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ADVISING ELDERLY CLIENTS AND THEIR FAMILIES

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16 Demystifying Neuropsychology in Elder Law Practice

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I. [16.1] INTRODUCTION

Attorneys and other professionals who routinely advise elderly clients and their families frequently must deal with questions of their clients' mental competence. Although primarily written for elder law and guardianship practitioners, this chapter will be useful to attorneys in other practice areas that involve neuropsychological testing or mental health. It is important to remember that the majority of older Americans retain competence to make personal and healthcare decisions. Presuming that old age equates to a lack of mental competence is a mistake. At a minimum, this error results in dismissing the concerns that our clients report. At most, this belief can result in the curtailment of our clients' rights. The other side of this coin is that age, medications, complex health conditions, and aging can indeed cause cognitive decline.

The reality is that we all will develop dementia — if we live long enough. This chapter is designed to provide the practitioner with useful information on navigating the legal aspects of human mental decline with the sensitivity and prudence we would appreciate when we reach this stage of life. This chapter also intends to help the practitioner understand how neuropsychological testing is useful to practitioners working with these vulnerable populations.

Even the best attorneys can leave themselves open to serious ethics and malpractice concerns if they do not consider their clients' mental competence. This includes determining whether a client can make complex decisions and whether a party to litigation should have a guardian. Regarding the ability to sign a contract or revoke a trust, practitioners must ensure their clients retain sufficient mental competence to do so. Likewise, in litigation practices, proper examination of expert witnesses requires the attorney to have a sufficient knowledge base about the field at issue to proceed competently.

This is not to say that a medical malpractice attorney must have an education in medicine or that a guardianship attorney must have a background in social work. However, the attorney should seek credible experts with the knowledge and experience to evaluate the client or prepare the practitioner to depose the opposing counsel's witness. There is obvious value in obtaining an expert evaluation when one's client's abilities are in question. It is equally important for practitioners to obtain expert consultation to help the attorney understand the adequacy of other experts' evaluations, propose meaningful questions, and identify issues the attorney may not have recognized. When cross-examining an adverse expert, preparation is key. Obtaining early consultation with an expert can greatly increase the effectiveness of cross-examination, as the attorney can go into the proceeding already aware of the issues, medical terms, and potential weaknesses of the expert to be examined.

Neuropsychological testing has been utilized more and more frequently when courts encounter complex questions relating to mental or "legal" capacity or decision-making. A 2016 article by neuropsychologist Paul M. Kaufmann explains that many clinical neuropsychologists devote far more time to forensic evaluations than previously: "Recent surveys show weekly hours devoted to forensic consultation increased 97% in the past decade." Paul M. Kaufmann, *Neuropsychologist Experts and Civil Capacity Evaluations: Representative Cases,* 31 Archives of Clinical Neuropsychology 487 (Sept. 2016).

This increased use of neuropsychological testing is largely related to the neuropsychologist's ability to assist the trier of fact in understanding an individual's specific thinking weaknesses and what abilities he or she still retains. This chapter aims to help attorneys in Illinois understand the value of using the best evidence available to determine mental competence. In short, this chapter will help practitioners:

a. recognize when a client may suffer from diminished competence;

b. understand legal standards surrounding mental competence;

c. understand the roles of different medical professionals;

d. recognize when to obtain an additional evaluation of a client;

e. understand how neuropsychological testing provides objective data;

f. understand how neuropsychological testing can be used in legal proceedings; and

g. identify ethical landmines when dealing with older clients and litigants with limited cognitive abilities.

This chapter introduces the reader to the broad nexus between law and neuropsychology and how the two frequently intersect in practice. Each section focuses on a narrow issue or set of issues related to any law practice that routinely deals with older adults or individuals suffering from cognitive limitations.

II. [16.2] PUTTING CAPACITY AND COMPETENCE IN CONTEXT

The terms "capacity" and "competence" are often used interchangeably in law practice but are distinct concepts.

Capacity is a psychological or medical construct that is relevant to legal practitioners but differs somewhat from the legal construct of competence. An individual's level of capacity may vary depending on the complexity of the activity in question and can fluctuate with time. One can have capacity at 9:00 a.m. but lack the same capacity at 9:00 p.m. Said another way, capacity is seen as existing on a continuum, something that can be an imperfect fit with Illinois' "all or none" approach to competency. Another reason neuropsychologists and other medical professionals utilize the term "capacity" is that determining competence is ultimately the responsibility of the finder of fact.

Competence, on the other hand, is a legal term of art. It is used in legal proceedings much the way terms such as "negligence," "burden," and "relevance" are used. For instance, to a layperson, something may be "relevant" to a case, but a court may define relevance very specifically in a particular context. In the same way, competence is a finding; it is something a court determines upon hearing evidence. The elements or tests of mental capacity that courts will require people to meet to show they are legally "competent" to perform a specific act will vary with the issue in dispute.

The patchwork of varying tests and judicial rulings have created a situation in which the unique attributes of a given individual must be evaluated carefully. Clearly, none of these determinations are particularly straightforward, as is reflected in the ambiguity of terms such as "moral implications" (see §16.7 below) or "free will" (see §16.8 below). Neuropsychologists can be retained in the legal disputes discussed in §§16.3 – 16.8 below to gain helpful insights and develop probative evidence for a court to use when determining competence.

Attorneys who regularly work with elderly clients are often the first to discover capacity issues. Although some attorneys may have developed unique expertise over years of practice and may even hold advanced degrees in health-related fields, most attorneys are not healthcare professionals. Often attorneys feel uncomfortable with being forced into a role in which they must perform some level of evaluation of their clients' competence. This discomfort is understandable; however, attorneys should remember that they are some of the best assessors of these areas. Because attorneys working regularly with individuals who may have diminished capacity have similar conversations over and over, they are uniquely suited to noticing when these conversations suggest challenges with thinking. Attorneys must still rely on clinicians for formal diagnosis related to competency, but in both transactional and litigation practices, attorneys are advised not to undervalue their skill at recognizing red flags.

The interface between any form of technical expertise and the needs of the courts is often tenuous. Further, with all the testing tools available to neuropsychologists, it is often difficult for attorneys and judges to deconstruct the terminology and implications of these reports to determine the key legal issues. Attorneys often skim reports, looking for keywords indicating whether an individual is competent to make financial or healthcare decisions. Further complicating this process is the fact that a clinical neuropsychological evaluation (one that is intended solely to clarify a diagnosis, for instance) only comments on issues of capacity if that neuropsychologist is aware this question has been raised. Most clinicians may be willing to opine on capacity only if they are specifically trained in doing so and choose to administer tests that are sufficient to support their conclusions. Attorneys continue to develop an understanding of the usefulness of a comprehensive neuropsychological evaluation as a means for objectively verifying mental capacity. Similarly, neuropsychologists continue to better recognize how to communicate their findings to the legal profession. Ultimately, attorneys and courts alike should strive to find the best evidence available. When it comes to mental capacity, neuropsychological testing is broadly considered the gold standard for the assessment of cognitive functioning. However, the expense of a comprehensive neuropsychological evaluation limits its usefulness to higher-stakes evaluations.

A. [16.3] Executing a Will

Illinois law generally requires a testator to be of sound mind and memory and have "sufficient mental capacity to know and remember who were the natural objects of his bounty, to comprehend the kind and character of his property, and to make disposition of his property according to some plan formed in his mind." *DeHart v. DeHart,* 2012 IL App (3d) 090773, ¶16, 978 N.E.2d 12, 365 Ill.Dec. 204.

B. [16.4] Signing a Contract or Executing a Deed

Illinois courts have long held people to a slightly higher standard for signing contracts, getting married, or executing deeds than that discussed in §16.3 above for executing a will. The question is generally whether "at the time of making the deed" the person "[knew] and comprehend[ed] the transaction in which he [was] engaged." *Francis v. Wilkinson,* 147 Ill. 370, 35 N.E. 150, 152 (1893). "[I]n other words, the mental capacity to be considered is that which exists at the time of the execution of the deed." *Id.* Someone is competent to execute these documents if "he is capable of transacting ordinary business, and acting rationally in the ordinary affairs of life. Buying and selling property, settling accounts, collecting and paying out money, or borrowing or loaning money, have been mentioned as instances of what is meant by the transaction of the ordinary affairs of business." 35 N.E. at 151.

C. [16.5] Serving as a Party to Litigation

Under 735 ILCS 5/2-619(a)(2), a dismissal can be brought if "the plaintiff does not have legal capacity to sue or . . . the defendant does not have legal capacity to be sued." Trial courts often make these decisions based on scant evidence when a plaintiff or defendant may have cognitive decline. A savvy attorney sometimes can move to force the other side to appoint a guardian or require that an agent under a valid power of attorney be substituted as the proper party.

D. [16.6] Tolling Statutes of Limitations

Pursuant to 735 ILCS 5/13-211, statutes of limitations are tolled when the party bringing the action is under a legal disability. See generally §6.55 of CIVIL PRACTICE: OPENING THE CASE (IICLE®, 2023). The issue of whether a litigant possesses the necessary capacity to act is a question of fact. In many cases, trial courts will hold a separate evidentiary hearing on this issue before trial on the merits of the case.

E. [16.7] Intimate Relationships

As older adults continue to be vital and sexually active even in their later years, the law has been forced to deal with situations in which elderly nursing home residents engage in intimate relationships, even after showing signs of cognitive decline. This challenging issue has led to some states creating criminal statutes relating to sexual consent capacity. Presently, there are several tests that states use to determine whether nursing homes can prohibit sexual conduct and whether to prosecute sexual assault charges. In Illinois, courts require that both parties to sexual acts have an understanding of the nature of the sexual act, as well as the moral implications of the act. See Stephanie L. Tang, *When "Yes" Might Mean "No": Standardizing State Criteria To Evaluate the Capacity To Consent to Sexual Activity for Elderly with Neurocognitive Disorders,* 22 Elder L.J. 449, 469 (2015). Overall, this area of the law is developing rapidly, and there are marked inconsistencies in how facilities and caregivers arrive at such decisions regarding intimacy and physical relationships between adults with cognitive limitations.

Significant problems exist, however, with the practical implementation of these protections in long-term care facilities and the like. Fundamentally, if clinical staff determine that a resident of

their facility is incapable of consenting to sexual contact but the resident has not been deemed incapable by a court of law, what basis do direct care staff have to prevent such contact? Multiple parties would reasonably object if long-term care facilities made decisions about their residents' ability to manage their finances, even when it was clear that capacity did not exist. Individuals with marginal capacity to consent to sexual contact are disproportionately unlikely to successfully bring a cause of action to prevent their facility from prohibiting these activities.

A second practical issue relates to the definition of sexual activity. Where is the line between affection and intimacy versus formal sexual contact? One major tool facilities have for the prevention of nonconsensual sex is disallowing one individual from going into another's room. However, it can be argued that the level of staffing needed to monitor this effectively is greater than the federally mandated minimum staffing levels. Many of us may remember, when younger, how we successfully circumvented our parents' oversight with similar intentions in mind.

