

PART

I



Aging Effects on
Decision-Making Capacity

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CHAPTER

1



Aging and Decision-Making Capacity: An Overview

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The following three examples introduce the complexities and challenges of assessing decision-making capacity in older adults.



Case Example: One Katrina Case

As Hurricane Katrina headed for New Orleans, residents were faced with difficult decisions. Should they stay? Should they leave? How should they decide? Michelle had lived in New Orleans her entire life. She had heard her parents tell stories of Hurricane Betsy and Camille. The lessons were simple: If you were on high ground in the city, you could survive a very strong hurricane. But Katrina was different. Forecasters were warning that it might be a category 5 storm when it hit New Orleans. Her parents were urging Michelle to evacuate, but Michelle was hesitating. Finally, her dad called: “It’s time to go. We need to get out now while we can.” Michelle was still not sure: “Our apartment is on high ground near the river. We will be okay.” Her dad, now worried that she would stay behind, finally said what he was most worried about: “You’re pregnant, and you have to be thinking about what the next few days will be like

not only for you but for that baby.” Does Michelle have the capacity to make this life or death decision for herself and her baby?

Case Example: The Day after Thanksgiving

Claire was tired after Thanksgiving dinner; tired and she had a headache. She took a quick nap and felt better. The next day, early in the morning, she awoke with the same headache. She went into the bathroom and sat down. The next thing she knew, she was in a brightly lit room, with a nurse standing by her bed. “Do you know where you are? Do you know what day it is?” “I have no idea where I am,” she thought. “November something?” she answered. “It’s February 6,” the nurse answered. And that was the first sign Claire had that things had changed.

Over the next several months, she slowly put together the pieces of the puzzle that was now her life. Her dog had alerted her husband, Charles, when Claire collapsed. Charles called 911 and the rescue squad stabilized Claire and got her to the local hospital. The doctors there correctly diagnosed a brain aneurysm and transferred her to another hospital, with neurosurgery facilities. After surgery to repair the aneurysm, she was in a coma for almost 3 weeks. Then she slowly regained consciousness, but had little sense of where she was, little sense of herself, and only small islands of memory, but no way to connect the dots. By late spring, she was aware of how much her life had changed: She could barely walk now, could not drive, had periodic unpredictable mood swings, and was facing daily home health aide visits when she was released from the hospital. She would never be able to work again. She was depressed and angry: “They should have let me die!” she shouted. The doctors wanted to perform one more surgery, to insert a shunt to allow them to relieve pressure on her brain. Claire was adamant: “No more surgery.” Does Claire have the capacity to make this decision?



Case Example: Hospice Request

David had been diagnosed with melanoma 2 years ago. At first, it looked like the surgery had been successful. But then the cancer reemerged and the news was sobering: stage 4. His doctor was direct and deliberate: “You have at most a year to live. You should put your affairs in order.”

The doctor had been an optimist. Now 9 months later David was receiving hospice care at home. He knew that the end was near. As a religious person, he was not afraid of death. In fact, his religious devotion gave him a great deal of comfort. But he was worried about those whom he would leave behind, in particular Jane. David had been part of Jane’s life for 19 years, ever since he married Jane’s mother, Barbara. Although David and Barbara were now divorced, David had been a fatherly presence for Jane, a consistent source of support and encouragement. David had two biological children—Jane’s half-brother, Dan, and another daughter, Pat. Pat and David had been estranged for several years; he refused to see her during his time in hospice.

During the week before his death, David called his lawyer. “I need your help. I want to adopt Jane, and I want to change my will. I want to write Jane into the will and I want to eliminate Pat from any inheritance.” Does David have the capacity to make this set of decisions?

Each of these cases represents the dilemmas of decision making: How do we assess people’s capacity to make decisions regarding themselves, their medical care, or their property? Does age matter in these deliberations? Our answers lie at the intersection of legal doctrine, behavioral science research, and clinical practice (Ganzini, Volicer, Nelson, & Deese, 2003). In crafting our answers, we try to balance two essential ethical principles: autonomy (or self-determination) and beneficence (protection) (Berg, Appelbaum, Lidz, & Parker, 2001; Moye & Marson, 2006).

