min.		
Assessts & Limitations of Interventions	55 min	<ul style="list-style-type: none"> Vignettes – Probate conservatorships Eco-Mapping – Mr. Smith 	
Closing, evaluations & survey	10 min		
TOTAL TIME	6.5 hrs		

WELCOME AND OVERVIEW



TIME ALLOTTED: 15 minutes

SLIDE 1

CLIENT DECISION-MAKING/CAPACITY FOR ADULT PROTECTIVE SERVICES & PUBLIC GUARDIAN



Curriculum developed by: Erika Falk,
Jane Kwon, Bonnie Olsen, Krista
Brown, Lori Delagrammatikas, Arlene
Diaz, Connie Draxler, Scarlett Hughes
and Carol Mitchell

Presented by Statewide APS Training
Project/Bay Area Academy
in collaboration with the
CA Association of PA/PG/PC

SLIDE 2

Welcome

- Trainer Introduction
- Agenda & Participant Materials
- Housekeeping
- Parking Lot

SLIDE 3

Framing the Day

- How Did We Get Here?
- Intention of Training Day
- Additional Training Component – e-Learning!
 - ▣ Available Spring 2011
- Additional Training Resources
 - ▣ <http://www.baa-aps.org/article.php?id=369>

SLIDE 4

Training Objectives

- *At the end of this training, participants will:*
 - ▣ *Identify practical frameworks to use in assessing the decision-making capacity of clients.*
 - ▣ *Identify what level of evidence is needed for cases in which client capacity is in question.*
 - ▣ *Demonstrate ways to gather, structure, and document observations about a client’s decision-making capacity for various audiences.*
 - ▣ *Describe the assets and limitations of various solutions/resources for clients with diminished capacity.*



January 2012

Dear Training Participant,

As a training program for the Academy for Professional Excellence at San Diego State University School of Social Work, we have begun a process of evaluating training delivered to Adult Protective Service workers. As part of this evaluation, we need your help.

At certain points during this training series, in addition to the usual workshop evaluation forms, you will be asked to complete various training evaluation activities.

These training evaluation activities have two main purposes:

1. To improve training effectiveness and relevance to your needs in helping you better serve adults and their families; and
2. To determine if the training has been effective in addressing the key learning objectives.

Our goal is to evaluate training, NOT the individuals participating in the training. In order to evaluate how well the training is working, we need to link each person's assessment data using a code. You will generate the code number using the first three letters of your mother's maiden name, the first three letters of your mother's first name, and the numerals for the day you were born. Please put this 8-digit ID code on each of your assessment forms, exactly the same way each time. ID code information will only be used to link demographic data to test data to ensure that the training is working equally well for all participants. Once this link is made, we will only look at class aggregate scores, not individual scores.

Only you will know your ID code refers to you. All individual responses to evaluation exercises are confidential and will only be seen by the Academy's training program and evaluation staff. Only group averages and percentages will be reported. Individual results will not be reported to your employer. Aggregate data may be used for future research to improve training for Adult Protective Service workers.

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If you agree to participate, you will fill out questionnaires administered before and after the training. The questionnaires will be coded with your ID code and all responses will be confidential.

There are no foreseeable risks to you from participating. There is also no direct benefit to you. Your responses will contribute to the development of a series of evaluation tools that will be able to accurately assess the effectiveness of adult protective service training. It is hoped that these tools will assist the Academy for Professional Excellence in improving training for adult protective service workers and therefore improve services to adults and families.

Your participation is voluntary and you may withdraw your consent and participation at any time. Participation or non-participation will have no effect on your completion of this training series.

By completing and submitting the questionnaire, you agree to participate. You further agree to permit us to use your anonymous responses in written reports about the training.

Your help with this evaluation process is greatly appreciated. Your feedback will be instrumental in helping to improve adult protective service training for future participants. If you have any questions about the evaluation or how the data you provide will be used, please contact:

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CLIENT DECISION-MAKING – PARTICIPANT'S MANUAL

Trainee ID Code

Date / /
M M D D Y Y

YOUR IDENTIFICATION CODE:

In order for us to track your evaluation responses while maintaining your anonymity, we need to assign you an *identification code*. We would like you to create your own *identification code* by answering the following questions:

1. What are the first three letters of your mother's *maiden* name?
Example: If your mother's maiden name was Alice Smith, the first three letters would be: **S M I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.
— — —
2. What are the first three letters of your mother's *First* name?
Example: If your mother's maiden name was Alice Smith, the first three letters would be: **A L I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.
— — —
3. What are the numerals for the DAY you were born?
Example: If you were born on November 29, 1970, the numerals would be **2 9**. If your birth date is the 1st through the 9th, please put 0 (zero) in front of the numeral (example **0 9**).
— —

Combine these parts to create your own identification code (example: **S M I A L I 2 9**). Please write your identification code in the space at the top right corner of all evaluation materials you receive.

Remember your identification code and write it at the top of every evaluation form provided to you throughout this training.

LEGAL FRAMEWORKS FOR CAPACITY



TIME ALLOTTED: 70 minutes

SLIDE 5

Legal Frameworks for Capacity



SLIDE 6

What is Legal Capacity?

- Legal capacity refers to a person's ability to make decisions and to be responsible for their decisions or acts. (CA Probate Code Section 810, et. seq.)
- California law presumes all adult persons have capacity. (CA Probate Code Section 810(a))
- *Handout 1 – CA Probate Codes 810-813*

SLIDE 7

Legal Thresholds for Capacity

- Different transactions and decisions have different requirements regarding capacity.
- Examples: Executing a will; making medical decisions; executing contracts; marrying or entering a registered domestic partnership; making gifts or conveyances.
- All of the foregoing transactions require different levels of capacity which are defined in the various California codes.

SLIDE 8

Legal Thresholds for Capacity

- Testamentary capacity - at the time of executing a will, did the testator understand the nature of the testamentary act; understand and recollect the nature and situation of the individual’s property; did the testator remember and understand their relationships with those whose interests are affected by the will. (CA Probate Code section 6100.5)

SLIDE 9

Legal Thresholds for Capacity

- Capacity to make medical decisions - is the person able to respond knowingly and intelligently to questions about the medical treatment, participate rationally in the treatment decision, and understand:
 - 1) the nature and seriousness of the illness;
 - 2) the nature of the medical treatment being recommended;
 - 3) the probable degree and duration of the benefits/risks of the recommended treatment;
 - 4) the nature, risks, benefits of any reasonable alternatives.(CA Probate Code section 813)

CLIENT DECISION-MAKING – PARTICIPANT'S MANUAL

HANDOUT 1 - CALIFORNIA CODES, PROBATE CODE SECTION 810-813 as of
December 2010

810. The Legislature finds and declares the following:

(a) For purposes of this part, there shall exist a rebuttable presumption affecting the burden of proof that all persons have the capacity to make decisions and to be responsible for their acts or decisions.

(b) A person who has a mental or physical disorder may still be capable of contracting, conveying, marrying, making medical decisions, executing wills or trusts, and performing other actions.

(c) A judicial determination that a person is totally without understanding, or is of unsound mind, or suffers from one or more mental deficits so substantial that, under the circumstances, the person should be deemed to lack the legal capacity to perform a specific act, should be based on evidence of a deficit in one or more of the person's mental functions rather than on a diagnosis of a person's mental or physical disorder.

811. (a) A determination that a person is of unsound mind or lacks the capacity to make a decision or do a certain act, including, but not limited to, the incapacity to contract, to make a conveyance, to marry, to make medical decisions, to execute wills, or to execute trusts, shall be supported by evidence of a deficit in at least one of the following mental functions, subject to subdivision (b), and evidence of a correlation between the deficit or deficits and the decision or acts in question:

(1) Alertness and attention, including, but not limited to, the following:

- (A) Level of arousal or consciousness.
- (B) Orientation to time, place, person, and situation.
- (C) Ability to attend and concentrate.

(2) Information processing, including, but not limited to, the following:

- (A) Short- and long-term memory, including immediate recall.
- (B) Ability to understand or communicate with others, either verbally or otherwise.

(C) Recognition of familiar objects and familiar persons.

(D) Ability to understand and appreciate quantities.

(E) Ability to reason using abstract concepts.

(F) Ability to plan, organize, and carry out actions in one's own rational self-interest.

(G) Ability to reason logically.

(3) Thought processes. Deficits in these functions may be demonstrated by the presence of the following:

- (A) Severely disorganized thinking.
- (B) Hallucinations.
- (C) Delusions.

(D) Uncontrollable, repetitive, or intrusive thoughts.

(4) Ability to modulate mood and affect. Deficits in this ability may be demonstrated by the presence of a pervasive and persistent or recurrent state of euphoria, anger, anxiety, fear, panic, depression, hopelessness or despair, helplessness, apathy or indifference, that is inappropriate in degree to the individual's circumstances.

(b) A deficit in the mental functions listed above may be

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considered only if the deficit, by itself or in combination with one or more other mental function deficits, significantly impairs the person's ability to understand and appreciate the consequences of his or her actions with regard to the type of act or decision in question.

(c) In determining whether a person suffers from a deficit in mental function so substantial that the person lacks the capacity to do a certain act, the court may take into consideration the frequency, severity, and duration of periods of impairment.

(d) The mere diagnosis of a mental or physical disorder shall not be sufficient in and of itself to support a determination that a person is of unsound mind or lacks the capacity to do a certain act.

(e) This part applies only to the evidence that is presented to, and the findings that are made by, a court determining the capacity of a person to do a certain act or make a decision, including, but not limited to, making medical decisions. Nothing in this part shall affect the decisionmaking process set forth in Section 1418.8 of the Health and Safety Code, nor increase or decrease the burdens of documentation on, or potential liability of, health care providers who, outside the judicial context, determine the capacity of patients to make a medical decision.

812. Except where otherwise provided by law, including, but not limited to, Section 813 and the statutory and decisional law of testamentary capacity, a person lacks the capacity to make a decision unless the person has the ability to communicate verbally, or by any other means, the decision, and to understand and appreciate, to the extent relevant, all of the following:

(a) The rights, duties, and responsibilities created by, or affected by the decision.

(b) The probable consequences for the decisionmaker and, where appropriate, the persons affected by the decision.

(c) The significant risks, benefits, and reasonable alternatives involved in the decision.

813. (a) For purposes of a judicial determination, a person has the capacity to give informed consent to a proposed medical treatment if the person is able to do all of the following:

(1) Respond knowingly and intelligently to queries about that medical treatment.

(2) Participate in that treatment decision by means of a rational thought process.

(3) Understand all of the following items of minimum basic medical treatment information with respect to that treatment:

(A) The nature and seriousness of the illness, disorder, or defect that the person has.

(B) The nature of the medical treatment that is being recommended by the person's health care providers.