F. [16.8] Criminal Consent Statutes

Illinois criminal courts have articulated a totality-of-the-circumstances test:

> [W]**e believe that the courts should broaden their inquiry in cases involving the inability to give knowing consent to more than just focusing on the IQ or mental ability of the alleged victim. All of the circumstances, including those facts that demonstrate control and its misuse by defendant over the exercise of complainant's free will, are germane to the issue of whether a particular complainant gave knowing consent.** *People v. Whitten,* 269 Ill.App.3d 1037, 647 N.E.2d 1062, 1067, 207 Ill.Dec. 569 (5th Dist. 1995).

G. [16.9] Firearm Owners Identification Cards

To legally possess firearms or ammunition, Illinois residents must have a Firearm Owners Identification (FOID) card, which is issued by the Illinois State Police (ISP) to any qualified applicant. Under the Firearm Owners Identification Card Act (FOID Act), 430 ILCS 65/1, *et seq.,* a qualified applicant

1. has not been adjudicated with a mental disability;

2. has not been a patient in a mental institution or any part of a medical facility for the treatment of mental illness within the past five years;

3. has not been involuntarily admitted into a mental health facility; and

4. is not intellectually disabled or developmentally disabled, among other exclusions. See 430 ILCS 65/4.

As such, competency related to firearms comes up in the practice of elder law in various ways. The most common application in the elder law arena is in guardianship proceedings when a court adjudges a respondent to be a person with a disability. Upon adjudication, the court must direct the

clerk of the circuit court to notify the ISP's FOID office and forward the order within seven days after entry. 755 ILCS 5/11a-24. The ISP shall notify the National Instant Criminal Background Check System. *Id.* The ISP has authority to revoke and seize the ward's FOID card. See 430 ILCS 65/8.

Elder law practitioners may also encounter issues with FOID related to individuals receiving or having received mental health treatment and involuntary commitments. A person who (1) has been a patient in a mental health facility or (2) has had his or her FOID card revoked or denied because he or she was a patient in a mental health facility is not permitted to obtain a FOID card (even after the five years has elapsed, in the case of a denial or revocation) unless he or she receives (1) a mental health evaluation by a physician, clinical psychologist, or qualified examiner as defined under the Mental Health and Developmental Disabilities Code, 405 ILCS 5/1-100, *et seq.,* and (2) a certification that he or she is not a clear and present danger to himself or herself or others. 430 ILCS 65/8(u).

The Illinois Department of Human Services (DHS) is authorized under the FOID Act to have a FOID Mental Health Reporting System. See DHS, *Illinois Firearm Owners Identification (FOID) Mental Health Reporting System,* www.dhs.state.il.us/page.aspx?item=37393. The reporting system provides a website where qualified examiners and mental health facilities report an individual receiving or having received mental health treatment who is determined to be a clear and present danger or a person with a developmental or intellectual disability. DHS is tasked with reviewing and checking the data against the ISP's FOID files for matches.

Psychologists and neuropsychologists can assist with completing the Mental Health Certification for Firearm Possession form, should the respondent seek to appeal the revocation or denial of his or her application. The form is available on the ISP's website at https://isp.illinois.gov/typesofappeals/mhadmission#:~:text=to%20restore%20your%20firearms%20rights,not%20a%20clear%20and%20present. Specifically, this certification would be necessary if the disqualifying factor(s) involves an intellectual disability, a developmental disability, and mental health treatment including an analysis of posing a clear and present danger. Specifically, "clear and present danger" questions surround the risk of future violence or suicide. While a comprehensive review of violence risk assessment in the context of firearms ownership is beyond the scope of this section, the following will be provided as a brief introduction. Readers interested in learning more about psychometrically validated risk assessment methods are referred to J. Reid Meloy et al., Ch. 1, *Threat Assessment and Threat Management,* INTERNATIONAL HANDBOOK OF THREAT ASSESSMENT (2d ed. 2021), and Gianni Pirelli and Sarah DeMarco, FIREARMS AND CLINICAL PRACTICE: A HANDBOOK FOR MEDICAL AND MENTAL HEALTH PROFESSIONALS (2023).

Illinois' statute provides for an appeal process under 430 ILCS 65/10, but it does not specify particular tests that must be administered to complete a Mental Health Certification for Firearm Possession form. Because Illinois permits a physician, clinical psychologist, or qualified examiner to complete this certification, requiring specific tests would prohibit many qualified examiners (who are less likely to have training in psychometric test administration) from completing this certification. In short, a clinical interview and records review may be sufficient in many instances to complete the certification. However, more detailed assessments may be necessary in higher-risk or more complex situations.

Psychologists may base their opinions, in part, on formal "risk assessment" tools to support their basis set forth on the certification. Risk assessment tools fall into two categories, depending on the methodology upon which they are based. The first methodology is referred to as an "actuarial" approach, and the second is referred to as "structured professional judgment" (SPJ).

The actuarial approach utilizes statistical models and algorithms to calculate the examinee's future probability of violent behavior. These calculations are based on how closely the examinee's historical and demographic characteristics match those of a normative sample of individuals who became violent and those who did not. Actuarial approaches result in statements of the probability of future violence that are grounded in the same methods life insurance companies utilize to calculate the probability their insured may die in coming years.

By contrast, the SPJ approach allows the examiner to weigh the relative contribution of a more diverse set of factors relating to future violence. SPJ tools consist of a set of guidelines or complex "checklists" for what the examiner should consider when assessing risk. These tools allow the examiner to weigh the importance of various factors for that particular examinee. These SPJ tools also allow the incorporation of the empirical findings from the actuarial tools discussed above.

In essence, actuarial methods prioritize statistical prediction based on normative data, and SPJ methods emphasize the integration of empirical data with clinical judgment to assess risk on a more individualized basis. For example, consider a scenario with an examinee with multiple serious risk factors for future violence. Specifically, this fictional examinee has a history of committing violent acts at an early age, has been convicted of kidnapping and domestic violence, and violated the conditions of his or her conditional release from prison ten years ago. However, this individual also had an automobile accident three years ago, rendering him or her paralyzed from the neck down. A purely actuarial approach to risk assessment may result in a very precise-sounding statement that this individual has a 46-percent probability of violence within the next five years. Conversely, an SPJ model will consider similar factors but may result in an opinion that the examinee poses a low risk of future violence because of his or her lack of mobility — something actuarial models do not take into account very well.

H. [16.10] Diagnosis of Developmental Disabilities

The intricate relationship between autism (also referred to as "autism spectrum disorder" (ASD)) and intellectual disability (ID), coupled with the myriad of underlying causes, accentuates the vital role of neuropsychology in understanding, diagnosing, and managing these conditions. Standardized tests of intellectual functioning serve as essential tools for identifying and quantifying intellectual deficits. The nuanced understanding of intellectual functioning, particularly in the context of developmental disabilities, aids in diagnostic confirmation, more targeted interventions, and more appropriate supports. Elder law attorneys must recognize the significance of these psychological assessments and the underlying complexity of developmental disabilities, including ASD and ID, to ensure informed advocacy and appropriate legal protection for affected individuals.

1. [16.11] Standardized Tests of Intellectual Functioning

Standardized tests of intellectual functioning are integral to the diagnosis of intellectual disability in accordance with the American Psychiatric Association's DIAGNOSTIC AND

STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, TEXT REVISION (DSM-5-TR) (5th ed. 2023). Specifically, Criterion A necessitates the identification of significant limitations in intellectual functioning, often represented as an "IQ score" of approximately 70 or below. These tests, designed by psychologists and mental health professionals, provide a uniform and empirical method to gauge intellectual capacity, allowing for a systematic and unbiased evaluation. See also §16.68 below.

2. [16.12] Intellectual Deficits in Autism Spectrum Disorder and Other Developmental Disabilities

Intellectual deficits are not unique to intellectual disability but are often present in autism spectrum disorder and other developmental disabilities. Although individuals with ASD may present intellectual deficits, it is not a required criterion for diagnosis. The nuanced relationship between intellectual functioning and developmental disabilities demands thorough assessment, as the presence of intellectual deficits may exacerbate challenges in social interaction, communication, and adaptive functioning. Psychologists play a critical role in differentiating intellectual deficits from the specific behavioral characteristics of ASD, tailoring interventions, and assisting in long-term planning. See also §16.25 below.

3. [16.13] Diagnostic Overlap Between Autism Spectrum Disorder and Intellectual Disability

The diagnostic overlap between autism spectrum disorder and intellectual disability can be complex and multifaceted. Individuals may be diagnosed with both conditions, reflecting a confluence of intellectual deficits and impairments in social interaction and communication that are central to ASD. The overlap may lead to challenges in distinguishing between the two conditions and, consequently, in determining appropriate treatments and supports. Moreover, intellectual functioning may vary widely within ASD, with some individuals displaying above-average intelligence and others meeting the criteria for ID. This overlap emphasizes the necessity for comprehensive assessment by specialized mental health professionals, capable of discerning the intricate interplay between the two conditions.

4. [16.14] Medical Disorders That Cause Developmental Disabilities

Autism spectrum disorder and intellectual disability can result from a myriad of underlying biological causes and medical disorders. Genetic factors, such as fragile X syndrome or Down syndrome, may lead to ID, while disorders like Rett syndrome have been associated with ASD. Environmental factors, including prenatal exposure to certain infections or toxins, may also contribute to the development of these conditions. Furthermore, metabolic disorders, traumatic brain injuries, and certain infections during infancy can lead to ID. Other events occurring at the time of or shortly after birth can also lead to symptoms that either meet the criteria for ASD and ID or mimic them. Epilepsy is also much more common among both disorders. The complex interplay of genetic, environmental, and medical factors necessitates interdisciplinary collaboration for accurate diagnosis and effective intervention.

Certain diagnoses are required to be reported to the Illinois Department of Human Services' Firearm Owners Identification Mental Health Reporting System (see www.dhs.state.il.us/page.aspx?item=37393), *e.g.,* determinations of developmental disability (*e.g.,* ASD, brain injury, cerebral palsy, and fetal alcohol syndrome) and ID (*e.g.,* formal diagnosis of ID, Down syndrome, and other genetics-related intellectual disabilities). Practitioners may be surprised to know that mental illness diagnoses (*e.g.,* schizophrenia, dementia, bipolar disorder, or a substance abuse disorder) would not be required to be reported unless the individual was adjudicated mentally incompetent, found to be a clear and present danger, or has a history of psychiatric treatment in a mental health facility.

5. [16.15] Collaborative Solutions

Guardianship should be the last resort, and appointment of a guardian should be ordered only to promote the well-being of the person with a disability, to protect the person from neglect, exploitation, or abuse, and to encourage the development of the person's maximum self-reliance and independence. "Guardianship shall be ordered only to the extent necessitated by the individual's actual mental, physical and adaptive limitations." 755 ILCS 5/11a-3(b). If possible, a limited guardianship should always be considered.

Given the recent media/celebrity cases regarding guardianship, there has been a strong societal and political push for less restrictive options to guardianship. Effective February 27, 2022, the Supportive Decision-Making Agreement Act, 755 ILCS 9/1, *et seq.,* creates less restrictive alternatives to guardianship for adults with intellectual and developmental disabilities. Under the Act, an adult with an intellectual or developmental disability (known as the "principal") can set forth an agreement naming a "supporter" who can assist in decision-making for him or her. 755 ILCS 9/10. The goal is to allow persons with intellectual and developmental disabilities more control and the support needed to navigate life. Through the support and assistance of others, they can make decisions for themselves. The Act sets forth a sample agreement to utilize as well. See 755 ILCS 9/50. While this new paradigm is gaining traction, how it operates in practice leaves questions about whether it is meeting the goal of promoting personal autonomy.