Our answers reflect assumptions regarding three interacting elements: the person, the process, and the context (Smyer, 1996). Bronfenbrenner (1989), Lewin (1935, 1951), and Lawton (1998, 2000) remind us that these elements shape behavior and development across the life span. The other chapters in this volume will provide detailed discussions of each of these elements. The purpose of this chapter, however, is to provide a framework for thinking about decision-making capacity, using the person, process, and context as a focus.

THE PERSON

Definitions of decision-making capacity and incapacity have changed over time, developing a “legal fiction” of competency among older adults. Legal fictions are often developed in times of transition within the law (Sabatino, 1996). In the absence of national consensus on the defining elements of decision-making incapacity, there is a natural development of case-by-case and state-by-state legal fictions of capacity and incapacity and of the person.

Anderer (1990) noted that there has been an evolution in states’ definitions of incapacity and, by extension, of decision-making capacity as well. Early on, many states equated advanced age (e.g., age 65) with disability. In essence, reaching an advanced age led to a presumption of possible disability.

This equation of age and disability was supplanted with the expectation that the presence of a disabling condition would have to be shown in order to secure a ruling of incapacity. Over time, however, this standard also changed, as the legal fiction caught up with gerontological research. It was no longer sufficient to carry a diagnosis of a disabling condition. Instead, the focus shifted to the functional impairment that accompanied the disabling condition (Grisso, 2003). In many ways, this development paralleled increased attention to activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in clinical and research practice (e.g., Lawton, 1988).

The most recent developments of state definitions of incapacity have included a necessity for action by the state. This aspect emphasizes the

Table 1.1 District of Columbia Incapacity Tests

Aspect	Statute
Cognitive test	“Incapacitated individual” means an adult whose ability to receive and evaluate information effectively or to communicate decisions is impaired without court assistance or the appointment of a guardian or conservator, . . .
Behavioral test	. . . to such an extent that he or she lacks capacity to manage all or some of his or her financial resources or to meet all or some essential requirements for his or her physical health, safety, habilitation, or therapeutic needs . . .
Necessity test	. . . without court assistance or the appointment of a guardian or conservator.”

Source: DC Code Annotated §21–2011(11) 2005.

conditions under which the state must intervene, the situations in which the duty of beneficence (protection) supersedes the assumption of the individual’s autonomy.

The current best practice of legal fiction regarding incapacity among older adults requires three tests: cognitive, behavioral, and necessity. In Table 1.1, the District of Columbia statute is outlined as an example.

The absence of a national consensus on the legal fiction of capacity and incapacity requires clinicians and researchers to understand the relevant statutes in their own locale. As we see in the next section, states can vary not only on the legal fiction of the person, but also on their underlying assumptions regarding the process of decision making.

THE PROCESS

U.S. case law suggests four core abilities are essential in decision-making capacity: expressing a choice, understanding, appreciation, and reasoning (Appelbaum & Grisso, 1988; Moye & Marson, 2006). Expressing a choice implies the ability to take in information and the ability to convey a preference that is relatively consistent. Understanding implies the ability to comprehend information, including the risks and benefits of various actions. Age-related changes in cognitive functioning (see Foster, Cornwell, Kisley, & Davis, Chapter 2, this volume) and diseases of later

life (see Moye, Karel, Azar, & Gurrera, 2004; Wood & Tanius, Chapter 4, this volume) affect these two abilities.