(C) The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person's health care providers, and the consequences of lack of treatment.

(D) The nature, risks, and benefits of any reasonable alternatives.

(b) A person who has the capacity to give informed consent to a proposed medical treatment also has the capacity to refuse consent to that treatment.

SLIDE 10

Legal Thresholds for Capacity

- Capacity to contract - all persons are capable of contracting except minors, persons of unsound mind, and persons deprived of civil rights. (CA Civil Code section 1556)
- As to persons with unsound mind, there is a rebuttable presumption that a person is of unsound mind if the person is substantially unable to manage his or her own financial resources or resist fraud or undue influence. (CA Civil Code section 39)

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Legal Thresholds for Capacity

- Capacity to marry - marriage is defined as a personal relation arising out of a civil contract between a man and a woman, to which the consent of the parties capable of making that contract is necessary. (CA Family Code section 300(a))

SLIDE 12

CA Conservatorship

- A conservatorship is a legal proceeding wherein a court appoints a surrogate decision-maker (aka Conservator) for a person who is no longer able to act or make their own decisions.
 - Of the Person: for individuals who are unable to provide properly for their personal needs for physical health, food, clothing or shelter. (CA Probate Code 1801(a))
 - Of the Estate: for individuals who are substantially unable to manage their own financial resources or resist fraud or undue influence. (CA Probate Code 1801(b))
- These conservatorships are governed by the California Probate Codes and are generally heard in the superior courts sitting in probate matters.
- *Handout 2 – CA Probate Code Section 1800-1804*

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HANDOUT 2 - CALIFORNIA CODES, PROBATE CODE SECTION 1800-1804 as of December 2010

1800. It is the intent of the Legislature in enacting this chapter to do the following:

- (a) Protect the rights of persons who are placed under conservatorship.
- (b) Provide that an assessment of the needs of the person is performed in order to determine the appropriateness and extent of a conservatorship and to set goals for increasing the conservatee's functional abilities to whatever extent possible.
- (c) Provide that the health and psychosocial needs of the proposed conservatee are met.
- (d) Provide that community-based services are used to the greatest extent in order to allow the conservatee to remain as independent and in the least restrictive setting as possible.
- (e) Provide that the periodic review of the conservatorship by the court investigator shall consider the best interests of the conservatee.
- (f) Ensure that the conservatee's basic needs for physical health, food, clothing, and shelter are met.
- (g) Provide for the proper management and protection of the conservatee's real and personal property.

1800.3. (a) If the need therefor is established to the satisfaction of the court and the other requirements of this chapter are satisfied, the court may appoint:

- (1) A conservator of the person or estate of an adult, or both.
 - (2) A conservator of the person of a minor who is married or whose marriage has been dissolved.
- (b) No conservatorship of the person or of the estate shall be granted by the court unless the court makes an express finding that the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee.

1801. Subject to Section 1800.3:

- (a) A conservator of the person may be appointed for a person who is unable to provide properly for his or her personal needs for physical health, food, clothing, or shelter, except as provided for the person as described in subdivision (b) or (c) of Section 1828.5.
- (b) A conservator of the estate may be appointed for a person who is substantially unable to manage his or her own financial resources or resist fraud or undue influence, except as provided for that person as described in subdivision (b) or (c) of Section 1828.5. Substantial inability may not be proved solely by isolated incidents of negligence or improvidence.
- (c) A conservator of the person and estate may be appointed for a person described in subdivisions (a) and (b).
- (d) A limited conservator of the person or of the estate, or both, may be appointed for a developmentally disabled adult. A limited conservatorship may be utilized only as necessary to promote and protect the well-being of the individual, shall be designed to encourage the development of maximum self-reliance and independence of the individual, and shall be ordered only to the extent necessitated by the individual's proven mental and adaptive

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limitations. The conservatee of the limited conservator shall not be presumed to be incompetent and shall retain all legal and civil rights except those which by court order have been designated as legal disabilities and have been specifically granted to the limited conservator. The intent of the Legislature, as expressed in Section 4501 of the Welfare and Institutions **Code**, that developmentally disabled citizens of this state receive services resulting in more independent, productive, and normal lives is the underlying mandate of this division in its application to adults alleged to be developmentally disabled.

(e) The standard of proof for the appointment of a conservator pursuant to this section shall be clear and convincing evidence.

1802. Subject to Section 1800.3, a conservator of the person or estate, or both, may be appointed for a person who voluntarily requests the appointment and who, to the satisfaction of the court, establishes good cause for the appointment.

1803. A conservator of the estate may be appointed for a person who is an absentee as defined in Section 1403.

1804. Subject to Section 1800.3, a conservator of the estate may be appointed for a person who is missing and whose whereabouts is unknown.

SLIDE 13

Standards of Proof

- Beyond a Reasonable Doubt
- ***Clear and Convincing Evidence*****
- Preponderance of Evidence
- *****Probate Code Section 1801(e) mandates the application of Clear and Convincing Evidence as the standard of proof in conservatorship cases...***

- *Handout 2 – CA Probate Code 1800-1804*
- *Handout 3 – Consanguinity Chart-Probate Code*

SLIDE 14

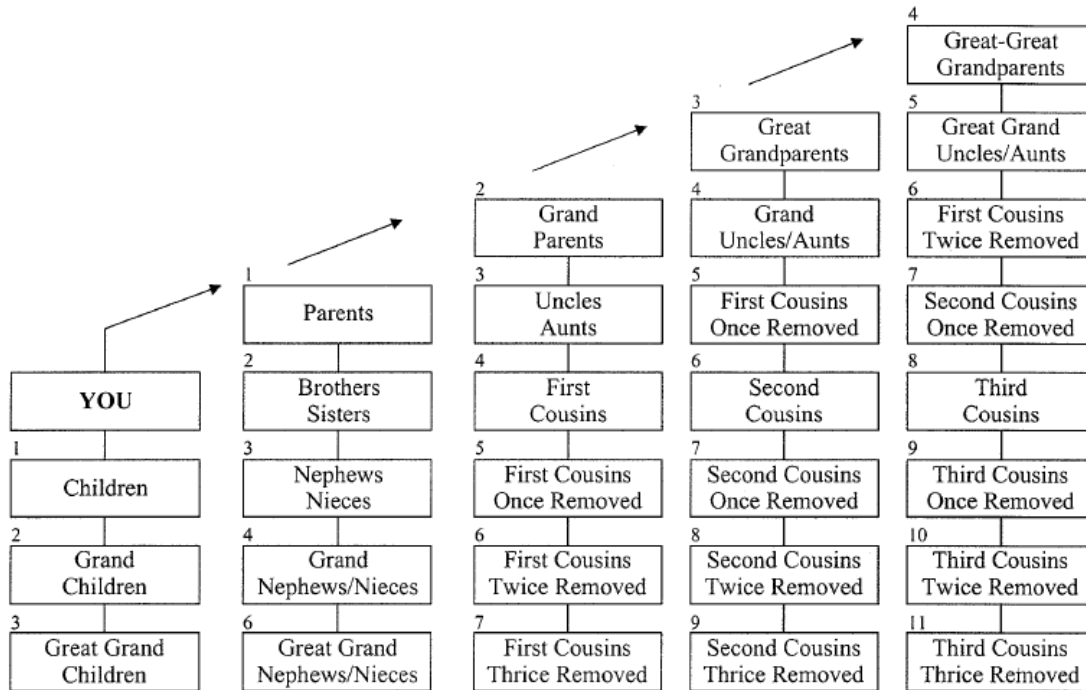
LPS Conservatorships Distinguished

- LPS conservatorships are governed by the Welfare and Institutions Code.
- Designed specifically for gravely disabled individuals due to a psychiatric illness which renders them incapable of providing for food, clothing, shelter, and they are unwilling or unable to accept voluntary psychiatric treatment.
- Different procedures and Conservator powers from Probate Conservatorships.
- *Handout 4 – LPS Holds Chart*

HANDOUT 3

Degrees of Family Relationships

Degrees of relationship by blood (consanguinity)



Relationships by Marriage (Affinity)

A relationship by blood is also referred to as being related by consanguinity. A relationship by marriage is sometimes referred to as being related by affinity.

A husband and wife are related in the first degree by marriage. For other relationships by marriage, the degree of relationship is the same as the degree of underlying relationship by blood. Example: John and Steve are brothers and are therefore second-degree relatives by blood. John’s wife, Linda, is related to Steve in the second degree by marriage.

See Tex. Gov’t Code Section 573.025

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Relatives

Probate Code Section 1821(b), in pertinent part:

The petition shall set forth, so far as they are known to the petitioner, the names and addresses of the spouse or domestic partner, and of the relatives of the proposed conservatee within the second degree. If no spouse or domestic partner of the proposed conservatee or relatives of the proposed conservatee within the second degree are known to the petitioner, the petition shall set forth, so far as they are known to the petitioner, the names and addresses of the following persons who, for the purposes of Section 1822, shall all be deemed to be relatives:

- 1) a spouse or domestic partner of a predeceased parent of a proposed conservatee
- 2) the children of a predeceased spouse or domestic partner of a proposed conservatee
- 3) the siblings of the proposed conservatee's parents, if any, but if none, then the natural and adoptive children of the proposed conservatee's parents' siblings
- 4) the natural and adoptive children of the proposed conservatee's siblings

Notice to Relatives re:Petition for Conservatorship

Probate Code Section 1822, in pertinent part:

Notice shall be mailed to the spouse or registered domestic partner, if any, of the proposed conservatee at the address stated in the petition and to the relatives named in the petition at their addresses stated in the petition

Standard of Proof

The degree or level of proof demanded in a specific case.

Examples:

- 1) Beyond a Reasonable Doubt – there is no reasonable explanation other than what is presented; this is the highest level of proof demanded; usually in criminal cases where you are potentially taking away a person's liberty by incarceration or death.
- 2) **Clear and Convincing evidence – it is highly probable that the evidence presented is true.
- 3) Preponderance of the Evidence – more likely than not that the evidence presented is true; 51% likely; usually in civil cases where no personal liberty is at stake.

**Probate Code Section 1801(e) mandates application of this standard of proof in conservatorship cases. Clear and Convincing standard is a higher standard of proof than proof by a preponderance of the evidence. Application of higher standard of proof for conservatorships because potentially taking away a person's right to make their own decisions re: finances, personal care, medical treatment.