In the context of collaborative decision-making, neuropsychological evaluations provide useful information to assist in determining the most appropriate (and least restrictive) environment to foster independence. Further, determinations of level of care will necessarily involve the consideration of many different factors. However, objective assessment of intellectual functioning (see §16.68 below) and the ability to function independently within the community (see §16.39 below) are central to making these determinations accurately. In short, this objective data allows psychologists and neuropsychologists to provide greater detail about what would benefit their examinee. Going beyond only offering value to the finder of fact, these comprehensive evaluations also assist caregivers and supporters to know

a. what level of care the individual needs;

b. next steps to expand the individual's independent function;

c. decisions the individual can make independently;

d. decisions the individual can make with assistance; and

e. decisions the individual may be unable to make collaboratively.

We all can agree that an approach to decision-making that strikes a balance between honoring an individual's preferences and ensuring good decisions are made is a worthy endeavor. We should also acknowledge that striking that balance is a much more difficult task for a supporter to achieve than for a guardian who can make decisions unilaterally. For this reason, ensuring that supporters have adequate guidance about the needs and capabilities of their principal becomes that much more important as our society moves toward this model of decision-making. Significant materials on supported decision making can be found on the American Bar Association's website at www.americanbar.org/groups/law_aging/resources/guardianship_law_practice/supported-decision-making.

III. [16.16] OVERVIEW OF HEALTH PROFESSIONS

The public often confuses the various health professionals involved in their care. The clearest example of this involves psychiatrists versus psychologists or neuropsychologists versus neurologists. Attorneys who encounter mental capacity issues will benefit from understanding the qualifications and roles of the various health professionals they will encounter. While there are a wide variety of professions whose opinions are relevant to questions of competence, §§16.17 – 16.23 below discuss those most frequently encountered by legal practitioners.

A. [16.17] Physicians

Primary care physicians and geriatricians (geriatric physicians) are medical doctors (*i.e.,* clinicians with M.D. or D.O. degrees). These professionals serve as the initial point of contact for their patient's medical needs. These clinicians commonly engage in the following:

1. managing routine health needs;

2. treating common medical concerns that emerge throughout the lifespan;

3. providing referrals to specialists for complex medical problems (*e.g.,* diagnosing dementia, performing orthopedic surgery, etc.; see §16.18 below);

4. coordinating services with other entities (*e.g.,* hospitals, physical therapy clinics, home health, etc.); and

5. collaborating with specialist referral sources.

B. [16.18] Specialist Physicians

Medical specialists are clinicians with M.D. or D.O. degrees and undergo specific and focused residencies to become highly trained to treat a narrow range of illnesses and conditions. In the context of mental health and cognitive assessment, the following are the most frequent players:

1. Psychiatrists are physicians who specialize in treating emotional disorders such as depression, anxiety, schizophrenia, etc. Few psychiatrists perform objective evaluations or provide counseling. Most are focused on the pharmacologic treatment (*i.e.,* medications) of emotional disorders.

2. Neurologists are physicians who diagnose and treat disorders such as dementia, Parkinson's Disease, stroke, etc. Neurologists rely more on objective data, including neuroimaging (see §16.71 below). Most neurologists focus on treating brain-based disorders rather than performing evaluations assessing an individual's day-to-day abilities.

C. [16.19] Advanced Practice Providers

In today's rapidly changing healthcare marketplace, medical groups, practices, and hospitals rely heavily on providers who are not physicians but meet certain standards for acting as primary care providers and specialists. Pursuant to Illinois certification requirements, some of these practitioners are required to enter into a collaboration agreement with a licensed physician. Specifically, physician assistants (PAs) are advanced practitioners who collaborate directly with physicians. They hold advanced degrees, generally a master's-level graduate degree. These providers prescribe medications, make referrals, and generally provide primary care in much the same way physicians do.

On the other hand, nurse practitioners (NPs) hold graduate degrees in nursing and are not required to enter into a collaboration agreement with a physician. They may have designations such as MSN (Master of Science in Nursing), APRN (Advanced Practice Registered Nurse), FNP (Family Nurse Practitioner), or DNP (Doctor of Nursing Practice). Some advanced NPs may specialize in wound care, obstetrics, or anesthesiology. Like PAs, these providers may prescribe medications, perform certain medical procedures, order labs and radiology exams, and make referrals, much like physicians do.

D. [16.20] Counselors and Clinical Social Workers

Mental health clinicians come in many varieties. In Illinois, mental health counselors may hold various diplomas and licensure designations, such as MA, MSW, LSW, LPC, LCPC, or LCSW. These clinicians, sometimes referred to collectively as therapists, are generally involved in counseling (*i.e.,* talk therapy) in some manner. In medical settings, they also coordinate various patient needs and engage in the complex process of discharge planning.

E. [16.21] Clinical Psychologists

A psychologist is a doctoral-level clinician (Psy.D., Ph.D., or sometimes Ed.D.) trained in counseling (*i.e.,* talk therapy) and diagnostic testing related to psychological disorders. In the context of the elderly population, licensed clinical psychologists commonly provide psychotherapy and diagnostic testing related to the emotional functioning of their patients.

F. [16.22] Clinical Neuropsychologists

Neuropsychologists are doctoral-level psychologists (Psy.D., Ph.D., or sometimes Ed.D.) who have undergone extensive training in brain diseases' physiological and behavioral underpinnings. One source defines neuropsychology as "an applied science concerned with the behavioral expression of brain dysfunction." Muriel Deutsch Lezak et al., NEUROPSYCHOLOGICAL ASSESSMENT, p. 3 (5th ed. 2012). In essence, neuropsychology is applying the scientific method to the measurement and description of human thinking abilities. It also should be noted that neuropsychologists' diagnostic skills are useful when diagnosing psychological (*i.e.,* emotional or feelings) disorders as well.

G. [16.23] How Health Professionals Work Together

None of the disciplines mentioned in §§16.17 – 16.22 above should be construed as superior or inferior to any other, as they all work in concert to manage the unique needs of each individual patient. Different clinical situations and different legal questions require the strengths of different experts. As an example, in the case of a patient who has suffered a stroke (*i.e.,* when a blood vessel in the brain becomes clogged or bursts), a primary care physician may coordinate care between the following specialists:

1. a neurologist monitoring recovery and using brain imaging to track the progression of underlying causes of the stroke;

2. a cardiologist managing blood pressure to reduce the likelihood of a second stroke;

3. a psychiatrist treating the depression this individual experiences following his or her loss of functioning with medications;

4. a psychologist providing talk therapy to help the individual manage the loss of functioning following a stroke or his or her fear of another stroke occurring;

5. a social worker working with the patient's family to understand the changes their loved one has experienced and working to ensure needed services are in place, including obtaining appropriate living supports or social services; and

6. a neuropsychologist involved with assessing the degree and type of cognitive and emotional impairment the individual is experiencing, helping other providers understand the nature of cognitive challenges the individual now suffers from, and developing strategies to compensate for these cognitive limitations.

The above example primarily relates to the clinical (*i.e.,* medical) management of someone who suffers from a cognitive condition that limits his or her functioning. Sections 16.24 – 16.42 below address the intersection of medical determinations with the legal field (*i.e.,* forensic evaluations.)

IV. PHYSICIAN REPORTS

A. [16.24] Adequacy and Limitations of Physician Reports

Illinois guardianship proceedings must be initiated with a report from a licensed physician. Still, because of the brevity of these reports, the specifics of the examinee's actual abilities often need to be supplemented or elaborated on in greater detail by other experts. For instance, Cook County Circuit Court Form CCP 0211A, Report of Physician, https://services.cookcountyclerkofcourt.org/forms/forms/pdf_files/ccp0211.pdf, is merely a two-page report, and it reflects a great deal of subjectivity. Indeed, it can be problematic to meet the burden of proving someone should be determined incompetent as a matter of law solely based on such limited evidence. As such, one of the most common situations in which elder law attorneys call on neuropsychologists is in guardianship proceedings. See also DuPage County Form 3844, Report of Physician, https://18thjudicial.org/18thjudicial/download/3844 (NOTE: The URL immediate commences download of the file.).

Frequently, the physician completing the physician report is the primary care physician. Many physicians who execute these reports have known their patients for years. Treaters who have known their patients for an extended period have unique insights into their patients' current functioning. However, this long-standing relationship may fuel personal biases at times. For instance, the physician may be friends with the patient or his or her primary caregiver, feel sympathetic to one party, or have personal preferences for which family member would make a better guardian. These are natural inclinations and not necessarily motivated by malicious intent, but they can be challenging to separate from that physician's clinical judgment. In other cases, physicians may have limited interactions with their patients and may share a given patient with other providers. Additionally, in the course of a routine office visit, physicians are unable to perform in-depth evaluations of cognitive abilities or decisional capacity. Assessment of cognitive functioning has to compete with general medical management and is not a core focus of primary care.

When general practice physicians agree to write a physician report, they generally evaluate the patient for a few minutes before deciding on the need for a guardian. Due to the limited nature of the physician's examination surrounding competence matters, their conclusions are typically based on educated anecdotes. Even if the physician has treated the patient for years and had thousands of patients with similar symptoms, the nature of the clinician's training means that his or her conclusions are limited to experience and observation and are ultimately a judgment call. Further complicating life for the legal practitioner, these physician reports tend to be brief, rarely reference the reasoning used to make the determination, and are generally based on the expert's impression rather than objective data.

Similarly, psychiatrists often are called on to make decisions regarding the functional capacity of individuals they evaluate. Psychiatrists who regularly work with individuals who have dementia, for instance, often have useful information to provide regarding their mental state and the presence of a psychiatric disability. A psychiatrist's opinion can be useful depending on how grossly impaired the patient is. In more complex cases, the fact that psychiatrists' opinions tend to be based on a relatively brief interview and their clinical insight, as opposed to objective data about the person's measured abilities, limits the value of their determinations. Of note, the above statements primarily relate to clinical psychiatrists. Forensic psychiatry is a separate subfield that works more frequently with such legal questions.

Neurologists likewise work with individuals suffering from a wide variety of cognitive disorders. Neurologists' training is such that they are attuned to various symptoms that impact decisional capacity. Because neurology's primary focus involves the treatment of neurologic disorders (rather than assessing the nature and extent of cognitive disability), neurologists are typically less able to address an individual's day-to-day strengths and weaknesses in the same way neuropsychological testing can. Additionally, neurologists infrequently employ objective measures of daily functioning.

B. [16.25] Who Can Complete a Physician Report?

In recent years, changing the requirements for the physician report was a topic of many proposed bills in the legislature. On July 23, 2021, P.A. 102-109 (eff. Jan. 1, 2022) was signed into law by Governor Pritzker. P.A. 102-109 amended §11a-9 of the Probate Act of 1975, 755 ILCS 5/1-1, *et seq.,* to provide that "in the case of an intellectual disability, a psychological evaluation of the respondent that has been performed by a clinical psychologist licensed under the Clinical Psychologist Licensing Act, [225 ILCS 15/1, *et seq.,*] within one year from the date of filing the petition [for guardianship]" is an appropriate report under the Act. 755 ILCS 5/11a-9(a). This is a helpful change because psychologists have specialized training in assessing intellectual and developmental disability that most physicians do not have. Of note, physicians and other professionals may also opine on this subject and their evaluations may be used as a basis for the physician report.