Jurisdictions will vary in the extent to which they emphasize the last two elements: appreciation and reasoning. Frank and Smyer (1998) suggested that “rationality dependent” standards have been excluded from more recent statutes that emphasize “appreciation dependent” processes. Rationality dependent definitions, as outlined by Roth, Meisel, and Lidz (1977) followed four standards: evidencing a choice; the reasonableness of the choice; the rationality of the reasons for the choice; and actual understanding. Stanley, Guido, Stanley, and Shortell (1984) emphasize rationality of the choice as well as the quality of the reasoning, as evidenced by weighing risks and benefits. Some have argued, however, that rationality and reasonableness are too subjective to be used as criteria for assessing an individual’s decision-making capacity. Moreover, cultural influences may affect significantly the definition of rationality or reasonableness (see Karel, Chapter 7, this volume).

For example, consider one aspect of the California Probate Code:

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. (California Probate Code §813)

In contrast, appreciation-dependent approaches emphasize the person’s ability to appreciate the consequences of her or his actions or decisions. Appelbaum and Grisso’s work (1988) represents this approach. They emphasized assessing the individual’s understanding of information presented, including its relevance for the person and the person’s ability to weigh the consequences of action or inaction.

Again, the California Probate Code offers an example:

A deficit in the mental functions listed above may be 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. (California Probate Code §811)

Marson and his colleagues provide an excellent example of clinically useful research that illustrates both a rational standard and an appreciation of the consequences of actions or decisions, even in the face of cognitive impairment (e.g., Marson, Cody, Ingram, & Harrell, 1995; Marson, Ingram, Cody, & Harrell, 1995). They use a treatment scenario to assess decision making by older adults with mild Alzheimer’s disease (AD), older adults with moderate AD, and older adults in a control group:

Let us suppose that last night you awoke with sharp pains in your chest. You woke up hot and sweaty. You had problems breathing, and you felt dizzy. Today you have seen me, your doctor. I run some tests and I find out that you have two blocked blood vessels in your heart. (Marson, Ingram, et al., 1995)

Marson and his colleagues point out in Table 1.2 that there are several legal standards for the capacity to consent to treatment.

As Figure 1.1 summarizes, the performance of the groups varied by the legal standard applied. Under the most basic standards, evidencing a choice and making a reasonable choice, the majority of all three groups were deemed competent. However, as the cognitive demands of

Table 1.2 Legal Standards for Capacity to Consent

Standard	Capacity
S1	To evidence a treatment choice
S2	To make the reasonable choice (when the alternative is manifestly unreasonable)
S3	To appreciate the consequences of the choice
S4	To provide rational reasons for choice
S5	To understand treatment situation, choices, and respective risks/benefits

Source: “Assessing the Competency of Patients with Alzheimer’s Disease under Different Legal Standards,” by D. C. Marson, K. K. Ingram, H. A. Cody, and L. E. Harrell, 1995, *Archives of Neurology*, 52, pp. 949–954.