HOA.753839.1

HANDOUT 4

LPS HOLDS CHART

LPS HOLDS EVALUATION & TREATMENT	CRITERIA			COURT PROCEEDINGS
	GRAVELY DISABLED	DANGER TO SELF	DANGER TO OTHERS	
72-HOUR WIC 5150	ONE OR ALL MAY APPLY			<ol style="list-style-type: none"> No probable cause hearing May request Riese hearing (Decision regarding Riese carries through 14-day hold)
14 DAY WIC 5250 3-DAY EXTENSION WHEN CONSERVATORSHIP APPLIED FOR	ONE OR ALL MAY APPLY			<ol style="list-style-type: none"> Probable cause hearing must be held during first 4 days of hold unless patient request by-pass writ of habeas corpus, 24 hr. postponement, and signs voluntary or is discharged. Patient may request one writ of habeas corpus hearing at any time during 14-day hold. Riese hearing may be requested anytime during 14-day hold. Each subsequent hold requires a new Riese hearing.
ADDITIONAL 14-DAY WIC 5260		ONLY CRITERIA WHICH APPLIES		<ol style="list-style-type: none"> No probable cause or court hearing required. Original additional 14 certification form and 2 affidavits must be sent to mental health court. Patient may request writ of habeas corpus any time during 14-day period. New Riese hearing may be requested anytime during 14-day period.
30-DAY WIC 5270	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Probable cause hearing must be held during first 4 days of hold unless patient requests by-pass writ of habeas corpus, 24 hr. postponement, and signs voluntary or is discharged. Patient may request writ of habeas corpus any time during 30-day period. New Riese hearing may be requested anytime during 30-day period.
180-DAY WIC 5300 RENEWABLE			ONLY CRITERIA WHICH APPLIES	<ol style="list-style-type: none"> Requires contact with D.A. several days prior to expiration of 14-day hold. Requires the District Attorney to file a petition with the court and an arraignment hearing in court. New Riese hearing may be requested anytime during 180-day period.
TEMPORARY CONSERVATORSHIP 30 DAYS TO 6 MONTHS	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Requires application by the treating physician to the Public Guardian's Office Judge reviews application and determines whether to grant or deny temporary conservatorship (T-Con). Patient may request writ of habeas corpus any time during T-Con period. New Riese Petition may be filed with County Counsel. Hearing held in Dept. 95A.
"PERMANENT" CONSERVATORSHIP 1 YEAR RENEWABLE	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Requires court hearing in Dept 95A. Physician may be required to testify in court. Patient may request re-hearing on conservatorship, rights denied, disabilities imposed once every six months.
RE-APPOINTMENT OF "PERMANENT" CONSERVATOR	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Requires conservator petitioning for reappointment and a court hearing.

NOTE: Each hold requires a new Riese hearing except when going from the 72 hour to the 14-day Superior Court of California, Los Angeles County, Office of the Counselor in Mental Health

lps_holds_chart.doc

SLIDE 15

Proving Incapacity in Court for a Probate Conservatorship

- Courts require evidence of a deficit in one or more of a person's mental functions AND evidence of a correlation between the deficit(s) and the decision/acts in question.
 - A mere diagnosis is not enough
 - Functional test
- Categories of mental functions examined: alertness & attention; information processing; thought processes; ability to modulate mood & affect.

SLIDE 16

Who Evaluates a Person's Mental Functions

- A California licensed physician; or
- A psychologist with at least 2 years of experience diagnosing dementia; or
- An accredited practitioner of a religion that relies on prayer alone for healing

SLIDE 17

Capacity Declarations

- A 3-page Judicial Council Form (GC 335); 4th page is the Dementia attachment (GC 335A) which is optional
- Form used by a physician, psychologist, or religious practitioner to enable a court to determine if:
 - A proposed conservatee is able to attend a court hearing
 - A proposed conservatee has the capacity to give informed consent to medical treatment
 - A proposed conservatee has dementia, and if so, whether a secured perimeter facility is needed and/or if the proposed conservatee would benefit from dementia medications

SLIDE 18

Importance of Capacity Declarations

- This is your medical evidence – it is a medical professional’s evaluation of a person’s capacity based on assessment of that person’s mental functions.
- The Capacity Declaration includes assessments of the exact categories of mental functions a court looks at in determining a person’s capacity.

SLIDE 19

Importance of Capacity Declarations (cont.)

- Generally, courts will not grant a conservator the power to make medical decisions on behalf of a conservatee without a capacity declaration
- Generally, courts will not grant a conservator the power to authorize the administration of dementia medications or placement in a secured-perimeter care facility without a capacity declaration
- *Note: The GC335 is currently under revision*

SLIDE 20

Myths & Realities of Capacity Declarations

- *From your own experience, what are the myths and realities of Capacity Declarations?*

SLIDE 21

Myths & Realities
of Capacity Declarations

SLIDE 22

Myths & Realities
of Capacity Declarations (cont.)

SLIDE 23

Talking to Doctors



SLIDE 24

Situations to Contact Doctors

- Doctor is reporting party
 - Rare
 - Thanks for making referral- positive feedback
 - “What’s the best way to give you feedback?”
 - May have BIG EXPECTATIONS of APS
- Doctor not reporting party
 - APS needs some baseline medical information
- Doctor works with APS
 - MDT, Forensic Center

Slide 25

Communication Tips

- Brief
 - 2 minute attention span
 - Err on the side of brevity
- Summary statement – 2-3 sentences
 - First give end of case
 - What conclusion would you like?
 - How can they help?
 - What do you want?
- Follow-up in writing
 - Put details there

Slide 26

Legality of Doctor Data Sharing

- WIC 15753, 15753.5, and 15754
 - Multidisciplinary team
 - Doctors are part of the MDT
- HIPAA (*HIPAA Handout*)
- Release of information
- Doctor may resist due to confidentiality
 - DA or law enforcement can obtain by other means if needed

SLIDE 27

Activity: Capacity Declaration

- Review GC-335 & GC-335A in your manual
- Find the flaws
- You have 5 minutes
- *Handout 5 – Common CAP DEC Errors*

HIPAA Handout

“45 CFR §164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

A covered entity may use or disclose protected health information without the written authorization of the individual, as described in § 161.508, or the opportunity for the individual, as described in §164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity’s information and the individual’s agreement may be given orally.”

“(c) Standard: disclosures about victims of abuse, neglect, or domestic violence.

(1) Permitted Disclosures. Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:”

“(2) Informing the Individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.”

CFR = Code of Federal Regulations

HANDOUT 5

Legal, Ethical, and Best Practice Issues- PARTICIPANT MANUAL

Capacity Declaration: GC335

GC-335

	ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address): TELEPHONE NO.: _____ FAX NO. (Optional): _____ E-MAIL ADDRESS (Optional): _____ ATTORNEY FOR (Name): _____	To keep other people from seeing what you entered on your form, please press the Clear This Form button at the end of the form when finished.
Name and Address	SUPERIOR COURT OF CALIFORNIA, COUNTY OF _____ STREET ADDRESS: _____ MAILING ADDRESS: _____ CITY AND ZIP CODE: _____ BRANCH NAME: _____	
	CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name): _____ <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	
	CAPACITY DECLARATION—CONSERVATORSHIP	CASE NUMBER _____
Must mark A, B, or C	<p style="text-align: center;">TO PHYSICIAN, PSYCHOLOGIST, OR RELIGIOUS HEALING PRACTITIONER</p> <p>The purpose of this form is to enable the court to determine whether the (proposed) conservatee (check all that apply):</p> A. <input type="checkbox"/> is able to attend a court hearing to determine whether a conservator should be appointed to care for him or her. The court hearing is set for (date): _____ . (Complete item 5, sign, and file page 1 of this form.) B. <input type="checkbox"/> has the capacity to give informed consent to medical treatment. (Complete items 6 through 8, sign page 3, and file pages 1 through 3 of this form.) C. <input type="checkbox"/> has dementia and, if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she needs or would benefit from dementia medications. (Complete items 6 and 8 of this form and form GC-335A, sign and attach form GC-335A. File pages 1 through 3 of this form and form GC-335A.) (If more than one item is checked above, sign the last applicable page of this form or form GC-335A if item C is checked. File page 1 through the last applicable page of this form; also file form GC-335A if item C is checked.) COMPLETE ITEMS 1–4 OF THIS FORM IN ALL CASES.	
	<p>GENERAL INFORMATION</p> 1. (Name): _____ 2. (Office address and telephone number): _____ 3. I am a. <input type="checkbox"/> a California licensed <input type="checkbox"/> physician <input type="checkbox"/> psychologist acting within the scope of my licensure with at least two years' experience in diagnosing dementia. b. <input type="checkbox"/> an accredited practitioner of a religion whose tenets and practices call for reliance on prayer alone for healing, which religion is adhered to by the (proposed) conservatee. The (proposed) conservatee is under my treatment. (Religious practitioner may make the determination under item 5 ONLY.) 4. (Proposed) conservatee (name): _____ a. I last saw the (proposed) conservatee on (date): _____ b. The (proposed) conservatee <input type="checkbox"/> is <input type="checkbox"/> is NOT a patient under my continuing treatment.	
		Must be dated
	<p>ABILITY TO ATTEND COURT HEARING</p> 5. A court hearing on the petition for appointment of a conservator is set for the date indicated in item A above. (Complete a court hearing.) a. <input type="checkbox"/> The proposed conservatee is able to attend the court hearing. b. <input type="checkbox"/> Because of medical inability, the proposed conservatee is NOT able to attend the court hearing (check all items below that apply) (1) <input type="checkbox"/> on the date set (see date in box in item A above). (2) <input type="checkbox"/> for the foreseeable future. (3) <input type="checkbox"/> until (date): _____ (4) Supporting facts (State facts in the space below or check this box <input type="checkbox"/> and state the facts in Attachment C): _____	
		If B, must check boxes
	I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: _____	
Name!	Signature!	Include # of pages
	_____ (TYPE OR PRINT NAME)	_____ (SIGNATURE OF DECLARANT)
	Form Adopted for Mandatory Use Judicial Council of California GC-335 [Rev. January 1, 2004]	Page 1 of _____ Probate Code, §§ 813, 1801, 1825, 1851, 1910, 2350.5 American LegalNet, Inc. www.USCourtForms.com

12/13/2010

Version 2

Legal, Ethical, and Best Practice Issues- PARTICIPANT MANUAL

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/>	ESTATE OF (Name):	CASE NUMBER:
<input type="checkbox"/> CONSERVATEE <input type="checkbox"/>	PROPOSED CONSERVATEE	

6. EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS

Note to practitioner: This form is **not** a rating scale. It is intended to assist you in recording your *impressions* of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.

(Instructions for items 6A–6C): Check the appropriate designation as follows: **a** = no apparent impairment; **b** = moderate impairment; **c** = major impairment; **d** = so impaired as to be incapable of being assessed; **e** = I have no opinion.)

A. Alertness and attention

(1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)

a b c d e

(2) Orientation (types of orientation impaired)

a b c d e Person

a b c d e Time (day, date, month, season, year)

a b c d e Place (address, town, state)

a b c d e Situation ("Why am I here?")