C. [16.26] Translating Physician Report Criteria to Clinical Terminology

Article 11a of the Probate Act of 1975, 755 ILCS 5/11a-1, *et seq.,* pertains to the adjudication of disability and the appointment of a guardian. It specifies the conditions under which an individual may be deemed disabled due to mental deterioration, physical incapacity, mental illness, or developmental disability. Under 755 ILCS 5/11a-9, a physician report must accompany the petition for appointment of a guardian. Sections §§16.27 – 16.35 below describe, from a medical professional's perspective, how the elements of the required report might be translated into more clinical terminology.

1. [16.27] Nature and Type of Respondent's Disability

As distinct from a diagnosis, a description of a disability outlines limitations and is agnostic to the cause of these limitations. When assessing the nature and type of disability, examiners may use terms such as "symptoms," "indications," "signs," "impairment," or "dysfunction."

The examiner must also determine whether the limitation is clinically significant. Many people have weaknesses in certain areas. However, the central question when determining whether a symptom is disabling is whether these limitations rise to a level that significantly limits daily functioning rather than representing a relative weakness not uncommon in the general population. Examiners may encounter fewer challenges when forming these opinions because identifying the presence of disability is a common task medical professionals conduct. Limitations to accurately identifying types of disability are often attributable to the time it takes to assess multiple areas and access to collateral informants.

2. [16.28] Impact of Disability

In this element of the physician report, the examiner should articulate how the disability affects what the respondent can do in the real world. Terminology practitioners may see here include "deficits in functioning," "activities of daily living," or "impairment of higher-order functioning." When responding to this element, the examiner might discuss, for example,

a. how language weaknesses prevent the respondent from expressing a preference;

b. how memory impairment limits recall of previously falling prey to a telephone scam;

c. how the respondent's disorganized thinking impairs the ability to weigh options; or

d. how the respondent's amputated leg limits his or her ability to perform basic self-care.

Limitations to accurately identifying the impact of a disability on daily functioning may include a lack of access to objective measures of the degree to which abilities are impaired, but making these determinations is a core function most examiners are trained in.

Impact of disability on decision-making. The presence of one or more disabilities does not immediately mean that the respondent is incapacitated. For instance, a lack of calculation ability may not pose particular risks to the respondent when he or she generally uses cash for only small purchases. Other terminology used may include "decisional capacity," "management," or "executive decisions." Examiners may consider impairment in decision-making to be present when

a. the respondent's logical reasoning ability is heavily influenced by his or her psychotic belief system;

b. the respondent's intellectual ability limits the consideration of potential consequences; or

c. dementia limits the respondent's ability to grasp abstract concepts.

Identifying the impact of a disability on daily functioning is an area most examiners will have had training in, especially when assessing competence to make medical decisions. It is less common for many experts to have training on applying clinical constructs to the elements of testamentary capacity.

Impact of disability on independent functioning. As mentioned above, the presence of a disability is not relevant to competence if it does not directly influence the respondent's safety at home, ability to pay bills, or ability to take medications as prescribed. Terminology used may include "activities of daily living" (ADLs) and "instrumental activities of daily living" (IADLs.) The various ADLs outlined in Peter F. Edemekong et al., ACTIVITIES OF DAILY LIVING (2023), include

a. ambulating (the extent of an individual's ability to move from one position to another and walk independently);

b. feeding (the ability of a person to feed oneself);

c. dressing (the ability to select appropriate clothes and to put the clothes on);

d. personal hygiene (the ability to bathe and groom oneself and maintain dental hygiene and nail and hair care);

e. continence (the ability to control bladder and bowel function); and

f. toileting (the ability to get to and from the toilet, use it appropriately, and clean oneself).

The same authors describe "instrumental ADLs" as those tasks "that require more complex thinking skills, including organizational skills." These common IADLs involve

a. transportation and shopping (the ability to procure groceries, attend events, and manage transportation, either by driving or by organizing other means of transport);

b. managing finances (including the ability to pay bills and managing financial assets);

c. shopping and meal preparation (the ability to shop for food, clothing, and other items required daily and the ability to perform the various tasks necessary to prepare a meal);

d. housecleaning and home maintenance (the ability to clean a kitchen after eating, maintain living areas in a reasonably clean and tidy manner, and keep up with home maintenance);

e. managing communication with others (the ability to manage telephone and mail); and

f. managing medications (the ability to obtain medications and take them as directed).

Opining on the management of ADLs is something most examiners will have ample training in. However, these determinations can be hampered by the examiner's access to information. If asked directly about their ability to manage their finances or cook for themselves, most people, regardless of actual ability, will express no concerns. Similarly, the same changes in cognitive functioning that limit the respondent's ability to manage independently are also expected to limit his or her recognition of his or her decline. When respondents have "poor insight" into their functioning, interviewing loved ones or caregivers can provide much of this information. However, the availability of more than one collateral informant can be limited. Alternately, the quality of information provided by available informants could be colored by their intentions or their preferred outcome of the examination.

3. [16.29] Underlying Diagnosis of Disability

A diagnosis can be thought of as a shorthand way for one clinician to communicate with another about a cluster of symptoms often seen together. For instance, the cluster of symptoms seen in Alzheimer's disease differs from the cluster seen after a stroke, which also differs from what is seen after a head injury. The cluster for each diagnosis is organized into what is referred to as "diagnostic criteria."

Diagnoses are intended to describe clusters that are relatively distinct from one another. However, there is often overlap between the symptoms of different disorders. For instance, attention deficit hyperactivity disorder and a mild traumatic brain injury can both have deficits in attention. Similarly, difficulties with memory can be seen in both Alzheimer's disease and stroke.

Diagnosing is a process all medical experts have ample training in. Most of the challenges in this area will likely be encountered on the practitioner's end, as he or she understandably has less exposure to these intricacies. For example, what is referred to as a stroke, for simplicity's sake, might elsewhere be described as a cerebral infarction, an acute ischemic stroke, a cerebrovascular accident, major neurocognitive disorder due to vascular disease, vascular dementia, or several other things.

Another challenge encountered by practitioners is that their clients may be assigned a nonspecific descriptor such as "Dementia," "Alzheimer's," or "Unspecified Dementia." This can be a shorthand way of denoting significant cognitive changes when there is insufficient information to diagnose definitively. Nonspecific diagnoses can come when they are made quickly (*e.g.,* in an emergency room when there is little time for an in-depth evaluation). In other instances, a primary care physician may make an educated guess with the expectation that a specialist will make a more specific diagnosis at a later date.

Diagnoses that are preceded by the abbreviation "r/o" indicate that the patient is being referred to "rule out" (prove or disprove) a suspected diagnosis. This is a hint to the specialist of what might be going on, but it should not be considered an official diagnosis. For instance, after an automobile accident, a patient may be referred for a computed tomography (CT) scan to rule out a brain bleed in several ways. For instance, this may include

a. "Motor vehicle collision with head trauma";

b. "Altered mental status and/or brief loss of consciousness";

c. "Rule out intracranial hemorrhage";

d. "Rule out skull fractures"; and

e. "Rule out cerebral contusions."

4. [16.30] Manifestations of Disability

Clinicians should describe how the disability presents behaviorally, cognitively, emotionally, and physically, providing specific examples when possible. Some manifestations are readily apparent, such as when the respondent's memory, or "fund of knowledge," is on display in the first minutes of interaction. Similarly, someone with a stroke experiences challenges expressing himself or herself verbally or has apparent difficulty walking. Other manifestations might include impulsivity, quickness to anger, or combativeness. Similar to challenges to assessing the impact of disability on decision-making described in §16.28 above, a lack of information from collateral sources can limit examiners' ability to identify more subtle manifestations of disability.

5. [16.31] Analysis and Evaluation of Respondent's Mental and Physical Condition

Evaluation of the respondent's mental and physical condition. The examiner should describe the respondent's mental and physical health, including any conditions that interact, called "comorbid conditions." Having multiple comorbid conditions could be thought of as "one plus one equals three." For instance, having a vision impairment and dementia may make it incredibly difficult for the respondent to navigate the home he or she has lived in for years.

Description of the respondent's educational condition. Educational status can impact cognitive skills, such as comprehension and abstract thinking. Therefore, the clinician should describe the respondent's educational background and its potential impact on his or her current cognitive functioning. For instance, someone who has not had access to appropriate primary education may have had some long-term mild deficits in managing his or her finances. As that individual enters the early stages of dementia, his or her marginal mathematical abilities would be expected to decline disproportionately.

Description of the respondent's social skills. The clinician should assess the respondent's capacity to adjust behavior to meet environmental demands and describe his or her social skills. This includes factors such as the ability to ask for help when moving a chair across the room or his or her quickness to anger with caregivers. Maintaining social connections and interacting with others regularly is tremendously important in maintaining brain health. While strong social skills and community involvement are not central to the examiner's ultimate opinion, this is a good prognostic indicator. The prevention of isolation is also very relevant to the quality of life and the general mental health of the respondent and should feature prominently in his or her treatment plan.

6. [16.32] Opinion on Necessity of Guardianship

After a thorough evaluation, the examiner should articulate if a guardian is necessary to support the respondent's decision-making, daily functioning, or both. These opinions are a condensation of the information in §§16.27 – 16.31 above and includes the preferences of the respondent. A careful examination of these factors is essential to protecting the rights and welfare of the respondent, ensuring that decisions made on his or her behalf are in his or her best interests and respecting his or her autonomy and dignity as much as possible.

Opinion on the scope and type of guardianship. Clinicians should clarify the necessary level of guardianship, considering the respondent's residual decision-making capacities and areas of independence.

Reasons for guardianship opinion. This section should outline the clinician's rationale for his or her opinion on guardianship, incorporating findings from all previous sections of the physician report.

Opinion on the respondent's incapacity to make decisions. The clinician should state whether the respondent is wholly or partially incapable of making personal and financial decisions.

Decisions the respondent can and cannot make. If the respondent has partial decision-making capacity, the clinician should specify the types of decisions the respondent can and cannot make, grounding this in his or her cognitive assessment.

7. [16.33] Suitable Living Arrangements

Based on the assessment, the clinician should recommend the most suitable living arrangement for the respondent, considering his or her disability, decision-making capacity, and physical health. Other factors to be considered include the rate at which his or her cognitive abilities are declining, whether a spouse can provide assistance to him or her, or the proximity of loved ones to visit regularly and be on the lookout for dangers.

8. [16.34] Treatment or Habilitation Plan

Finally, the clinician should propose an appropriate treatment or habilitation plan for the respondent, considering his or her cognitive, emotional, and physical needs.

9. [16.35] Physician Report Conclusion

In sum, the Probate Act of 1975 demands a comprehensive evaluation of a respondent's cognitive, physical, and social functioning (which informs decisions about the necessity, scope, and type of guardianship) to complete the required physician report. A clinician's meticulous evaluation and interpretation of these components can significantly impact the respondent's well-being and autonomy.