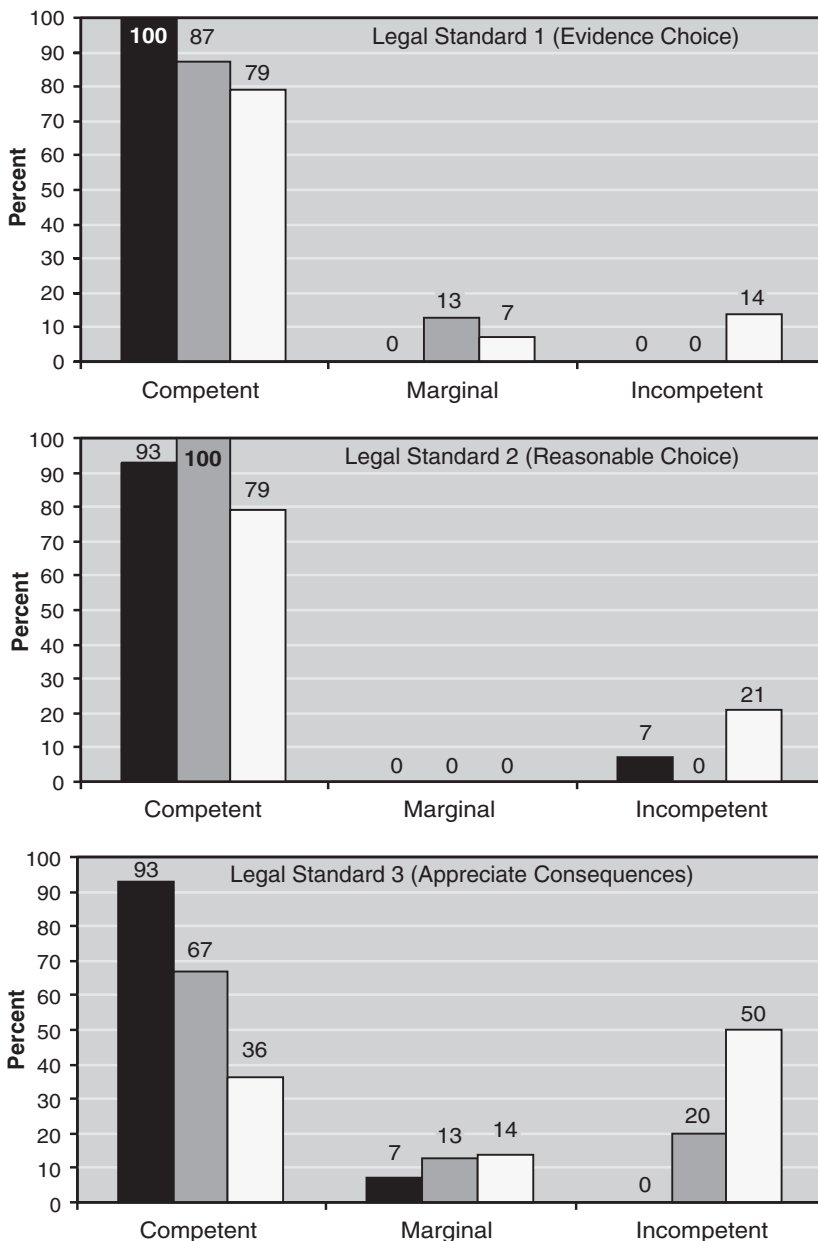


Figure 1.1 Competency Outcomes. Black represents older controls, grey represents patients with mild AD, and white represents patients with moderate AD. From “Assessing the Competency of Patients with Alzheimer’s Disease under Different Legal Standards,” by D. C. Marson, K. K. Ingram, H. A. Cody, & L. E. Harrell, 1995, *Archives of Neurology*, 52, pp. 949–954. Adapted with permission.