(3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)

a b c d e

B. Information processing. Ability to:

(1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)

i. Short-term memory a b c d e

ii. Long-term memory a b c d e

iii. Immediate recall a b c d e

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)

a b c d e

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)

a b c d e

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)

a b c d e

(5) Reason using abstract concepts. (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)

a b c d e

(6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)

a b c d e

(7) Reason logically.

a b c d e

C. Thought disorders

(1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)

a b c d e

(2) Hallucinations (auditory, visual, olfactory)

a b c d e

(3) Delusions (demonstrably false belief maintained without or against reason or evidence)

a b c d e

(4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior).

a b c d e

Mark ALL questions

Must not be all a's and e's are to be avoided

(Continued on next page)

Legal, Ethical, and Best Practice Issues- PARTICIPANT MANUAL

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/>	ESTATE OF (Name):	CASE NUMBER:
<input type="checkbox"/> CONSERVATEE <input type="checkbox"/>	PROPOSED CONSERVATEE	

Name

6. (continued)

D. Ability to modulate mood and affect. The (proposed) conservatee has does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. (If so, complete remainder of item 6D.) I have no opinion.

Must mark has/does not

(Instructions for item 6D: Check the degree of impairment of each inappropriate mood state (if any) as follows: a = mildly inappropriate; b = moderately inappropriate; c = severely inappropriate.)

Anger	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Euphoria	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Helplessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Anxiety	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Depression	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Apathy	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Fear	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Hopelessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Indifference	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Panic	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Despair	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>				

If D is marked "has", must complete E

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6A–6D

- (1) do NOT vary substantially in frequency, severity, or duration.
- (2) do vary substantially in frequency, severity, or duration (explain; continue on Attachment 6E if necessary):

F. (Optional) Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is stated below stated in Attachment 6F.

This is the opportunity to indicate any environmental or social factors that compound the mental capacity issues.

Must complete

ABILITY TO CONSENT TO MEDICAL TREATMENT

7. Based on the information above, it is my opinion that the (proposed) conservatee

- a. has the capacity to give informed consent to any form of medical treatment. This opinion is limited to medical consent capacity.
- b. lacks the capacity to give informed consent to any form of medical treatment because he or she is either (1) unable to respond knowingly and intelligently regarding medical treatment or (2) unable to participate in a treatment decision by means of a rational thought process, or both. The deficits in the mental functions described in item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

Must complete

(Declarant must initial here if item 7b applies:)

Number of pages attached:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME)

(SIGNATURE OF DECLARANT)

2nd signature!

ACTIVITY CAPACITY DECLARATION

GC-335

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address): TELEPHONE NO.: _____ FAX NO. (Optional): _____ E-MAIL ADDRESS (Optional): _____ ATTORNEY FOR (Name): _____	FOR COURT USE ONLY
SUPERIOR COURT OF CALIFORNIA, COUNTY OF _____ STREET ADDRESS: _____ MAILING ADDRESS: _____ CITY AND ZIP CODE: _____ BRANCH NAME: _____	
CONSERVATORSHIP OF THE <input checked="" type="checkbox"/> PERSON <input checked="" type="checkbox"/> ESTATE OF (Name): <i>Janet Smith</i> <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	
CAPACITY DECLARATION—CONSERVATORSHIP	CASE NUMBER

TO PHYSICIAN, PSYCHOLOGIST, OR RELIGIOUS HEALING PRACTITIONER
 The purpose of this form is to enable the court to determine whether the (proposed) conservatee (check all that apply):
 A. is able to attend a court hearing to determine whether a conservator should be appointed to care for him or her. The court hearing is set for (date): _____ . (Complete item 5, sign, and file page 1 of this form.)
 B. has the capacity to give informed consent to medical treatment. (Complete items 6 through 8, sign page 3, and file pages 1 through 3 of this form.)
 C. has dementia and, if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she needs or would benefit from dementia medications. (Complete items 6 and 8 of this form and form GC-335A; sign and attach form GC-335A. File pages 1 through 3 of this form and form GC-335A.)
 (If more than one item is checked above, sign the last applicable page of this form or form GC-335A if item C is checked. File page 1 through the last applicable page of this form; also file form GC-335A if item C is checked.)
COMPLETE ITEMS 1-4 OF THIS FORM IN ALL CASES.

GENERAL INFORMATION
 1. (Name): *Ima Doktor, MD*
 2. (Office address and telephone number): *123 East Main Street
Springville, CA 94504*
 3. I am
 a. a California licensed physician psychologist acting within the scope of my licensure with at least two years' experience in diagnosing dementia.
 b. an accredited practitioner of a religion whose tenets and practices call for reliance on prayer alone for healing, which religion is adhered to by the (proposed) conservatee. The (proposed) conservatee is under my treatment. (Religious practitioner may make the determination under item 5 ONLY.)
 4. (Proposed) conservatee (name): *Janet Smith*
 a. I last saw the (proposed) conservatee on (date): _____
 b. The (proposed) conservatee is is NOT a patient under my continuing treatment.
ABILITY TO ATTEND COURT HEARING
 5. A court hearing on the petition for appointment of a conservator is set for the date indicated in item A above. (Complete a or b.)
 a. The proposed conservatee is able to attend the court hearing.
 b. Because of medical inability, the proposed conservatee is NOT able to attend the court hearing (check all items below that apply)
 (1) on the date set (see date in box in item A above).
 (2) for the foreseeable future.
 (3) until (date): _____
 (4) Supporting facts (State facts in the space below or check this box and state the facts in Attachment 5):

It will upset her.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
 Date: *Ima Doktor, MD* *Ima Doktor*
 _____ _____
 (TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

Form Adopted for Mandatory Use
Judicial Council of California
GC-335 (Rev. January 1, 2004)

CAPACITY DECLARATION—CONSERVATORSHIP

Page 1 of _____
 Probate Code, §§ 811,
 813, 1801, 1825,
 1881, 1910, 2356.6
 American LegalNet, Inc.

CLIENT DECISION-MAKING – PARTICIPANT'S MANUAL

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	CASE NUMBER:
---	--------------

6. EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS

Note to practitioner: This form is *not* a rating scale. It is intended to assist you in recording your *impressions* of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.
(Instructions for items 6A–6C): Check the appropriate designation as follows: a = no apparent impairment; b = moderate impairment; c = major impairment; d = so impaired as to be incapable of being assessed; e = I have no opinion.)

A. Alertness and attention

- (1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)
 a. a b c d e
- (2) Orientation (types of orientation impaired)
 a. a b c d e Person
 a. a b c d e Time (day, date, month, season, year)
 a. a b c d e Place (address, town, state)
 a. a b c d e Situation ("Why am I here?")
- (3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)
 a. a b c d e

B. Information processing. Ability to:

- (1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)
 i. Short-term memory a b c d e
 ii. Long-term memory a b c d e
 iii. Immediate recall a b c d e
- (2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)
 a. a b c d e
- (3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)
 a. a b c d e
- (4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)
 a. a b c d e
- (5) Reason using abstract concepts. (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)
 a. a b c d e
- (6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)
 a. a b c d e
- (7) Reason logically.
 a. a b c d e

C. Thought disorders

- (1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)
 a. a b c d e
- (2) Hallucinations (auditory, visual, olfactory)
 a. a b c d e
- (3) Delusions (demonstrably false belief maintained without or against reason or evidence)
 a. a b c d e
- (4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior).
 a. a b c d e

(Continued on next page)

CLIENT DECISION-MAKING – PARTICIPANT'S MANUAL

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	CASE NUMBER:
---	--------------

6. (continued)

D. **Ability to modulate mood and affect.** The (proposed) conservatee has does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. (If so, complete remainder of item 6D.) I have no opinion.

(Instructions for item 6D: Check the degree of impairment of each inappropriate mood state (if any) as follows: a = mildly inappropriate; b = moderately inappropriate; c = severely inappropriate.)

Anger	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Euphoria	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Helplessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Anxiety	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Depression	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Apathy	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Fear	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Hopelessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Indifference	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Panic	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Despair	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>				

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6A–6D

- (1) do NOT vary substantially in frequency, severity, or duration.
 (2) do vary substantially in frequency, severity, or duration (explain; continue on Attachment 6E if necessary):

F. (Optional) Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is stated below stated in Attachment 6F.

She has dementia.

ABILITY TO CONSENT TO MEDICAL TREATMENT

7. Based on the information above, it is my opinion that the (proposed) conservatee

- a. has the capacity to give informed consent to any form of medical treatment. This opinion is limited to medical consent capacity.
 b. lacks the capacity to give informed consent to any form of medical treatment because he or she is **either** (1) unable to respond knowingly and intelligently regarding medical treatment **or** (2) unable to participate in a treatment decision by means of a rational thought process, **or both**. The deficits in the mental functions described in item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

(Declarant must initial here if item 7b applies: _____.)

8. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

Ima Dokter MD

(TYPE OR PRINT NAME)

Ima Dokter MD

(SIGNATURE OF DECLARANT)

CLIENT DECISION-MAKING – PARTICIPANT'S MANUAL

GC-335A

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	CASE NUMBER:
---	--------------

**ATTACHMENT TO FORM GC-335, CAPACITY DECLARATION—CONSERVATORSHIP,
ONLY FOR (PROPOSED) CONSERVATEE WITH DEMENTIA**

9. It is my opinion that the (proposed) conservatee HAS does NOT have dementia as defined in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*.
- a. **Placement of (proposed) conservatee.** (If the (proposed) conservatee requires placement in a secured-perimeter residential care facility for the elderly, please complete items 9a(1)–9a(5).)
- (1) The (proposed) conservatee needs or would benefit from placement in a restricted and secure facility because (state reasons; continue on Attachment 9a(1) if necessary):

 - (2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include (describe; continue on Attachment 9a(2) if necessary):
She has dementia
 - (3) The (proposed) conservatee HAS capacity to give informed consent to this placement.
 - (4) The (proposed) conservatee does NOT have capacity to give informed consent to this placement. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9a(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of his or her actions with regard to giving informed consent to placement in a restricted and secure environment.
 - (5) A locked or secured-perimeter facility is is NOT the least restrictive environment appropriate to the needs of the (proposed) conservatee.
- b. **Administration of dementia medications.** (If the (proposed) conservatee requires administration of psychotropic medications appropriate to the care of dementia, please complete items 9b(1)–9b(5).)
- (1) The (proposed) conservatee needs or would benefit from the following psychotropic medications appropriate to the care of dementia, for the reasons stated in item 9b(5) (list medications; continue on Attachment 9b(1) if necessary):