V. NEUROPSYCHOLOGICAL TESTING

A. [16.36] Benefits of Neuropsychology in Legal Matters

The tools that neuropsychologists employ to draw their conclusions are well-tested, widely subjected to peer review, and have known error rates. Additionally, these tests have been designed to ensure they can be administered to examinees in a consistent, repeatable manner. Because of this scientific approach to collecting information, neuropsychologists' conclusions are less reliant on clinical judgment and opinion and more dependent on verifiable and objective data. Attorneys and examinees alike are often surprised to learn that a thorough neuropsychological evaluation usually consists of six or more hours of face-to-face interactions with an examinee. Of this time, the majority is spent objectively testing that examinee's abilities.

There are many times when the question at hand is simple enough or the individual's level of disability is so clear cut that a physician report is sufficient. See §§16.24 – 16.35 above. When an individual's level of impairment is less clear or there is a great deal of contention around the adjudication of competence, however, a neuropsychological evaluation may be warranted.

B. [16.37] Benefits of Objective Testing

What differentiates neuropsychological testing from a physician report is the administration of formal tests that compare the examinee's performance on these tests to what is considered "average" or typical. These tests assess a wide variety of neuropsychological "domains," which include

1. attention and focus;

2. use of language to express oneself or understand others;

3. memory;

4. planning and mental organization (*i.e.,* executive functioning);

5. spatial abilities (*e.g.,* reading a map, navigating, depth perception);

6. motor coordination (*i.e.,* the ability to open a jar or button a shirt); and

7. general intelligence.

Further, assessments of daily abilities can be found in §16.39 below. Descriptions of how impairments within these domains influence competence and the practitioner's ability to work with the client can be found in §§16.61 – 16.70 below.

A list of frequently administered neuropsychological tests and definitions of commonly used neuropsychological terminology can be found in §16.110 below.

C. [16.38] Neuropsychological Test Administration

It is important to note that neuropsychological tests are administered in a consistent and standardized manner. Once the examinee is given a battery of tests (*i.e.,* a variety of tests assessing all cognitive domains discussed in §16.37 above), his or her performance can be compared to what is typical of an individual of the same age and education. This comparison group is referred to as a "normative sample." Comparing an examinee's abilities to a standard allows neuropsychologists to use objective data to draw valid, reliable conclusions about the examinee's abilities. This reliance on objective data subsequently reduces neuropsychologists' reliance on pure clinical judgment and increases the accuracy of the conclusions drawn. This neuropsychological testing data, combined with other medical and daily living information, allows a neuropsychologist to identify the correct diagnosis.

More importantly, from the practitioner's perspective, forensic neuropsychological evaluations go beyond a simple yes/no opinion about competence. Instead, these evaluations can provide context, address complex questions, and aid the court in understanding the type, nature, and extent of cognitive impairment from which the examinee suffers. Of equal importance when determining decisional capacity, neuropsychological testing also identifies areas of intact functioning (*i.e.,* abilities left untouched by disease). Lastly, the nature of neuropsychological testing promotes transparency. Neuropsychological evaluations lay out the logic behind the underlying conclusions drawn through the description of the data relied on.

D. [16.39] Measuring Real-World Abilities

In addition to neuropsychological tests that assess memory, attention, etc., the field has developed specialized tools that allow neuropsychologists to measure an individual's ability to

perform certain real-world functions, referred to as "activities of daily living." For example, if the question at hand involves an individual's ability to maintain financial independence, a functional test to assess these abilities might involve giving the examinee two utility bills, a fake checkbook, and a check register in which to enter the amounts. Scoring that individual's performance would compare the accuracy of the examinee's math skills and ability to complete simple transactions. Alternatively, the examinee might be given instructions on preparing a microwave meal, allowing him or her to demonstrate how he or she would proceed. Once someone has completed these assessments, the accuracy of his or her performances is then compared to those of other individuals his or her age.

Similarly, if there are questions related to an individual's ability to live independently, functional ability testing involving the examinee's ability to remember to take medications at a certain time or to count the change he or she should receive after a transaction can be very useful. Likewise, the examinee might be asked what steps to take if he or she sees smoke coming from a neighbor's home.

Other assessments of daily living skills take the form of questionnaires administered to an examinee's loved ones that measure that examinee's daily living skills. These tests allow for meaningful information to be collected on that examinee's ability to cook, clean his or her home, remember medical appointments, communicate with the world, etc. In short, integrating some of these functional assessments into a forensic neuropsychological evaluation further extends both the utility and accuracy of the neuropsychological evaluation in legal settings.

E. [16.40] Why Neuropsychological Evaluations Are Reliable and Valid

When an examinee approaches the evaluation process in a forthcoming manner and exerts good effort during testing, the tests psychologists and neuropsychologists use demonstrate high levels of statistical reliability and validity. Reliability refers to the consistency of scores obtained from a given instrument. Validity refers to how well the test measures the neuropsychological domain or the aspect of psychological functioning the test purports to measure. When someone exerts insufficient effort on cognitive tests or inaccurately responds to questionnaires, the value of these tests can be compromised.

For most clinical neuropsychologists (as distinct from forensic neuropsychologists), a patient who lies, feigns symptoms, or embellishes a little bit is not a central concern. This is because the stakes of a general medical procedure are lower than if it relates to his or her finances or freedom. As such, when there is no discernible motivation for an individual to want to appear other than he or she truly is (*e.g.,* malingering, dissimulation, etc.), only minimal methods of detecting these dishonest human tendencies are necessary.

Forensic neuropsychologists deal with individuals involved in legal proceedings who often may be motivated to "put on a show" and portray themselves as less impacted by their conditions than they realistically are. Alternatively, there are situations (*e.g.,* personal injury cases) in which an examinee may be motivated to exaggerate symptoms. Finally, an examinee may perform in a manner that does not accurately reflect his or her true abilities because of a general disinterest in

the process. When the stakes are high and an examinee is motivated to try to fool the examiner, that individual is described as "motivated by secondary gain." When there is the potential for secondary gain, elaborate and sensitive validity indicators are employed to verify that the data collected is representative of the individual's true functioning.

These validity indicators are often referred to as tests of effort or malingering tests. They are designed to gauge, for example, the level of effort an individual puts into performing at his or her best on an IQ test or his or her level of honesty when answering questions about emotional functioning. These validity indicators, in conjunction with the core tests measuring various neuropsychological domains, are valuable because they allow neuropsychologists to know the statistical probability that an examinee's measured performance or subjective self-report is representative of his or her real-life functioning. While the specifics of how these validity indicators work is unnecessary for practitioners to understand fully, practitioners should be aware of these assessments because they will be referenced in any forensic neuropsychological evaluation and some clinical neuropsychological evaluations.

When being evaluated for competence, examinees are generally motivated to perform as well as they can on neuropsychological tests (*i.e.,* their memory or executive abilities). Conversely, attempting to perform better on these cognitive tests than one is truly capable of is rather difficult. Other than obtaining and memorizing the "right" answers or practicing neuropsychological tests ahead of time, it is difficult to perform better on a test of cognitive abilities than the true clinical picture would warrant.

When being evaluated for psychological disorders (*i.e.,* depression, anxiety, schizophrenia), it is common for individuals whose competence is being evaluated to make efforts to appear more well-functioning than the objective reality may be. In these situations, "validity indicators" that are embedded into many tests administered alert the neuropsychologist when an individual's approach to a given test is less than open and honest.

Because the meaning of the core tests neuropsychologists administer is understood through the lens of the examinee's performance on these measures of openness and effort, the practitioner is well advised to brief the client on their existence. The existence of these validity indicators should not be conveyed as a warning. Rather, this discussion allows the practitioner to encourage the client to be as open and forthcoming as possible. Clients also can be reassured that the likelihood of accidentally "tripping" one of these validity indicators is quite small. Indeed, adding these validity checks to the overall evaluation process is a fundamental part of what moves the neuropsychological assessment of competence from the speculative realm toward a more objective and verifiable process.

F. [16.41] What Psychological Tests Measure

Although this chapter is primarily devoted to discussing neuropsychological testing, it is worth mentioning that traditional psychological testing is often relevant to answering questions that come before the court. Psychological testing assesses the presence of emotional disorders such as depression, bipolar disorder, schizophrenia, post-traumatic stress disorder, etc. Like neuropsychological testing, psychological testing is flexible regarding the variety of questions it

can answer. These emotional disorders directly impact an individual's decisional capacity and exacerbate cognitive disorders such as dementia. Emotional functioning also directly impacts an individual's ability to consult meaningfully with his or her attorney. In extreme situations, those with schizophrenia may develop belief systems that their attorneys or the judges are out to get them. In more commonplace scenarios, decisions made by individuals suffering from depression may be skewed by their sense of hopelessness or their wish to die. Similarly, individuals suffering from anxiety may be reluctant to make statements that could evoke a negative reaction from those close to them.

A brief discussion of emotional disorders attorneys are likely to encounter can be found in §§16.56 – 16.60 below. Exhaustive criteria for these diagnoses can be found in the American Psychiatric Association's (APA) DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, TEXT REVISION (5th ed. 2023). Most neuropsychologists are familiar with these psychological tests and integrate them regularly into comprehensive neuropsychological batteries.

G. [16.42] How Cognitive Impairment Impacts Competence

In §16.2 above, the distinction was made between mental capacity and legal competence and how these terms work in practice. Attorneys may find it useful to understand how severe impairments within individual cognitive domains can limit a client's competence in relation to a specific legal matter. Likewise, it may be useful to understand how milder impairments in these areas may necessitate that practitioners interact differently with their clients.

As attorneys gain experience dealing with the same cases and working with older clients, they develop proficiency and finesse for explaining things to clients with limited mental capacity. This can be counterproductive because it can help clients mask their limited understanding. When an attorney notices his or her typical manner of communication with a client is failing, it should raise concerns about that individual's competence. Assuming, of course, that the attorney is an effective communicator, clients may have trouble working with the attorney for a variety of different reasons, including

1. poor ability to track a conversation because of limited attention or confusion;

2. challenges voicing a clear preference or understanding the words the attorney is using;

3. forgetting topics previously discussed or decisions previously made; and

4. misunderstanding information discussed that is just "over his or her head."

The reader should be aware that statements made in §§16.43 – 16.60 below on diagnoses represent typical presentations of a given disorder. They are generalizations of some of the core symptoms seen in that disorder, but many individual symptoms are not absolutely necessary to make a given diagnosis. Further, it is not uncommon for elements of one diagnosis to be seen in another.

VI. DEFINITIONS OF COGNITIVE DISORDERS

A. [16.43] Dementia

Dementia is not a single, monolithic entity; rather, it is an umbrella term denoting wide-ranging types of cognitive decline. There are many different types of dementia, and they are differentiated by their respective cognitive/symptomatic patterns and the underlying physical causes of brain deterioration. The most common types of dementia include

1. Alzheimer's disease (see §16.44 below);

2. vascular dementia (see §16.45 below);

3. dementia with Lewy bodies (see §16.46 below);

4. frontotemporal dementia (see §16.47 below); and

5. advanced AIDS (see §16.48 below).

To add confusion, these diagnoses also may be labeled as "major neurocognitive disorder due to _____." Specifically, the practitioner may see "Major Neurocognitive Disorder due to Alzheimer's Disease." While the underlying biological reason for individual dementia varies from one diagnosis to the next, all dementias involve a deterioration of some combination of cognitive domains. These specific areas of decline depend heavily on the type of dementia and are part of what helps clinicians differentiate the different types. Second, in all dementias, the level of deterioration is also important. Specifically, for a diagnosis of dementia to be made, the individual's cognitive impairments must impair his or her day-to-day functioning significantly.