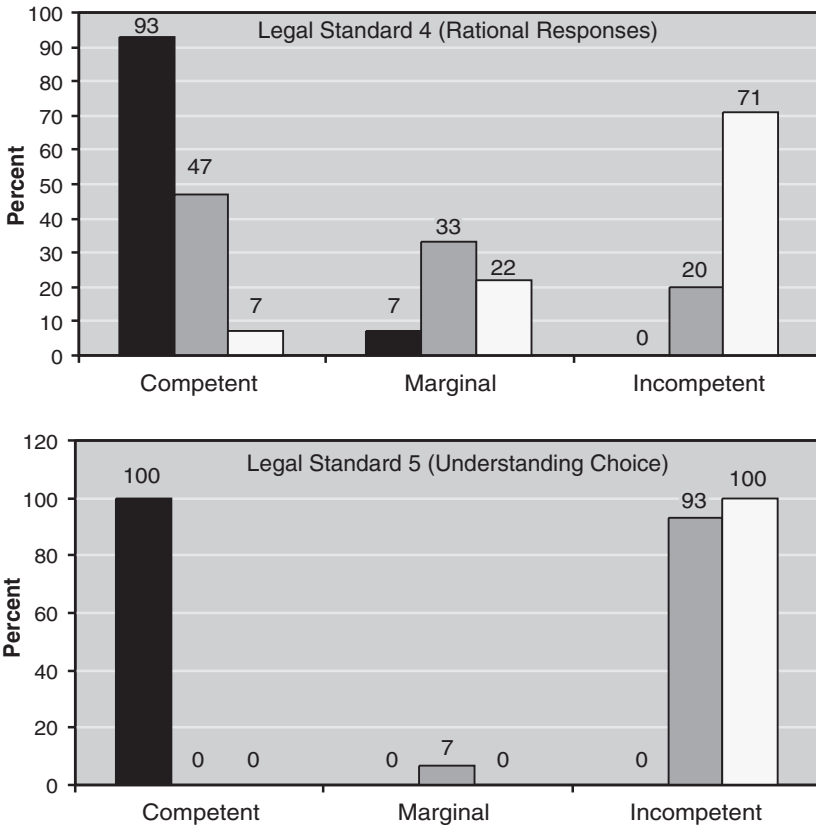


Figure 1.1 (Continued)

the standard increase (e.g., appreciating the consequences, providing rational responses, or understanding the consequences of their choices), larger percentages of those with mild and moderate AD were deemed incompetent.

Marson and his colleagues have also examined the capacity of older adults with mild and moderate AD in financial domains (Marson et al., 2000; see Hebert & Marson, Chapter 11, this volume). Here, too, they outlined several different standards of capacity, ranging from having basic monetary skills (Standard 1) to evidencing financial judgment (Standard 6). In these domains, the majority of patients with moderate AD were deemed incapable on the most basic standard (basic monetary skills), while over half of those with mild AD were deemed capable on

this standard. On the most stringent criterion, however, only 13% of those with mild AD were deemed capable.

Others in this volume (e.g., Moye, Chapter 8, this volume) and elsewhere (e.g., Moye & Marson, 2006) map psychological functioning onto these elements of expressing a choice, understanding, appreciation, and reasoning. For now, however, there is a simple message: You must understand the emphasis—rationality dependent or appreciation dependent—of the jurisdictions you are practicing in. This emphasis will shape your assessment and reporting approaches.

THE CONTEXT

Legal and public policy developments provide a context for the increasing salience of issues of decision-making capacity. In this section, two examples highlight how these issues will become increasingly important: consumer-directed, community-based long-term care; and driving. In both domains, mental health professionals will be called on to balance autonomy and beneficence. In both domains, mental health professionals' practice will be shaped by demographics and by state-level legal and policy emphases. In both domains, state legislatures and executive offices play a key role in defining who has the capacity to be involved in key processes of self-maintenance in later life: planning for their own long-term care and continuing to be a licensed driver. In both domains, states will focus increased attention on functional capacities as the press of an aging population makes long-term care and personal mobility increasingly important issues at the intersection of public policy and personal life.

Consumer-Directed, Community-Based Long-Term Care

Over the past 20 years, legal, policy, and familial concerns have assured the growing reliance on consumer-directed, community-based long-term care. Legally, the 1999 U.S. Supreme Court *Olmstead* decision found that under the Americans with Disabilities Act undue institutionalization qualifies as discrimination when three conditions hold: treatment professionals have determined that community placement is appropriate; the individual does not oppose transfer to a less restrictive

setting; and placement can be “reasonably accommodated” (National Council on Disabilities, 2003).

The National Council on Disabilities (NCD) recently reviewed the federal and state responses to the *Olmstead* decision. On the federal level, there were two major developments. In 2001, the president signed an executive order to provide technical assistance to the states for implementing responses to the decisions. In 2004, there was a commitment to a money-follows-the-person rebalancing demonstration, allowing states to seek home- and community-based waivers for long-term care services. The states have underscored the need to address systemic and fiscal barriers to responding to the *Olmstead* decision. Not surprisingly, NCD (2003) concluded that there is no consistency in approach across the states. There is, however, increasing pressure for states to develop community-based alternatives to institutional care, particularly in the area of mental health and long-term care (Cook & Jonikas, 2002; Dougherty, 2003). The federal government will award \$1.75 billion of money-follows-the-person (MFP) grants over the next 5 years, beginning in January, 2007 (Fox-Grage, Coleman, & Freiman, 2006). This assures that states will be increasingly focused on home- and community-based long-term care options, and older adults’ capacity for being maintained in the community.