 - (2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include (describe; continue on Attachment 9b(2) if necessary):
she has dementia
 - (3) The (proposed) conservatee HAS capacity to give informed consent to the administration of psychotropic medications appropriate to the care of dementia.
 - (4) The (proposed) conservatee does NOT have the capacity to give informed consent to the administration of psychotropic medications appropriate to the care of dementia. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9b(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate his or her actions with regard to giving informed consent to the administration of psychotropic medications for the treatment of dementia.
 - (5) The (proposed) conservatee needs or would benefit from the administration of the psychotropic medications listed in item 9b(1) because (state reasons; continue on Attachment 9b(5) if necessary):
she has dementia

10. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

Uma Dokter, MD
(TYPE OR PRINT NAME)

Uma Dokter
(SIGNATURE OF DECLARANT)

Form Adopted for Mandatory Use
Judicial Council of California
GC-335A [New January 1, 2004]

**DEMENTIA ATTACHMENT TO
CAPACITY DECLARATION—CONSERVATORSHIP**

Page 1 of 1
Probate Code, § 2356.5

American LegalNet, Inc.
www.USCourtForms.com

Break



TIME ALLOTTED: 10 minutes


CLINICAL FRAMEWORKS FOR CAPACITY



TIME ALLOTTED: 60 minutes

SLIDE 28

Clinical Frameworks of Capacity



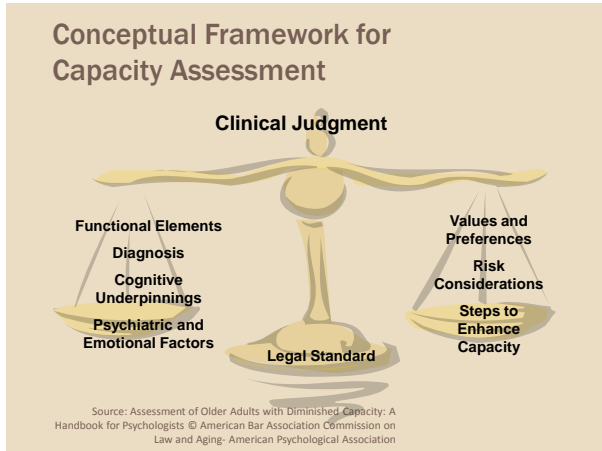
SLIDE 29

Historical Perspective & Caveats

- Clinical evaluation of decisional capacity is an evolving field
- Capacity assessment is a new practice area for psychologists
- Confusion about the term capacity
- Confusion from referring parties

Source: Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists © American Bar Association Commission on Law and Aging- American Psychological Association

SLIDE 30



HANDOUT 6

Capacity Worksheet for Psychologists

Source: Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists by the ABA Commission on Law and Aging and the American Psychological Association (2008). Please read and review the handbook prior to using the worksheet.

Name: _____ Date(s) of Evaluation: _____

Psychologist: _____ Place of Evaluation: _____

A. Pre-Assessment Screening

Issue	Questions to consider
What functional and decisional capacities are in question:	What types of decisional or functional processes are in question? What data are needed? Am I appropriately qualified to assess these?
Who is involved in this case:	Who is the client? Who are the interested parties? Who is requesting the evaluation? Who sees the report? Is the court or litigants involved?
Who is the older adult:	What is the person’s history, age, cultural background, primary language, sensory functioning?
When does this evaluation need to be completed:	How urgent is the request? Is there a court date? What is the time frame of interest?
Where and how will the evaluation take place:	In what setting does the evaluation take place? What accommodations are needed to maximize performance?
Why is this question being raised:	Why now? What is the history of the case? Will a capacity evaluation resolve the problem? Have all less restrictive alternatives and interventions been exhausted?
Is the patient medically stable:	Have all temporary and reversible causes of cognitive confusion been assessed and treated?

B. Informed Consent

Understanding:	Issues to disclose
	Why is the evaluation requested? Procedures involved in evaluation? Potential risks? Potential benefits? Uses of the report? Limits on privacy and confidentiality?

- Understands and consents Questionable understanding but assents
 Understands and refuses Questionable understanding but refuses

C. Setting up the Assessment: Legal Standard and Functional Elements

What is the legal standard for the capacity in question?
What are the functional elements to consider?

D. Record Review

Medical records	Diagnoses Laboratory Tests Imaging Other Treatments Medications
Legal records	Documents filed in the court Financial statements HCP/POAHC documents
Other Records	

E. Collateral Interviews

Family
Staff/ Professional Caregivers
Other

F. Accommodating and Enhancing Capacity During the Assessment

Assess recent events and losses, such as bereavement Explore medical factors such as nutrition, medications, hydration Select tests in consideration of cultural and language issues; Administer tests in primary language Select tests that are validated for the age of the person Assess ability to read and accommodate reading difficulties Adjust seating, lighting; Use visual and hearing aids Consider fatigue; Take breaks; Use multiple testing sessions

G. Assessment Data

Functional elements (list from 4B above):	<input type="checkbox"/> Objective Assessment	<input type="checkbox"/> Clinical Interview
<p>1. _____ Level of impairment: Describe:</p> <p>2. _____ Level of impairment: Describe:</p> <p>3. _____ Level of impairment: Describe:</p> <p>4. _____ Level of impairment: Describe:</p>		
Cognitive Underpinnings (possible domains):	<input type="checkbox"/> Objective Assessment	<input type="checkbox"/> Clinical Interview
<p>1. Sensory Acuity</p> <p>2. Motor Activity and Speed of processing</p> <p>3. Attention and Concentration</p> <p>4. Working memory</p> <p>5. Short term/recent memory and Learning</p> <p>6. Long term memory</p> <p>7. Understanding or Receptive Language</p> <p>8. Communication or Expressive Language</p> <p>9. Arithmetic</p> <p>10. Verbal Reasoning</p> <p>11. Visual-Spatial and Visuo-Constructional Reasoning</p> <p>12. Executive Functioning</p> <p>13. Other</p>		
Psychiatric/Emotional Factors (possible domains):	<input type="checkbox"/> Objective Assessment	<input type="checkbox"/> Clinical Interview
<p>1. Disorganized Thinking</p> <p>2. Hallucinations</p> <p>3. Delusions</p> <p>4. Anxiety</p> <p>5. Mania</p> <p>6. Depressed Mood</p> <p>7. Insight</p> <p>8. Impulsivity</p> <p>9. Noncompliance</p> <p>10. Other</p>		

CLIENT DECISION-MAKING – PARTICIPANT’S MANUAL

Values	Possible Considerations
	What is the older adult’s view of the situation? Preferences for how decisions made? And by whom? Preferences for living setting? Goals including self assessment of quality of life? Concerns, fears, preferences, religious views? Preferences for spending and saving? Impact of culture, age, sexual orientation, diversity? Views about guardianship (if applicable)?
Risks	Possible Considerations
	Is the risk new or old? How serious is the risk? How imminent is the risk? What is the risk of harm to self? To others? Are there concrete instances of failure? How objective is the assessment of risk?

H. Findings

Diagnoses and Prognoses	Possible Considerations
	What diagnoses account for the deficits? Can conditions be treated? Are deficits likely to get better, worse or stay the same? When should the older adult be re-evaluated?

Capacity Framework	Capacity Conclusions
1) The functional abilities constituent to the capacity; 2) Cognitive abilities, psychiatric/emotional functioning, and medical diagnoses and prognosis, <i>as they relate to the functional abilities</i> ; 3) The individual’s values, social network, and the specific risks of the capacity situation.	<input type="checkbox"/> Has capacity for decision / task in question <input type="checkbox"/> Lacks capacity for decision / task in question <input type="checkbox"/> Has marginal capacity for decision / task in question (if the case is not being adjudicated, recommended course of action)

Steps to Enhance Capacity	Would the Older Adult benefit from:
	Education, training, or rehabilitation? Mental health treatment? Occupational, physical, or other therapy? Home and/or social services? Assistive devices or accommodations? Medical treatment, operation or procedure? Other?

SLIDE 31

Comparisons:

Legal	Clinical
Transactions <i>Can a person 'transact' certain things- e.g. make a will?</i>	Domains <i>How well does a person function in various neuropsychological domains- e.g. memory, executive functioning?</i>
Binary <i>Is capacity present or lacking? Is black and white- like an on/off switch- seeks 'yes' 'no' answers.</i>	Continuous <i>Capacities are variable continuums in which there may be no bright lines.</i>
Conceptual <i>Offer a simple conceptual template- but does not specify concrete tests that tap the abilities needed</i>	Operational <i>Fills in the detail about operational abilities necessary to meet legal standard but must link to relevant legal standard</i>

Source: Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists © American Bar Association Commission on Law and Aging- American Psychological Association

SLIDE 32

Appearance

- Description
 - Grooming, apparent age, abnormal physical traits, weight, interaction with others
- Relevance to capacity
 - May indicate general mental condition and may reveal problems with judgment.
- Possible sources of information

SLIDE 33

Orientation

- Description
 - Can state name (and other identifying info), place, time, reason for interview
- Relevance to capacity
 - Good general index of patient's awareness; standardization of questions is main virtue; could signal delirium if precipitous change
- Possible sources of information

SLIDE 34

Attention

- Description
 - ▣ Attend to a stimulus without being distracted by extraneous environmental stimuli
 - ▣ Concentrate on a stimulus over brief time periods
- Relevance to capacity
 - ▣ Basic function necessary for processing information-sensitive to delirium. May be impaired in brain-based and emotional disorders.
- Possible sources of information

SLIDE 35

Memory

- Description
 - ▣ Memory is a general term for a mental process that allows the individual to store experiences and perception
- Relevance to capacity
 - ▣ Necessary for all decision making.
 - ▣ Underpins functioning at home and performing critical activities.
- Possible sources of information

SLIDE 36

Receptive Language

- Description
 - ▣ Understand written, spoken or visual information
- Relevance to capacity
 - ▣ Critical to understanding options, especially regarding new problems or new treatments
- Possible sources of information

SLIDE 37

Expressive Language

- Description
 - Express self in words or writing
 - State choices
- Relevance to capacity
 - Basic function necessary to convey choices in decision making
- Possible sources of information

SLIDE 38

Arithmetic/Mathematical Skills

- Description
 - Understand basic quantities
 - Make simple calculations
- Relevance to capacity
 - Important for routine financial tasks and financial decision-making
- Possible sources of information

SLIDE 39

Reasoning

- Description
 - Compare two choices
 - Reason logically about outcomes
- Relevance to capacity
 - Critical in almost all decision making- ability to weigh options
- Possible sources of information

SLIDE 40

Visual-Spatial and Visuo-Constructional Reasoning

- Description
 - ▣ Visual-spatial perception
 - ▣ Visual problem solving
- Relevance to capacity
 - ▣ Essential for driving and basic functioning at home and in the community
- Possible sources of information

SLIDE 41

Executive functioning

- Description
 - ▣ Plan for the future
 - ▣ Demonstrate judgment
 - ▣ Inhibit inappropriate responses
- Relevance to capacity
 - ▣ Important to avoid undue influence
 - ▣ Essential for most decision making
- Possible sources of information


SLIDE 42

Insight

- Description
 - ▣ Acknowledge deficits
 - ▣ Acknowledge the potential benefit of intervention
 - ▣ Accept help
 - ▣ Often considered part of “executive function”
- Relevance to capacity
 - ▣ Critical to the use of less restrictive alternatives
- Possible sources of information

SLIDE 43

Practice



SLIDE 44

Vignette- Wanda Jones

- Age 87, lives alone
- Has fallen, calls 911, taken to ER
- Paramedics note confusion, unbathed, home dirty, urine and feces in home, meds in disarray, empty wine bottles
- Hospitalized for heart failure, malnutrition, dehydration- stabilizes with treatment
- Cognition improves but still has memory problems- brain scan shows mild cerebrovascular disease

SLIDE 45

Vignette- Wanda Jones, cont.