Simply having a diagnosis of dementia does not mean that an individual is necessarily incapacitated. Ideally, individuals are identified early in the dementing process to benefit from treatments to slow cognitive decline. Individuals in the earlier stages of the dementing process are likely competent to make the various decisions discussed in this chapter. However, even in the earlier stages, dementia may impede the ability to perform particularly complex tasks, such as reviewing and executing a contract or handling complex real estate transactions. The difficulty level varies between tasks, so it is important to consider the complexity of what needs to be done alongside the client's level of deterioration.

In the early stages of dementia, symptoms may include a lack of motivation, sadness, and possibly some memory lapses. As the disease progresses, memory abilities worsen, as does the individual's quality of judgment. There is also often difficulty communicating with others (*e.g.,* not understanding others or being unable to find a certain word when speaking). As dementia worsens, patients have increasing difficulty with these abilities, as well as marked disorientation (*e.g.,* getting lost while driving) and behavioral changes (*e.g.,* acting out or anger). In late-stage dementia, difficulties with speaking, swallowing whole food, and walking independently emerge. Sections 16.44 – 16.48 below provide more specific information on the common dementias listed in this section.

1. [16.44] Alzheimer's Disease

Dementia of the Alzheimer's type is the single most common form of dementia. Alzheimer's disease is characterized by deposits of proteins in the brain called neurofibrillary plaques and tangles, accompanied by the death of many neurons (brain cells) within the brain. The most common cognitive areas that are deficient among individuals with Alzheimer's disease include memory and language abilities, although as the disease progresses, it slowly encompasses every cognitive area.

2. [16.45] Vascular Dementia

Vascular dementia, also called multi-infarct dementia, develops after blockages or bleeds in blood vessels (called infarcts) within the brain that causes areas of the brain "downstream" of those blockages or bleeds to be deprived of sustenance. As a result, multiple individual areas within the brain essentially die off, causing a diffuse pattern of tiny brain injuries. Because these dead spots can be anywhere in the brain, vascular dementia is associated with various cognitive challenges. Attention abilities tend to be most impacted, and memory difficulties appear somewhat less severe in individuals with vascular dementia. That said, planning, organization, language, and spatial abilities can all be impacted, depending on the area the infarct occurred. Like all dementias, as vascular dementia progresses, more symptoms occur, and the severity of each symptom increases.

Relatedly, a stroke occurs when a large blockage or bleed in the brain occurs, causing a substantial area of tissue to be starved and eventually die off. In this way, a stroke is similar to the process that causes vascular dementia; however, a stroke is different in terms of the size of the area that is deprived of oxygen and sugar. The type of stroke that stems from a bleed within the brain is called a hemorrhagic stroke, and the type of stroke that stems from a blockage (*e.g.,* blood clot, etc.) is called an ischemic stroke. Like vascular dementia, strokes result in various cognitive challenges depending on the brain area where they occur. Finally, a stroke can cause dementia (if it was a serious enough stroke) or cause less severe and more isolated symptoms such as memory challenges or difficulties speaking.

3. [16.46] Lewy Body Dementia

Lewy body dementia is the third most common dementia. Like Alzheimer's disease (see §16.44 above), this dementia results from a protein accumulating in the brain. Symptoms of Lewy body dementia can be somewhat similar to those seen in Alzheimer's disease; however, it is more likely that individuals with Lewy body dementia will experience sleep disturbances, visual hallucinations, stiffening of muscles, and the possibility of a tremor. Individuals suffering from Lewy body dementia also may exhibit increased fluctuations in day-to-day cognitive functioning.

4. [16.47] Frontotemporal Dementia

Frontotemporal dementia (FTD) also may be referred to as "frontolobar degeneration," "primary progressive aphasia," "progressive supranuclear palsy," or "Pick's disease." This somewhat less common dementia (in comparison to those discussed in §§16.44 – 16.46 above) occurs when nerve cells in the front of the brain (frontal lobes) and sides of the brain (temporal

lobes) begin to die. While this dementia causes challenges with judgment, memory, and language, the most visible symptoms of this dementia include behavioral or personality changes. These behavioral changes commonly include marked impulsivity (*e.g.,* gambling or saying inappropriate things) and a tendency to "act out" aggressively or engage in obsessive, ritualistic behaviors. These obsessive behaviors may involve clapping or tapping one's fingers. The ritualistic behaviors may involve very rigid, set bedtime rituals or walking a certain path around the nursing home repeatedly.

5. [16.48] Advanced AIDS

Individuals who are in the advanced stages of acquired immunodeficiency syndrome (AIDS) can initially demonstrate symptoms of slowed speed of thinking, behavioral changes, and difficulties with motor coordination. With time, these symptoms are accompanied by more global cognitive challenges affecting many abilities.

B. [16.49] Delirium

Delirium is a state of significant confusion that occurs in response to some other medical problem. For instance, someone who is ill with a systemic infection (*e.g.,* a urinary tract infection), is under the influence of mind-altering medications, or has some toxin at a high level in the body is likely to be delirious. The nature of delirium is that it can begin quite quickly and fluctuate dramatically throughout a given day or week. Importantly, delirium generally clears up rapidly when the cause is effectively treated (*e.g.,* antibiotics for a urinary tract infection or dialysis for someone with kidney failure). Generally, delirium causes a great deal of impairment in awareness, attention, and orientation to space and time.

C. [16.50] Multiple Sclerosis

Multiple sclerosis (MS) is a type of demyelinating disorder. Specifically, a substance called myelin wraps around most of the length of a neuron and facilitates the transmission of information or "signals." The neurons in the brain have long "axons" that are metaphoric pipelines that transmit information from one neuron to the next. When this myelin sheath breaks down, this neuronal information is slowed or entirely blocked. As a result, brain function changes, and information no longer moves around smoothly. Early symptoms of MS include tingling in the extremities, fatigue, and difficulties with vision. As it progresses, MS can result in various other cognitive symptoms. The course of MS is often referred to as relapsing and remitting, which means that a person's MS improves and gets worse periodically throughout his or her lifetime. Therefore, at certain times of a given year or even month, an individual suffering from MS may be competent, and at other times he or she may not be competent. Like a stroke, MS can cause dementia (see §§16.43 – 16.48 above), or it can cause less severe thinking difficulties that show up only while speaking, remembering, etc.

D. [16.51] Traumatic Brain Injury

A traumatic brain injury (TBI) is also referred to as a mild traumatic brain injury (mTBI), a concussion, or simply a "head injury." This occurs when some force acts on the head to cause the brain to hit the inside of the skull, when "bruising" happens within the brain, or when forces cause

"tearing" of brain cells. The cognitive changes stemming from this type of injury depend greatly on what brain areas are most impacted. Commonly, however, attention and executive functioning are most heavily impacted. Injuries of this type are also thought to be cumulative. In other words, multiple head injuries can "add up" throughout an individual's lifetime because the brain does not completely recover from each individual injury. This means that, in old age, individuals who have had multiple head injuries in the past may be more susceptible to dementia. Said another way, the cognitive abilities of someone who has been in a significant car accident or played many years of football in his or her youth are expected to decline more and earlier in life than those of someone who has not sustained head injuries.

E. [16.52] Parkinson's Disease

Parkinson's disease is classified as one of a handful of movement disorders. It is a neurodegenerative disorder in which cells within a small area of the brain called the substantia nigra die, causing a decrease in the production of the neurotransmitter dopamine. Individuals in the early stages of Parkinson's disease demonstrate a stiffening or "rigidity" of the muscles, shaking, and slowed speed of movement called "bradykinesia." With time, this shaking — or tremor, as it is referred to clinically — becomes more severe, and a combination of thinking and behavioral problems may arise. Depression is commonly seen among individuals with Parkinson's disease. Unfortunately, the medications that can be effective in treating Parkinsonian disease symptoms can also cause psychosis if not monitored closely. In its most advanced form, Parkinson's disease is associated with dementia-level impairments.

F. [16.53] Intellectual Disability

Intellectual disability, also referred to as Intellectual Developmental Disorder and historically as "mental retardation," is a combination of low intelligence (*i.e.,* low IQ) and poor ability to manage activities of daily living such as self-care tasks. Individuals suffering from an intellectual deficiency often have a history of special education classes, poor performance in work or unemployment, social deficiencies, and a greater-than-average number of emotional disorders.

Of particular relevance to practitioners dealing with issues of guardianship, Criterion A of the American Psychiatric Association's DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, TEXT REVISION (5th ed. 2023), criteria for the diagnosis of ID are

> **[**d**]eficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, are confirmed by both clinical assessment and individualized, standardized intelligence testing.**

Psychologists and neuropsychologists perform a central role in administering standardized intelligence tests. Further, someone with an ID may have additional accompanying or comorbid diagnoses such as communication disorders, motor disorders, sensory disorders, impulsivity disorders, bipolar disorder, depressive disorders, and many others. It is also common for individuals

with developmental disabilities to have IDs and vice versa. While these comorbid diagnoses may or may not be central to a need for guardianship, understanding how they impact functioning is always central to developing treatment plans, identifying levels of care, and, often, obtaining entitlements.

G. [16.54] Pseudodementia

Pseudodementia is not a universally recognized diagnosis, but it represents a well-established concept in the medical field. Pseudodementia is a dementia-like presentation that, unlike true dementia, can improve by treating an individual's underlying depression. It appears that in the elderly, symptoms of depression can often be expressed in the form of decreased cognitive functioning. It may be that depression "slows down" a brain that is already less efficient because of advancing years, causing cognitive symptoms that normally might not emerge for years to do so earlier. Fortunately, when the depression is appropriately treated, individuals with pseudodementia revert to their prior level of cognitive functioning fairly rapidly.

H. [16.55] Old Age

Old age alone is a very important factor in cognitive function. Most cognitive abilities, even in healthy individuals, decline after middle age. The speed of this natural decline also increases with increasing age. In other words, the rate of decline between ages 70 and 75 is slower than what is seen from ages 75 to 80. In addition to these natural changes, the likelihood of developing one of the dementias discussed in §§16.43 – 16.48 above increases dramatically as one ages. Individuals solely suffering from cognitive changes of old age are likely to retain competence longer than those with diagnosable cognitive disorders.

VII. [16.56] DEFINITIONS OF EMOTIONAL DISORDERS

There is an artificial distinction between what is considered an emotional (*i.e.,* psychological or psychiatric) disorder and what is considered a cognitive disorder, such as those discussed in §§16.43 – 16.55 above. The reality is that both types of disorders stem from dysfunction of one type or another within the same organ — the brain. Nevertheless, to maintain clarity, the disorders typically considered psychological or psychiatric are described in this section and §§16.57 – 16.60 below to minimize confusion.

The emotional problems an individual might experience are too numerous to list in this chapter, but those disorders most likely to impact competence include psychosis (*e.g.,* schizophrenia), depression, bipolar disorder, and certain personality disorders. While these psychological disorders interact with neurologic problems in such a way that one plus one may equal more than two, the complexity of that discussion is beyond the scope of this chapter. However, the practitioner should be aware that one disorder can essentially exacerbate the worst aspects of another disorder and vice versa.