The *Olmstead* decision occurred during a period of increased fiscal pressure on state budgets, caused, in part, by the increasing burden of Medicaid. For example, from 1991 to 2001, Medicaid spending grew at an annual rate of 11% nationwide. From 2001 to 2004, the annual growth rate for spending declined to 9% and the 2004 to 2005 growth rate was 6%, reflecting the increasing state and federal pressure on cost containment. Nationally, the Medicaid program spent more than \$305 billion in fiscal year 2005, with approximately 35% spent on long-term care (Kaiser Family Foundation, 2007). The impact on state budgets has been clear: in fiscal year 2003, 21% of state budgets was spent on Medicaid expenditures (American Association for Retired Persons, 2004), adding pressure and increasing calls for cost containment at the state and federal levels. At the same time, policy makers and advocates are increasingly exploring less restrictive and less expensive community-based long-term care alternatives to institutional care. Their explorations

require, however, a clear sense of who has the capacity to direct consumer-directed care in the community.

As Moyer and Marson (2006) note, assessing the capacity for independent living requires straddling a “somewhat fuzzy line” among the family, clinical, and judicial roles in responding to adults’ changing capacities. Family members have an important, direct stake in these issues: estimates suggest that there are more than 44 million caregivers in the United States; 21% of U.S. households include a caregiver. The majority of family caregivers (59%) provide care without calling on paid caregivers. For a sizeable minority (41%), however, paid help shares the challenges of caregiving (National Alliance for Caregiving, 2005).

Fiscal and family concerns have coalesced as states have pursued various options for home- and community-based long-term care, especially in their emphasis on consumer-directed care. Wiener (2006) summarized the key aspects of consumer-directed home care programs: “These programs give consumers control over who provides services, when they are provided, and how these services are delivered” (p. 29).

One example of consumer-directed, community-based long-term care is the Cash and Counseling Demonstration and Evaluation (CCDE) program (Brown et al., 2005). The CCDE program operates under waivers from the Centers for Medicare and Medicaid services and is now under way in a total of 15 states. Under CCDE, the consumer is able to flexibly manage a budget equivalent in value to what an agency would spend on personal care attendants for that individual under the traditional system. The participant can use that budget to hire workers (even relatives) and/or purchase a whole range of goods and services, assistive devices, or home renovations. CCDE also allows consumers to designate representatives, such as relatives or friends, to help make decisions about managing care. The CCDE program offers counseling regarding hiring and managing caregivers and fiscal management services to help consumers/participants handle their program responsibilities. The CCDE program was originally implemented in three states: Arkansas, New Jersey, and Florida. Evaluations of the CCDE implementation found that the program improved the health and well-being of care recipients and their caregivers, while costing no more than traditional services (Dale & Brown, 2005;

Foster, Brown, Phillips, & Carlson, 2005). Recent analyses of the CCDE data have focused on an important issue: Does mental illness affect consumer direction of community-based care? Researchers have found that the CCDE program worked just as well for older clients with mental illness as for those with other health problems but without mental illness (Shen, Smyer, Mahoney, Loughline, & Mahoney, in press).

This experience with CCDE is an important harbinger of issues that will become increasingly important for mental health professionals, older consumers, family caregivers, and policy makers. There are increasing legal, fiscal, and familial pressures to provide community-based, consumer-directed long-term care. Since care recipients typically have a combination of physical and mental health challenges, mental health professionals will be called on to assess the capacity of older adults to participate in care decisions. Much of this volume provides tools to make these assessments.

Assessing Driving Capacity

Our society is a mobile society, placing a premium on driving. Driving is a complex activity that requires both physical and cognitive skills. However, medical conditions, medications, and functional limitations may pose significant challenges for older drivers (Carr, Duchek, Meuser, & Morris, 2006; Cohen, Wells, Kimball, & Owsley, 2003). As a result, many older adults fear a variation on a once-familiar question: “Mom, may I have the car keys?”