- Reports depression in hospital- refuses formal assessment
- Begs to be discharged, assures team she can manage meds, personal care and meals at home
- Dislikes idea of home care- values her independence and wants to return to her home of 40 years
- Team asks, “is she competent”?

SLIDE 46

Wanda’s Capacity?

- What are the legal standards in question?
- What would APS need/want to know to ensure a safe discharge?
- How might a psychologist investigate the team’s question?
- What would make this a case for the PG?

SLIDE 47

Legal Standards

- Does the client have capacity make informed decisions?
- Can client provide properly for personal needs?
 - Physical Health, Food, Clothing and Shelter
- Can the client manage finances, resist fraud or undue influence?
- Are there viable alternatives to conservatorship?
 - Power of Attorney
 - Representative Payee
 - Trust
 - Family or Significant Others
 - Home Care Options
 - Supportive Services

SLIDE 48

APS Response

- Ask hospital to re-attempt psych eval for depression
- Needs a caregiver to be considered a safe discharge- would lead to APS asking about her finances, social support
- Recommend home health if insists on going home
- House call from mental health/substance abuse program

SLIDE 49

How Psychologist Might Evaluate

- Administer objective cognitive tests if cooperative or through interview if not cooperative
- Assess mood to determine if depression alone or in combo with factors is limiting her functioning
- Assess for delirium – present, resolving
- Assess for history of alcohol abuse
- Assess decision-making capacity through hypothetical problem-solving questions
- Interview hospital staff regarding response to nursing care, OT, PT, ST
- Obtain records or interview PCP regarding level of functioning prior to this episode – baseline functioning

SLIDE 50

What Would Make This a PG Case?

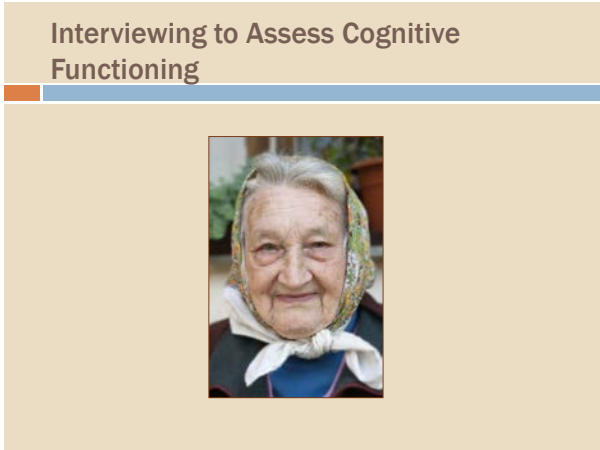
- Answers to the legal standards questions
- Capacity declaration that declares the client lacks capacity
- No one willing, able or appropriate to serve as conservator
- No viable alternatives to conservatorship

INTERVIEWING TO ASSESS COGNITIVE FUNCTIONING

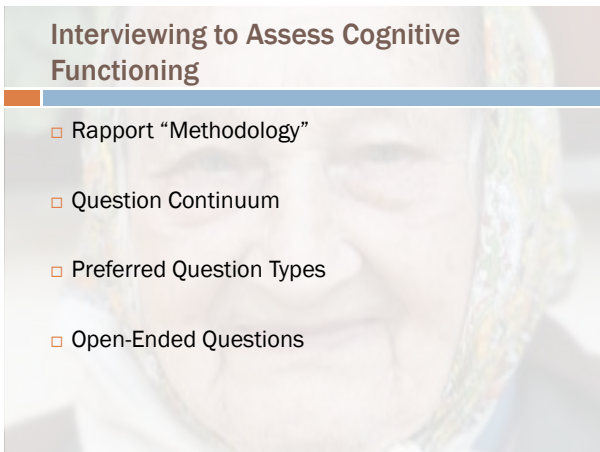


TIME ALLOTTED: 30 minutes

SLIDE 51



SLIDE 52



Handout 7 – Interviewing to Assess Cognitive Function

- **Rapport Building “Methodology”**

- Start with non-threatening subjects.
- Find a common, non-threatening shared interest.
- Mirror the victim’s body language, posture, and language pace.
- Respect the victim’s needs (time limitations, fatigue, pain tolerance, need for bathroom breaks, etc.)

Mirroring the victim’s body language may feel artificial when you first start consciously thinking about it but it is effective in making the other person feel you “get him”. (Most of us do it, to some extent, unconsciously.) It’s a communication dance we do when we are actively attending to the other person. And, doing it intentionally will help you signal that you are attending to those you are interviewing.

- **Question Continuum**

- Moves from open-ended to close ended questions.
- Moves from more confidence in the accuracy of the information (with open-ended questions) to less confidence (with close-ended questions).

- **Preferred Question Types**

- Open-ended general questions
- Open abuse-related questions
- Invitational questions (Tell me more)
- Narrative cue (I see)
- Focused questions
- Disclosure clarification

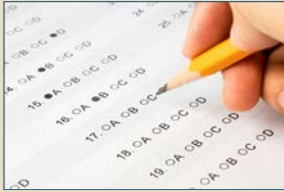
- **Open-Ended Questions**

Can observe general level of:

- Cognitive organization - Understand and answer the question?
- Social appropriateness - Read social cues, obey conventions?
- Safety awareness - Disclosure is too much too soon?
- Language functioning - Anything unusual/unexpected (e.g. slurring?)
- Insight - Why do they think they are meeting with you?

SLIDE 53

Screening Tools



SLIDE 54

Pros and Cons of Screens in General

- Cons
 - Depending on setting- often administered and interpreted incorrectly
 - Inappropriate tools for subject/population
 - May feel distancing or artificial in flow of interview
 - Can make clients anxious or paranoid

SLIDE 55

Pros and Cons of Screens in General

- Pros
 - Consistency of observation/data across subjects
 - Better coverage within subjects- may correct bias
 - Informs treatment planning
 - Evidence-based data to advocate for better care
 - Document vulnerability/potential diminished or lack of capacity
 - Justifies interventions

SLIDE 56

**Barriers and Responses
to Using Screens**

- Barrier: It will shame my client if they cannot answer the question
- Response: It is often impossible to understand if a deficit exists unless directly asked.
- Barrier: It will interrupt rapport building to whip out a formal screen.
- Response: It is empathic to ask good, if difficult, questions- we would expect nothing less if we were going to a doctor.
- Barrier: I can just ‘weave in’ the assessment questions into the interview informally.
- Response: This may be adequate, but research shows that detection is better with formal screens.

SLIDE 57

**Tools to Assess Cognitive
Functioning**

- Sensitivity
- Specificity
- Handout 8 – Appendix C: Cognitive Assessment

HANDOUT 8

Appendix C. Cognitive Assessment

This section provides an overview of cognitive functioning and neuropsychological assessment, and is based on information available in key clinical references and the consensus of the working group. This appendix is not intended as a comprehensive or exhaustive discussion of cognitive or neuropsychological testing.

Cognitive Screening

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

Acronym	Screening Test Name	Screening Test Description
BIMC	Blessed Information Memory Concentration Test	33-point scale with subtests of orientation, personal information, current events, recall, and concentration. There is a short version with six items.
Cognistat	The Neurobehavioral Cognitive Status Examination	This screening test examines language, memory, arithmetic, attention, judgment, and reasoning.
MLDT	MacNeill Lichtenberg Decision Tree	This decision tree combines the use of brief screening measures (Benton’s Temporal Orientation Test and the Animal Naming test) with questions about environmental demand and a 3-item screen to rule out depression.
MMSE	Mini Mental State Examination	30-point screening instrument that assesses orientation, immediate registration of three words, attention and calculation, short-term recall of three words, language, and visual construction.
MoCA	Montreal Cognitive Assessment	30-point cognitive screening instrument that assesses visuospatial/executive, naming, memory, attention, language, abstraction, delayed recall, and orientation to time. http://www.mocatest.org/
MSQ	Mental Status Questionnaire	10-item, 10-point scale assessing orientation to place, time, person, and current events. It has low to modest sensitivity for detecting neurological illness.
7MS	The Seven Minute Screen	This screening instrument combines four tests, each with separate scores of various ranges: recall, verbal fluency, orientation, and clock drawing.
SLUMS	The Saint Louis University Mental Status Examination	11-item scale to detect mild cognitive impairment and dementia includes orientation, word memory, arithmetic, naming, clock drawing, story memory. http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf
SPMSQ	Short Portable Mental Status Questionnaire	10-point scale scored as a sum of errors on subtests of orientation, location, personal information, current events, and counting backwards. High scores (8-10) equals severe impairment. Race and age corrections to scores are available.
TICS	Telephone Interview for Cognitive Status	11-item scale developed for situations where in-person cognitive screening is impractical, although it can be administered face to face. Norms for English-speaking adults, ages 60-98 years.