A. [16.57] Thought Disorders

There are numerous psychotic thought disorders, but some common diagnoses include schizophrenia, schizoaffective disorder, and some types of bipolar disorder. An individual currently suffering a psychotic episode may be very disoriented and is often overly suspicious or paranoid about others' intentions. The individual may describe intense yet illogical fears or demonstrate confused thinking about how the world works. Individuals who are psychotic also develop delusions. Delusions are intensely held false beliefs that are often illogical and tend to be retained even in the face of clear evidence of how illogical that thinking is. Finally, psychosis is often accompanied by hallucinations, which can be visual, auditory, tactile, or olfactory (*i.e.,* smell) in nature. The most common types of hallucinations include auditory hallucinations of voices, which often say negative or harassing things to the individual. People who are psychotic can frighten those around them because of their bizarreness and periodic irrationality. The reality is that while there is a small subset of psychotic individuals who can become dangerous, the majority of individuals who have psychosis tend to be withdrawn and lethargic. Rather than posing a risk to others, this tendency to be withdrawn, lethargic, and disoriented increases the likelihood that they will be taken advantage of by those around them.

When working with psychotic individuals, it is best to avoid confronting them about the illogical nature of their delusional belief systems in the mistaken hope of convincing them otherwise. It is, however, beneficial to give assurances of being "on their side." It is always best to avoid entering into their delusional systems by, for example, making impossible promises such as, "I'll look into exterminators to deal with the little green people inside your walls." While this kind of strategy often works well at the moment, it is a poor long-term choice. This is because you have just made a promise you cannot keep with someone who already tends to be suspicious of others' intentions. In the end, unless the legal matter at hand is very simple, it is reasonably safe to assume an individual demonstrating anything other than mild psychotic symptoms may have diminished capacity (at the time, anyway) to interact meaningfully with the legal system or make decisions.

Psychotic spectrum disorders are treatable with medications, meaning individuals experiencing a psychotic break may be incompetent only temporarily. This scenario is seen frequently in criminal settings when an individual is charged with a crime but is unfit to stand trial because of his or her inability to "understand the nature and purpose of the proceedings against him or to assist in his defense." 725 ILCS 5/104-10. These individuals regain competence with time (usually a few months) of psychotherapeutic treatment and psychiatric medications. Without medications, psychotic spectrum disorders sometimes improve but rarely vanish. Generally speaking, the risks of allowing an individual's psychosis to go untreated outweigh the risks of taking antipsychotic medications. In short, someone who has psychosis will need psychiatric treatment.

B. [16.58] Mood Disorders

Depression and bipolar disorder are classified as mood disorders. Depression is characterized by subjective experiences of sadness, a decreased interest in life, decreased hope for the future, and feelings of helplessness. Depression is an emotional disorder also associated with cognitive symptoms. Not surprisingly, depression "slows down" all of the individual's mental processes. For this reason, depression tends to exacerbate other preexisting or emerging cognitive problems.

Among the elderly, depression can mimic dementia (see §16.54 above). In terms of the quality of thinking among depressed individuals, their pessimism, lack of hope, and in some cases feelings of helplessness about future improvement can heavily color the decisions they make at the moment. Essentially, if someone is deeply unhappy, cannot conceive of a better future, and assumes he or she will die soon, his or her decisions will likely be clouded, and his or her ability to act in his or her best interests is limited.

If depression is on one end of the spectrum, extreme happiness, excess energy, and high motivation are on the other. At first glance, excitement, boundless energy, and even a lack of need for sleep seem like a great thing. In practice, it can be rather debilitating. Bipolar disorder causes an individual's mood to swing back and forth from mania to depression, generally over the course of weeks or months. Those with bipolar disorder swing from feeling sad and lethargic to being energetic, motivated, irritable, and often irrational. During these manic episodes, the individual may make fantastical but unrealistic plans, jump from topic to topic (referred to as tangentiality), or spend vast sums of money on a whim. In short, his or her judgment is often impaired to some degree. While most individuals with bipolar disorder generally do not exhibit psychotic symptoms, in more extreme cases, individuals with bipolar disorder exhibit psychotic features (see §16.57 above) when they are at the height of their mania. Bipolar disorder alters an individual's attention and planning abilities. These factors, added to their distractibility and tangentiality, can make working with these individuals rather challenging. The symptomatic course of the illness (*i.e.,* ebbs and flows in impairment) is quite variable, and an individual may be entirely incompetent one week and fully competent the next week. Additionally, bipolar disorder is also very treatable with medications. Like the psychotic spectrum disorders discussed in §16.57 above, someone suffering from a more extreme manic episode will almost certainly need psychiatric treatment.

C. [16.59] Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) sufferers commonly deal with various emotional and cognitive challenges. The diagnostic criteria for PTSD begin with a person having experienced a terrifying or life-threatening event. Such events (especially repeated traumatic events) cause changes within the brain that alter that individual's ability to be calm and react reasonably to mildly threatening situations. Anxiety, sadness, significant fears, jumpiness, and flashbacks to the traumatic event are common. The same neurochemical changes that create difficulties controlling the fear response after an emotional trauma also damage the parts of the brain involved in memory. Additionally, individuals with PTSD often deal with attention difficulties that partly stem from being preoccupied with worrisome thoughts.

Notably, PTSD is known to resurface among the elderly as dementia sets in. It seems that many mental processes that keep these unpleasant memories at bay when younger decline as dementia develops. As a result, the dementing individual may begin to re-experience, often quite vividly, the traumas he or she was able to suppress during much of his or her adult life. This tendency can lead to behavioral outbursts and significant agitation, fear, or discomfort.

D. [16.60] Personality Disorders

Disorders falling into this category include diagnoses such as borderline personality disorder, dependent personality disorder, and antisocial personality disorder, among others. The hallmark

feature of all persons with personality disorders is that these individuals can be difficult to interact with on an interpersonal (*i.e.,* relational or communication) basis. In the most basic sense, individuals with personality disorders have a maladaptive pattern of behavior as well as a skewed (although not generally delusional) perception of the intentions of those around them. Additionally, their behavior is often inflexible and alienates those around them. These individuals may become angry, vacillate between loving and hating you, or try to lull you into a caretaker role. Some individuals with personality disorders demonstrate passive-aggressive behaviors or lack empathy. Other types of personality disorders may involve avoiding others around them or becoming very intrusive into the personal life of someone they might not know well. In general, personality disorders probably have to be severe to limit an individual's ability to make decisions competently. Still, like many other disorders, when combined with other cognitive factors (which alone may not have been sufficient to render an individual incapacitated), the combination may be enough to push the person into incapacity.

VIII. [16.61] IDENTIFYING SIGNS OF COGNITIVE DECLINE

Sections 16.62 – 16.70 below include practical suggestions to help practitioners become more attuned to the warning signs of cognitive weakness. A printable "cheat sheet" designed to help attorneys identify signs of cognitive slippage is provided in §16.111 below. This checklist can be a great tool for an attorney who may wonder about the competence of a client. Brief descriptions of diagnoses commonly impacting competence can be found in §§16.43 – 16.60 above.

A. [16.62] Attention Issues

Attention, in the most basic sense, is an individual's ability to be alert, to be oriented to his or her surroundings, to be aware of what is going on, and to focus on one matter while successfully avoiding distraction from things happening around him or her. Other commonly used synonyms for attention include "focus," "alertness," and "concentration." There are also aspects of attention that are similar to — and can be confused with — motivation and effort. When a person is deficient in the ability to attend to the task at hand, he or she will have trouble following a conversation, tend to "space out," and seem disoriented.

Quite frequently, individuals who appear to have difficulty with recalling information are actually deficient in their attentional abilities. In these instances, the parts of the brain responsible for memory are intact, but the individual's attention is so poor that information is not necessarily "getting in" to be remembered later. In essence, these people are not "forgetting" information that originally "got in"; they are metaphorically "not hearing" the information to later remember it. Differentiating between poor attention and poor memory can be done in a neuropsychological evaluation. The resulting treatment recommendations surrounding how the attorney can best assist a marginally competent client differ depending on whether the underlying problem relates to memory or attention. Further, the likelihood of being incompetent is higher for those with weak memory than those with weak attention.

A client's level of attention during a consultation is a good overall indicator of that client's ability to work meaningfully with his or her attorney. Counsel should make a mental note of the following:

1. Is the client drowsy or fully awake?

2. How interested does the client seem in what is being discussed?

3. Do little sounds in the office draw the client's focus away from the work at hand?

4. When making a statement, does the client "space out" and forget what he or she was discussing?

5. Does the client tend to respond to questions tangentially and end up way off topic?

When a client is more distractible than ideal, a handful of techniques help refocus that client's attention. First, practitioners can try to minimize distractions within the office. If there is noise, ensure the doors are closed to minimize this. Consider pulling the drapes to minimize visual distractions if the client's seat allows him or her to look outside. When talking to a client with a short attention span, it may make sense to limit the number of topics discussed in a single sitting. Simplifying the discussion and focusing on individual issues can be quite useful. Additionally, the client's attention can be focused by saying, "Right now, we are going to . . ." or "Look closely at . . ."

Attention, concentration, and level of disorientation are the factors that vary the most in severity for any individual throughout the day or week. Some people with dementia also have a predictable, repeated pattern of fluctuation in their attention/disorientation through a given day. The term "sundowning" describes a phenomenon whereby an individual is most alert and able to function in the morning but becomes progressively more confused and less able to function without assistance as the day goes on. What this means, practically, is that a client may be marginally competent at 10:00 a.m. but by late afternoon may have lost enough mental acuity that he or she is unable to make the same kinds of decisions reliably. Unfortunately, the term "sundowning" is a misnomer, as some individuals are less alert early in the day and more alert later on. The larger point remains that individuals' thinking abilities vary by the time of day and sometimes vary predictably.

B. [16.63] Language Issues

Language refers to the system of words that individuals use to communicate. Impaired language abilities can vary from obvious impairments to those that are subtly confusing for the practitioner. There are receptive (*i.e.,* listening) and expressive (*i.e.,* speaking) aspects of language, both of which can be measured through neuropsychological testing. More importantly, appropriate assessment and treatment by a speech language pathologist may allow many individuals to voice their preferences effectively and clearly.

Receptive language abilities refer to an individual's comprehension of what is being said to him or her. This is distinct from being hearing impaired. Instead, challenges with receptive language involve the neurologic process of understanding speech. For instance, it is common for individuals who have suffered a stroke that affected the brain's language centers to seem like they cannot hear you outwardly. In reality, these individuals may want to connect and participate, but their brains are not properly processing this language-based information. Individuals with difficulty

with receptive language abilities can appear confused or disinterested in what is happening. Alternately, these individuals can appear to have a poor memory of previous events or might remember information in a distorted fashion. Clearly, there is no expectation that a practitioner independently distinguishes poor memory and language issues. Rather, it is useful to be aware of the existence of these challenges because their presence likely indicates a need for formal evaluation. In practice, practitioners may notice receptive language disorders when the client (1) has challenges paraphrasing what he or she was just told, (2) has challenges following multi-step instructions, or (3) seems to lose focus in conversations. It should be noted that having lesser familiarity with the English language causes challenges with comprehension that are entirely separate from a receptive language disorder.