By 2030, adults 65 and older will represent 25% of licensed drivers (Insurance Information Institute, 2006). As our driving population ages, policy makers, family members and older adults themselves are appropriately concerned: The rate of risk for an accident for adults over age 75 is nearly equal to the risk for younger drivers, ages 16 to 24 (Hartford Financial Services, 2005a). We are also facing a major challenge balancing autonomy and beneficence.

Knapp and VandeCreek (2005) have outlined the ethical, legal, and practice issues that arise for mental health professionals working with older, impaired drivers. They note that state laws regarding driving vary in several important ways: Requiring vision testing for license renewal; requiring a test of road knowledge; varying these requirements

by ages; requiring health-care providers to alert the state if they have diagnosed a medical condition that will affect driving. Table 1.3 summarizes the significant variation state by state. It is a reminder that mental health professionals must be aware of the jurisdictional requirements that frame their own practice and the driving habits of their older clients.

Knapp and VandeCreek (2005) suggest a three-step model for mental health professionals to follow in working with older adults and their families around driving issues: (1) Be alert to triggers indicating a potential driving problem; (2) consider compensatory strategies; and (3) monitor the older adult's functioning in order to intervene as necessary.

Fortunately, there are informal and formal assessment approaches that can indicate potential driving problems. For example, there are self-assessment instruments that older adults can use to assess whether they should be concerned about their driving (e.g., American Association for Retired Persons, 2007). Similarly, there are checklists for family members to use in observing older drivers for patterns of driving limitations or impairments (e.g., Hartford Financial Services, 2005b). There are also structured interview formats for interviewing older drivers who are coping with cataracts (Owsley, Stalvey, Wells, & Sloane, 1999) or dizziness (Cohen et al., 2003), and these formats may be of broader interest, for use with both older drivers and their family members (comparing and contrasting their perspectives).

In addition to these informal assessments, mental health professionals may want to consider two more formal approaches: a driving simulation test and neuropsychological testing. Driving simulations are a useful proxy for actual road tests with older adults. The American Association for Retired Persons (AARP) now offers an online driving simulation at their web site (for a fee) and the Association for Driver Rehabilitation also has an online directory of member sites that can offer either a driving simulation test or a road test for older drivers (see www.aded.net).

Mental health professionals have been concerned with assessing older adults' driving performance for many years (e.g., Fitten, Perryman, & Wilkinson, 1995; Logsdon, Teri, & Larson, 1992). Recently, Szlyk Myers, Zhang, Wetzal, and Shapiro (2002) assessed the utility of a

Table 1.3 State Drivers License Renewal Laws Including Requirements for Older Drivers

State	Require Retest for Renewals at All Ages (1)			Age at Which States Require Older Drivers to Pass Tests			Require Doctors to Report Medical Conditions (2)	Age Limits on Mail Renewal		
	Vision	Road	Knowledge	Medical	Vision	Road			Knowledge	Medical
Alabama										
Alaska	X	(3)	X					69		
Arizona	X	(3)			65			70		
Arkansas	X									
California	X	(3)	X	(3)			X (4)	70		
Colorado	X	(3)	(3)	X				66		
Connecticut					65			65		
Delaware	(3)	(3)	(3)	(3)	(3)	(3)	X			
D.C.					70	75				
Florida	X	(3)	(3)		80					
Georgia	X			(3)			X			
Hawaii	X	(3)		(3)		(3)				
Idaho	X	(3)		(3)						
Illinois	(5)		X	(3)		75				
Indiana				(3)			(3)			
Iowa		(3)	(3)	(3)						
Kansas	X	(3)	X	(3)						
Kentucky	X	(3)		(3)						
Louisiana	X	(3)	X					70		
Maine					40, 62	(6)				
Maryland	X	(3)	(3)		40		(3)			
Massachusetts										
Michigan	X	(3)	X	(3)						

(continued)

Table 1.3 (Continued)