LUNCH



TIME ALLOTTED: 45 minutes

INTERVIEWING TO ASSESS COGNITIVE FUNCTIONING (cont)



TIME ALLOTTED: 30 minutes

SLIDE 58 – **Handout 9**

Video & Observation Activity

- Video 1 – Mrs. B - Initial Interview
- Video 2 – Mrs. B - MMSQ

- *Instructions - Use Video Interpretation Worksheet to take notes and formulate interpretations based on the observations listed.*
- *Review answers using Handout 9 – Video Interpretation*

Activity – Video Interpretation Worksheet

Observation	Notes	Write in your interpretation
1 Reports has good marriage but unable to report length of time		
2 Reports she has poor memory when can't recall family names		
3 Drew clock to instructions		
4 Copied overlapping pentagons		
5 Able to write a sentence to dictation		
6 Laughs frequently		

SLIDE 59

Observation #1:
Says she has a good marriage but is unable to report length of marriage

□ Possible Interpretations:

SLIDE 60

Observation #2:
Reports she has poor memory when unable to recall names

□ Possible Interpretations:

SLIDE 61

Observation #3:
Draws a clock as requested

□ Possible Interpretations:

SLIDE 62

Observation #4:
Poor copy of overlapping pentagons

□ Possible Interpretations:

SLIDE 63

Observation #5:
Able to write a sentence to dictation

□ Possible Interpretations:

SLIDE 64

Observation #6:
Laughs frequently

□ Possible Interpretations:

Handout 9 – Video Interpretation

	Observation	Poor Interpretation	Better Interpretation	Tips for Accurate Documentation
1	Reports she has a good marriage but is unable to accurately report length of marriage	Is happy in her marriage but overly dependent on husband	Is dependent on husband for specific information, lacks insight into cognitive loss, uses humor to cover	Avoid making interpretations about emotional status based on a few comments
2	Reports she has poor memory when can't recall family members names	Has insight into her memory loss	Has at least limited insight into impaired memory	Insight is often related to context
3	Drew clock to instructions	Can't tell time	Impaired attention to visual detail	Use terms that qualify and limit your interpretations
4	Copied overlapping pentagons	Should not be driving	Impaired visuospatial skills	Avoid offering opinions based on one piece of data
5	Able to write a sentence to dictation	Intact language abilities	Poor grammar, but spelling is intact. Expresses some insight into the testing situation	Be aware of all the components of a domain of function
6	Laughs frequently	Laughs inappropriately	Has an intact sense of humor, uses to distract from cognitive limitations	Multiple observations allows you to make broader interpretations

DOCUMENTATION – BRIEF REVIEW



TIME ALLOTTED: 15 minutes

SLIDE 65

Documentation ~ A Brief Review

SLIDE 66

Documentation

- Detailed and reliable case history, baseline data
- Evidence for legal involvement
- Accountability and liability
- Professionalism
- Consistency
- Justification for staff and funding for program
- Other

SLIDE 67

Activity

- Read the following narrative information carefully and answer the questions – T, F or Q

The client was oriented X3. She didn't remember the worker from her previous visit. She seemed confused and was unable to answer questions posed by the worker. Her son said that she didn't remember to buy food or take out the trash. Mr. Zachariah said that the client often failed to go to doctors' appointments. It was unclear what medication she should be taking. Mrs. Zachariah stated that everyone was being too critical. She left the room during the worker's discussion with Mr. Zachariah.

**ACTIVITY:
Documentation**

Read the following narrative information carefully:

The client was oriented X3. She didn't remember the worker from her previous visit. She seemed confused and was unable to answer questions posed by the worker. Her son said that she didn't remember to buy food or take out the trash. Mr. Zachariah said that the client often failed to go to doctors' appointments. It was unclear what medication she should be taking. Mrs. Zachariah stated that everyone was being too critical. She left the room during the worker's discussion with Mr. Zachariah.

Now read the following statements about the narrative. Circle "T" if the statement is true, "F" if the statement is false, and "Q" if you do not know if it's true or false.

- | | | | |
|---|---|---|---|
| T | F | Q | 1. The client knew what day of the week it was. |
| T | F | Q | 2. The client's son said that she forgot her doctor's appointments. |
| T | F | Q | 3. It was reported that the client was too confused to buy groceries. |
| T | F | Q | 4. The client knew her own address. |
| T | F | Q | 5. The client is not taking her medication properly. |
| T | F | Q | 6. The client was not taking out the trash. |
| T | F | Q | 7. Mrs. Zachariah was offended by her son's statements. |
| T | F | Q | 8. There was not very much food in the kitchen. |
| T | F | Q | 9. The client is ambulatory. |
| T | F | Q | 10. Mrs. Zachariah went to another room after she talked to the worker. |

SLIDE 68

Just the Facts

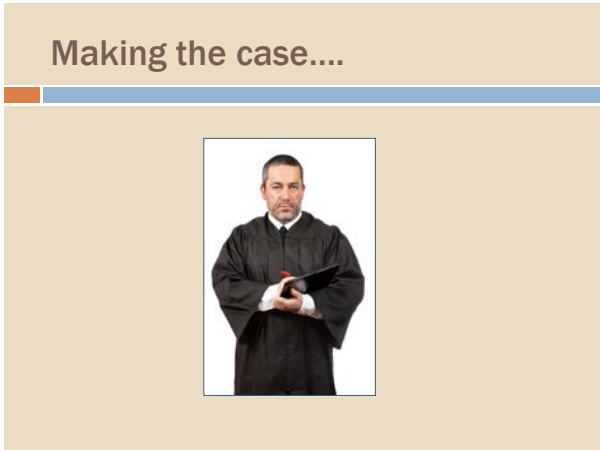
- Direct and systematic observations
 - What you saw, heard, smelled
- Information obtained by other professionals
 - Medical diagnosis and prognosis, Bank statements, Legal documents
- Direct quotes
- Clear language
 - Understood by any reader
 - Acronyms and lingo beware

MAKING THE CASE...

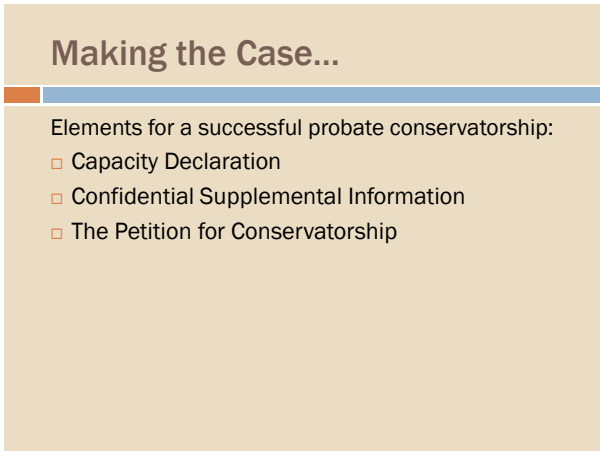


TIME ALLOTTED: 40 Minutes

SLIDE 69



SLIDE 70



SLIDE 71

Capacity Declaration

- Does the client suffer from dementia?
- Can the client attend a court hearing?
- What are client’s mental functions?

SLIDE 72

Confidential Supplemental Information

- *Inability to provide for personal needs*
- *Inability to manage financial resources*
- *Residence*
- Description of alternatives
- Services provided
- Supporting facts

□ *Handout 11 – Confidential Supplemental Information*

SLIDE 73

Personal Needs

Vague Statements or Conclusions	Specific/Fact-Based Statements
“The client has very bad personal hygiene.”	“Regardless of the time of day that the PG/PC visits her, Ms. Smith is always found in a dirty bath robe, which has multiple unidentifiable food particles and stains down the front of it. Her hair is unkempt all over and matted in places. Ms. Smith emits an overpowering body odor.”

SLIDE 74

Financial Resources

Vague Statements or Conclusions	Specific/Fact-Based Statements
“Mrs. Smith is too confused to manage her own finances.”	“Due to severe cognitive impairment, as a result of a stroke, Mrs. Smith is unable to manage her finances. On two of out three occasions when asked, she could not remember what the source, (or the amount) of her income is or her bank’s name. She double paid her mortgage four times in the past 6 months, because she did not remember paying it the first time. She did not remember to pay her utility bill, so her electricity was shut off for three days.”

SLIDE 75

Residence

Specific/Fact-Based Statements
“Ms. Preston lives alone and is not able to ambulate without assistance. There are no family members or friends who can assist her. Ms. Preston also has not been taking her heart medication, as demonstrated by a full bottle of medication, which should have been empty based on the date prescribed. Ms. Preston requires a placement where she can receive proper medication management, nutrition and socialization.”

SLIDE 76

Other Elements...

Descriptions of the Alternatives	<ul style="list-style-type: none"> •Informal assistance, care or interventions •Professional care assistance •Legal (DPA, POA, Trust, Rep Payee)
Services Provided	<ul style="list-style-type: none"> •Health care services, social services or estate management assistance the client received during the past year. • Another opportunity to describe what alternatives have been tried and failed.
Supporting Facts	For each alternative presented: <ul style="list-style-type: none"> •PG/PC must attest that the information was based on their own direct knowledge or they must attach an affidavit by another person to substantiate the claim.

SLIDE 77

A Note on Relatives...

- PG spends a lot of time seeking relatives
- Probate Code Section 1821(b)
- Probate Code Section 1822
- Consanguinity Chart (*Handout 3*)

SLIDE 78

The Petition for Conservatorship

- Packet containing:
 - Confidential Supplemental Information
 - Capacity Declaration with attachments
 - Petition
 - Original referral (varies by county)
- Based on Confidential Supplement Information
- Legal document, accessible by public
- Information presented in vague and general terms on the petition.

Handout 10 – Confidential Supplemental Information

- I. Unable to provide for personal needs
 - A. The information documented in this section of the confidential supplementation describes facts that support the PG/PC’s contention that the proposed Conservatee is **unable** to provide properly for his/her needs for physical health, food, clothing and shelter.
 - B. The information must provide specific examples from the proposed Conservatee’s daily life that are fact based and not conclusions.
 - C. The following chart gives examples of how to describe the living conditions in a clear, specific and factual manner:

Vague Statements or Conclusions	Specific/fact based Statements
<p>“Mr. Jones is cognitively impaired and confused.”</p>	<p>“Mr. Jones lives in a friend’s spare bedroom, but believes he is in his own home and wants the “people in his house” removed. He is unable to remember the date, city he is in, the names of his family members or what time of year it is (fall, winter, etc.). He believes he is still a practicing Attorney and states he plans to “sue these people in my house”. When asked how long he has lived in his current residence, he states, “why all my life”. In fact he has lived with his friend for 3 months.”</p>
<p>“The client’s surroundings were poor, unlivable and unsanitary. There was little to eat.”</p>	<p>“The apartment was extremely filthy. The floors were covered with cat feces, garbage, newspapers, and hundreds of roaches, both dead and alive. There was an unbearable stench of feces, urine and spoiled food throughout the apartment. The only food was some moldy bread, rotten bananas, and rotten apples on the counter, and some rancid smelling lunch meat, curdled milk, moldy cheese, moldy butter and beer the refrigerator”.</p>
<p>“The client has very bad personal hygiene”.</p>	<p>“Regardless of the time of day that the PG/PC visits her, Ms. Smith is always found in a dirty bath robe, which has multiple unidentifiable food particles and stains down the front of it. Her hair is unkempt all over and matted in places. Ms. Smith emits an</p>