State	Require Retest for Renewals at All Ages (1)			Age at Which States Require Older Drivers to Pass Tests			Require Doctors to Report Medical Conditions (2)	Age Limits on Mail Renewal		
	Vision	Road	Knowledge	Medical	Vision	Road			Knowledge	Medical
Minnesota	X		X							
Mississippi		(3)	(3)							
Missouri	X									
Montana	X	(3)								
Nebraska	X	(3)	(3)							
Nevada	X (7)	(3)	(3)	65			70 (8)	X		
New Hampshire	X				75					
New Jersey	(9)							X		
New Mexico										
New York		(3)	(3)							
North Carolina	X	(3)	X	(3)						
North Dakota	X	(3)	(3)							
Ohio	X	(3)	(3)							
Oklahoma	(9)									
Oregon					50			X		
Pennsylvania	(10)			(8)	45 (11)		45 (11)	X		
Rhode Island	X	(3)		(3)						
South Carolina	X	(3)	(3)		65					
South Dakota	X									
Tennessee	(12)									
Texas	X			(3)						
Utah		(3)	(3)		65			X		

Vermont				
Virginia	X	(3)		80
Washington	(3)	(3)	X	
West Virginia				X
Wisconsin		(3)	(3)	
Wyoming	X	(3)		

- (1) Periodic retests. Some states will waive vision retests for mail renewal or clean-record drivers.
- (2) Physicians must report physical conditions that might impair driving skills.
- (3) Retesting only for cause (e.g., after specific number of accidents or other points and infractions, for specific physical conditions) sometimes at examiner's discretion.
- (4) Specifically requires doctors to report a diagnosis of dementia.
- (5) 8-year vision re-examination.
- (6) Vision tests are required at first renewal at age 40; at every second renewal after age 40; at every renewal after age 62.
- (7) Except for in-state renewals by mail, unless applicant is over 70.
- (8) Renewing by mail.
- (9) 10 percent of all renewals are screened.
- (10) 10 percent of drivers at or over 45 randomly chosen for medical and/or vision test.
- (11) Random re-examination at specified age.
- (12) Will retest at renewal for nonspecified cause.

Source: "Older Drivers," by Insurance Information Institute, October 2006. Retrieved January 15, 2007, from <http://www.iii.org/media/hotttopics/insurance/olderdrivers>.

battery of neuropsychological tests in predicting older adults' driving performance. Their work involved two steps: (1) they surveyed neuropsychologists to assess what types of measures are currently used in assessing driving capacity; and (2) they assessed a sample of older drivers using the consensus battery of 12 measures, comparing their performance on the neuropsychological measures with their performance on a driving simulation task. The testing results were successful in differentiating older drivers with suspected dementia from unaffected older drivers. The psychological testing results were also correlated with the driving simulation results. In particular Trails A, Trails B, and Logical Memory (immediate) correlated with the largest number of driving measures (see Wood, Chapter 9, this volume, for more detail on neuropsychological testing).

The implications for psychological practice are clear and compelling. In the near future, many older adults and their family members will be asking for help in assessing older drivers' capacity for continued driving. Mental health professionals can draw on both informal and formal assessment approaches to assist in these difficult decisions. As they do so, they must be aware of their state's regulatory and statutory requirements regarding assessing driving risks.

CONCLUSION

This chapter provides a framework for considering the intersection of legal, social, and psychological approaches to assessing older adults' decision-making capacity. Mental health professionals are often called on to help older adults and their family members balance concerns for autonomy, beneficence, and risk. Older adults routinely seek assistance in making health-care decisions, decisions about their property and finances, and, eventually, decisions about their independence and interdependence. Mental health professionals bring to these exchanges an appreciation of the role of inter-individual differences in intra-individual change. Increasingly, our practice will require an ability to communicate our expertise to lawyers, judges, physicians, and family members. Three elements will shape psychological practice in these important areas: the changing

legal fiction of the competent person; the legal and psychological assessment process; and the political, legal, and social context.

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