CLIENT DECISION-MAKING – PARTICIPANT’S MANUAL

	overpowering body odor.”
--	--------------------------

II. Unable to manage financial resources

- A. The information documented in this section of the confidential supplementation describes facts that support the PG/PC’s contention that the proposed Conservatee is **unable** to manage his/her financial resources or to resist fraud and undue influence.
- B. The information must provide specific examples from the proposed Conservatee’s daily life that are fact based and not conclusions without specific facts to support them.
- C. The information presented must be from personal observations; or if the information was from another source, it must be verified by the PG/PC or substantiated with documentation (records or affidavits). It can not be based solely on the “opinion” of the PG/PC or the “opinion” of another source such as the APS social worker.
- D. The following chart provides examples of how to describe the actual financial facts that clearly demonstrate the client’s inability to manage his/her financial assets:

Vague Statements or Conclusions	Specific/fact based Statements
“Mrs. Smith is too confused to manage her own finances.”	“Due to severe cognitive impairment, as a result of a stroke, Mrs. Smith is unable to manage her finances. On two of out three occasions when asked, she could not remember what the source, (or the amount) of her income is or her bank’s name. She double paid her mortgage four times in the past 6 months, because she did not remember paying it the first time. She did not remember to pay her utility bill, so her electricity was shut off for three days.”
“Mr. Carney is unable to resist undue influence and he allows people to take advantage of him.”	Mr. Carney is unable to manage his financial resources or to resist fraud or undue influences. For example, Mr. Carney’s mortgage is three months past due. When asked why the mortgage wasn’t paid he replied, “well, my family members really needed help”. When asked where his ATM Card was, Mr. Carney told the PG/PC that he loaned it to his Grandson. This was verified

CLIENT DECISION-MAKING – PARTICIPANT’S MANUAL

	by the PG/PC. In addition, the Grandson admitted to “borrowing” \$5,000 from the Mr. Carney, who had no memory of the loan, and although very upset to learn of it, said, “well, my Grandson must have needed it” and said “family must help family”. The Grandson left the county after being contacted by the PG/PC regarding repayment of the loan.”
--	---

III. Residence

- A. This section describes where the client is currently living.
- B. It also indicates whether or not there is an intent to remove the client from his/her home.
- C. If there is an intention to move the client after a Conservator is appointed, you must provide specific facts that support the need to move the client. This section is particularly important given recent changes to the law that state the least restrictive environment is the home/residence of the proposed conservatee. Efforts to move a client from their home to a higher level of care require court authority, unless it is an emergency.

So for example the following statement would meet that requirement:

“Ms. Preston lives alone and is not able to ambulate without assistance. There are no family members or friends who can assist her. Ms. Preston also has not been taking her heart medication, as demonstrated by a full bottle of medication, which should have been empty based on the date prescribed. Ms. Preston requires a placement where she can receive proper medication management, nutrition and socialization.”

(**Note:** in some counties the courts require the PG/PC to articulate the amount of the client’s income and cost of care as evidence of the lack of financial resources).

IV. Description of Alternatives

This is a description of all the alternatives to Conservatorship which were tried, but which were not viable or successful and why they were not sufficient to meet the client’s needs. Some examples include:

- A. Informal assistance, care or interventions by family, friends, neighbors, church or social connections
- B. Professional care assistance (in-home care, board & care, skilled nursing care)
- C. Power of Attorney
- D. Durable Power of Attorney
- E. Trust (legal trust)
- F. Representative Payee

V. Services Provided

- A. In this section, you must describe what, if any, health care services, social services or estate management assistance the client received during the past year.

CLIENT DECISION-MAKING – PARTICIPANT'S MANUAL

B. This is another opportunity to describe what alternatives have been tried and failed.

VI. Supporting Facts

For each of the alternatives presented above in item “IV”, the PG/PC must attest that the information was based on the PG/PC own direct knowledge or the PG/PC must attach an affidavit by another person to substantiate the claim.

BREAK



TIME ALLOTTED: 10 minutes


ASSETS & LIMITATIONS OF INTERVENTIONS



TIME ALLOTTED: 55 minutes

SLIDE 79

Assets & Limitations of Interventions



SLIDE 80

Probate Conservatorship Vignettes

Activity :

- ▣ Case 1 - Mr. Williams
- ▣ Case 2 - Estella
- ▣ Case 3 - Margaret P.
- ▣ Case 4 - Marine C.

ACTIVITY:
Probate Conservatorship Vignettes

See Next Page

Case 1 - Mr. Williams

In May 2009, PG/PC received a referral from APS regarding Mr. Gordon Williams. Mr. Williams was a 79 year old Caucasian male. His marital status was single and he had the following physical characteristics: 6'2"; 170 lbs., gray hair and a white beard. He was referred to the PG's Office by APS, because he was living in a K-Mart parking lot in his 36 foot motor home.

Due to the reported urgency of the case, the PG Investigator and an APS worker went to visit Mr. Williams together. They found him to be confused, and not oriented to place or time. He believed he was in Colorado, on a trip to Arizona and was just in the K-Mart parking lot overnight. However, the K-Mart Manager, (who called APS) reported Mr. Williams had been in the parking lot for 3 weeks.

The client was physically frail as evidenced by his inability to go up and down the stairs of the RV. He also had a swollen toe that appeared to be infected. The RV was filthy, with molding and rancid food in the small refrigerator, on the counters and table. The floors were covered ankle deep in garbage and debris, including several dead mice. The RV's septic system was over-flowing and there was an unbearable stench of feces and urine. The only food in the RV was some crackers and beer. Mr. Williams' clothing was dirty, with what appeared to be urine stains on the front of his pants and multiple unidentifiable food particles and stains on his dingy white tee shirt. He emitted an overpowering body odor and had grim in the folds of his neck. His lack of hygiene demonstrated he was not bathing, or washing himself or his clothing. He could not remember what, if any, income he received and could not articulate a plan for obtaining money and food. He simply stated he would eat when he got to Arizona tomorrow. He could not remember what, if any, family he had or what the address was for his final destination in Arizona.

The client was pleasant, and willingly agreed to have his toe examined. The PG Investigator and APS worker arranged for the client to be admitted to a local acute care hospital, where the client stayed for the following two months due to a severely infected toe. During which time, the PG obtained a doctor's declaration, filed a Probate Conservatorship petition and obtained temporary of person and estate. The client was subsequently placed in a skilled nursing facility and treated for diabetes, malnutrition, sepsis, and COPD.

The client objected to the Conservatorship so a trial was held.

Questions:

1. *Does the client meet the legal and clinical criteria for conservatorship?*
2. *What may be the outcome of the trial? Why?*
3. *Would a conservatorship be helpful? Why?*

Case 2 – Estella

The Public Guardian received a Probate Conservatorship referral from the local hospital. The client was a 5 foot, 98lb, 42 year old single Mexican woman, the mother of a 10 year old daughter in her sister's custody and a history of prostitution. She was long-term homeless, and due to alcohol and drug use and possibly beatings, she was diagnosed with Korsakov's' syndrome, which presents with no short - term memory. She presented with a memory of less than one minute.

The client was ambulatory, continent of bladder and bowl and able to feed herself, but needed prompting or assistance for all self care and mealtimes. The client was unable to provide for herself or survive as homeless any longer. The client's sister, the only family in the country, could not care for the client; the sister was caring for the client's daughter as well as her own children. The client was unable to understand what conservatorship was and was unable to contest it due to her constant confusion.

Conservatorship sought by the PG and was granted.

The client was in the hospital needing placement. Due to her age and memory loss, locked SNF placement took 5 weeks to find. During the entire process the client's memory did not improve. The client had Medi-Cal. The client spent her days by the facility pay phone checking for change ever few minutes or so.

The client's sister was in the process of adopting the client's daughter, which was completed shortly after the client was placed. At that time the PG discovered that the client was an illegal alien. She received Medi-Cal only because her daughter was American born. After her daughter was adopted by her sister, the Medi-Cal was rescinded.

Questions:

1. *Can the conservatorship continue? Why?*
2. *List potential difficulties with this conservatorship and some possible solutions.*
3. *Is a conservatorship the best solution for client?*

Case 3 Margaret P.

August 2009 Public Guardian receives a referral from a Skilled Nursing Facility on Margaret P. an 87 year old female. The Referral indicates Adult Protective Services is also involved in the case. PG confirms APS involvement at time of referral and includes information in case set up for the assigned investigator.

Referral alleges that Margaret P. was being cared for by her son N.P. in an apartment that the two shared. Margaret initially admitted to an acute hospital that makes the APS referral with allegations of neglect. According to APS, Margaret was transferred to the SNF with stage 4 decubiti and that the son initially refused to allow the facility to debride the wound allegedly due to the cost of that care. He subsequently allows the debridement. Margaret is only 70 lbs on admission but reportedly has gained 5 lbs since admission. Son is allegedly an attorney but may not be currently licensed and he is reportedly difficult to deal with. Additionally, son also allegedly has Power of Attorney for his mother that was signed in February 2009 but APS reports that mother was found incapacitated by a physician in October 2008 at a previous SNF. Furthermore, APS and facility work with law enforcement to obtain a restraining order due to interference with care and to prevent son from taking mom from facility against medical advice. APS requests immediate attention by PG because the EPO will expire within a week. PG notes that investigation and notice requirements to file a temporary conservatorship will make that timeline impossible.

Contact with facility social worker reveals that son is aggressive and uncooperative with her and the treating staff. Son reports he is using mom's monthly income to pay rent, utilities and food for her and that he has no income but is the primary caregiver. Social worker reports there are allegations that son refused entrance of home health care workers into the apartment. Social worker indicates she believes Margaret has fluctuating capacity but the social worker also notes that there is a doctor's order that the client lacks capacity to give consent.

Questions:

1. *Does the client meet the legal and clinical criteria for conservatorship?*
2. *What may be the outcome of the trial? Why?*
3. *Would a conservatorship be helpful? Why?*

SLIDE 81

Activity - Eco-Mapping

- Strong connection _____
- Tenuous Connection - - - - -
- Stressful Connection + + + + + + + + + +
- Interrupted or Broken Connection
 _____ | | _____
- Arrows show the direction of energy →

**ACTIVITY:
Eco-mapping**

Mr. Smith

You are a 77-year-old retired high school administrator. You live alone. You have congestive heart failure and do not always take your medications as directed. You sometimes have trouble walking. You have been told that you lost \$30,000 dollars to Jamaican Lotto scammers but think this is patently ridiculous- you would never be that stupid. The following people/systems have an influence in your life.

SLIDE 82

Eco-Mapping

- *How will you integrate this tool into your practice?*
- *How will it help you in doing a more comprehensive assessment?*

CLOSING, EVALUATIONS & SURVEY



TIME ALLOTTED: 10 minutes

SLIDE 83

Closing & Evaluations

- Questions or comments?

- Please complete:
 - Satisfaction Survey
 - Training Needs Assessment

- Additional training resources can be found at <http://www.baa-aps.org/article.php?id=369>

- Thank you for your participation!

Please note: Evaluation Materials are located in the Evaluation Manual

Thank you for your hard work and making this training day a success!!