Expressive language disorders refer to challenges with putting thoughts into words effectively. Individuals with difficulty with expressive language abilities may substitute one word for another or, more commonly, have difficulty finding the word they are looking for (*i.e.,* "the tip-of-the-tongue" phenomenon). Technically, this word-finding difficulty is referred to as anomia. Word-finding difficulties often seem like a memory problem, but these phenomena are technically related to an individual's expressive language abilities. For instance, when a person is trying to find a word such as "airplane," he or she might be able to describe it as "the white thing up in the air, with wings . . . it flies . . . not a bird" but cannot bring the actual word "airplane" to mind. Other forms of expressive language-based dysfunction include calling something by an incorrect name. This may take the form of referring to a "coffee cup" as a "glass" or referring to a "plate" as a "tate." Often, practitioners will be able to work with individuals suffering from this level of impairment. In more serious language disorders, comprehension or expression may be so impaired that effective communication can be facilitated only by a medical professional such as a speech language pathologist or occupational therapist.

For individuals who have challenges with either receptive or expressive language, life can be tremendously frustrating. Not surprisingly, individuals with marginal competence already experiencing some difficulties are impacted much more when communication becomes more convoluted. Fortunately, there are some specific strategies that will allow these clients who are marginally competent to work with counsel, but this will generally necessitate the services of a medical professional.

Interestingly, some individuals with language challenges are entirely unaware of their difficulties. Whether an individual suffers from expressive challenges, receptive challenges, or a mix of both, it is often possible to help these individuals learn through repetition, clarification, and requests that the client paraphrase what had just been explained. Simply saying to your client, "Please repeat what I just explained. I'd like to know if I am making sense," is a powerful tool to confirm understanding — for both impaired and unimpaired individuals.

C. [16.64] Memory Issues

Memory is the ability to bring information previously learned or experienced to mind. Other commonly used synonyms for memory include "recollection" and "remembering." Memory is broken down in many ways by neuropsychologists. A few of these common distinctions refer to

1. whether the memory was for a recent event or something that happened remotely;

2. whether the memory is of language/verbal information or visual imagery; and

3. whether the memory is for bits of information or how to do something.

Many additional types of memory are studied, but the above aspects of remembering are most likely to be discussed in a neuropsychological evaluation. Memory is of particular concern in the context of competence because individuals often need to draw on a large base of information related to prior experiences, both recent and remote, to make good decisions at the moment. The attorney will see individuals with memory challenges as having problems recalling the specifics of previous conversations or having difficulties synthesizing new information in the context of past experiences.

Clients suffering from impaired memory often repeat themselves, have difficulty recalling recently discussed subjects, or provide vague or manufactured (confabulated) responses when asked a question they do not recall. It should be noted that strong memories of what happened many years ago (*e.g.,* as a child, at a retirement party, when a grandchild was born) do not indicate that an individual has an intact memory. Historical memories such as these can remain reasonably intact well into the middle stages of dementia. Conversely (and more relevant in competence determinations), clients with moderate dementia may not recall what they ate for breakfast, whether they took blood pressure medication that day, or even a matter enthusiastically discussed with their attorney just 20 minutes ago.

Memory abilities are particularly important to attorneys because many legal standards and factor tests are largely determined by a person's ability to retain information. Consider testamentary capacity, discussed in §16.3 above. The law merely requires a testator to know the objects of his or her bounty, which is just an antiquated way of saying the testator must be able to remember his or her heirs and assets. Likewise, there must be witnesses to a will. These witnesses sign an attestation clause that effectively states that they see the testator sign in their presence and that the witnesses believe the testator to be of "sound mind and memory."

Notice, however, that the standard says nothing about what diagnoses a person should have or what specific tasks the person must be able to perform. In fact, the law does not directly equate the presence of a given disorder with the immediate presumption of incompetence. Rather, the key is whether, at the moment of execution, the individual knew his or her heirs, could recall what possessions he or she had, and was capable of expressing who should get them. As "levels" or thresholds are concerned, this standard is among the lowest. As tasks become more complex, such as writing checks, balancing budgets, and so forth, a more nuanced evaluation is required. That said, the likelihood of lacking capacity and not having a diagnosable condition is low.

D. [16.65] Executive Function Issues

Executive functioning refers to the ability to plan, organize, or sequence tasks in a logical order. It also relates to knowing when to start an action and when to stop that action. Terms closely related to executive functioning include all of the things our parents encouraged us to do — "think before you act," "good things come to those who wait," or "you might want to plan that out before you do it."

The part of the brain heavily involved in executive functions (the frontal lobes) also allows us to perform complex functions such as comparing and contrasting, weighing options, working methodically through problems, comprehending complex and abstract ideas, and understanding how the world around us works. Without the ability to reasonably foresee the outcome of certain decisions made now, it stands to reason that deficits in these areas impact an individual's ability to make complex decisions in his or her best interests.

E. [16.66] Visual-Spatial Function Issues

Visual-spatial functioning refers to an individual's ability to accurately perceive the relationship between physical objects in the real world. It also represents the individual's ability to imagine the same objects. For instance, individuals with good visual-spatial abilities may be able to fix a broken lawnmower or assemble a shelving unit because they can see how different parts relate to each other in their minds. However, individuals with poor visual-spatial abilities may get lost while driving, wander aimlessly in their attorney's office after using the restroom, have difficulty with depth perception, or forget where they placed objects around the house. It is less likely that deficits in this area will impair decisional capacity but certainly impact the client's safety and ability to function within the community.

F. [16.67] Motor Function Issues

Motor functioning refers to an individual's ability to manipulate small objects and generally use his or her hands and legs to perform larger tasks. Other commonly used terms for motor functioning include "dexterity," "coordination," "grace," "agility," or "nimbleness." Individuals with poor motor functioning often have difficulties with activities of daily living, such as buttoning a shirt, brushing teeth, walking, driving, or using cutlery. It is important to know that motor functioning does not solely impact the hands and legs but, in fact, impacts all muscles in the body. Therefore, individuals with motor dysfunction or movement disorders may have difficulty with expressive language because the muscles needed to form words are not getting signals to perform as well as they might.

In the context of the tendency to fall onto the floor, both motor functioning and difficulties with balance tend to exacerbate an elder's difficulties in this area. Making a formal determination of whether neurologic aspects of balance versus difficulties with controlling the muscles in the legs underlie that individual's tendency to fall can be difficult. However, the larger point for practitioners to keep in mind is that an elderly individual is both more likely to fall and more likely to be injured during that fall than he or she would have been five or ten years earlier. Additionally, the disorientation seen in delirium (see §16.49 above) tends to increase the frequency of falls.

G. [16.68] Higher-Level Thinking and Intellectual Issues

Intellectual functioning includes a person's knowledge base, ability to reason using language, ability to reason using pictures, and ability to hold onto information long enough to perform a simple mental process on it, as well as the speed at which the individual's mind can process information. Other terms that relate to intellectual functioning include "IQ," "intelligence," "being logical," "being smart," and "intellectual disability" (previously referred to as "mental retardation").

Intellectual functioning correlates highly with understanding the matter at hand and making well-reasoned decisions. It is also relevant to note that an individual who, at the age of 40, is within the borderline range of intellectual functioning (*i.e.,* not intellectually disabled but of lower intelligence) should be capable of making most legal decisions. However, as this person ages and experiences cognitive decline, his or her overall ability to understand abstract concepts will decline more quickly. Essentially, if this individual started out somewhat "behind the curve" and then experienced further brain changes, his or her overall abilities are likely to drop more rapidly than another individual who had strong abilities to begin with.

An individual's ability to assist his or her attorney meaningfully often comes down to the quality of his or her judgment and ability to understand complex ideas, reason through those ideas, and weigh multiple options. There is also a benefit to being able to plan, sequence, prioritize, and generally stay organized. These skills are important in managing paperwork and staying organized mentally (*i.e.,* staying clear and focused). This general spectrum of cognitive abilities is referred to clinically as "higher cognitive functioning." These kinds of deductive reasoning abilities and the ability to demonstrate complex forethought separate humans from other mammals in a cognitive sense.

Intelligence, or IQ, represents an individual's general knowledge base and ability to work flexibly to figure out new things. When someone is lacking in these areas (*i.e.,* suffering from an ID), there comes a point at which the complexity of the matter at hand exceeds the individual's ability to comprehend. Suppose somebody lacks higher-order reasoning abilities or general knowledge about how the world works. In that case, little can be done to bolster the individual's cognitive abilities to the point that he or she can understand. It remains useful to discuss a limited number of things in a very concrete fashion with individuals with ID. Still, if a client can understand only very concrete matters, he or she is unlikely to draw distinctions and weigh options about matters complex enough to come to the court's attention. See also §16.53 above.

Intelligence is measured using a variety of tests, with different assessments catering to specific domains of cognitive functioning. Among the most commonly utilized are the Wechsler Intelligence Scale for Children (WISC) and the Wechsler Adult Intelligence Scale (WAIS), which measure general intelligence and are particularly prevalent in educational and clinical settings. The Stanford-Binet Intelligence Scale (SBIS) is another widely recognized test for assessing cognitive abilities across different age groups.

Because individuals can have dramatically different verbal versus nonverbal intelligence, other tests have been designed to limit the language component inherent to the WISC, WAIS, and SBIS. For example, the Test of Nonverbal Intelligence (TONI) is noteworthy for assessing intellectual ability without relying on language. The Leiter International Performance Scale (Leiter-R) is another significant test that measures nonverbal intelligence, particularly among those with speech or language limitations. These tests are particularly important when evaluating individuals with language barriers, cultural differences, or specific disorders that may interfere with verbal communication.

H. [16.69] Calculation Ability Issues

Calculation ability is just what it sounds like — the ability to make mathematical calculations. It is more commonly assessed in the context of academic assessments of children with suspected learning disabilities, but the utility of assessing an examinee's ability to do math as one of the components of evaluating financial competence is clear. Voicing a preference for the distribution of wealth does not necessarily require much calculation ability, but functioning in the world does require some basic calculation ability. However, as our society moves toward lesser reliance on physical money, the risks of being unable to make change or balance one's checkbook are also becoming less of a factor in daily life.

I. [16.70] Cultural Factors

It is important to be aware of the implications of culture, ethnicity, and the client's primary language on the working relationship. These cultural factors often drive the level of comfort a client has with his or her attorney. At times, customs unfamiliar to the practitioner can look like some forms of cognitive or emotional dysfunction. Alternatively, cultural factors could mask the presence of real dysfunction.

The client's comfort directly relates to how open he or she can be with the attorney and determines how he or she works with the attorney. Thus, awareness of these cultural factors is in the practitioner's interest, not only out of respect for the clients served but also because how one relates to a client makes the entire process infinitely easier. There is no need to delve into an individual's cultural history to accommodate these factors. Still, it may make sense to reach out to a friend or colleague who shares the client's cultural background and ask about factors that might come into play or what culturally determined expectations the client may have of his or her attorney.

For example, members of some cultures tend to talk "around a point," from the perspective of the predominant culture in the United States. Alternately, other cultures have varying degrees of comfort with "confronting" someone in a position of authority, such as an attorney. While practitioners may justifiably feel, "you are paying me, so of course you have a right to push back," this may not be a belief shared by the client. In certain circumstances, these individuals may "go along with" something or seem to work at cross purposes to what previously was agreed on.

Also, the European-American value of looking someone straight in the eyes while talking may be seen as disrespectful in some cultures, so the failure to meet one's gaze should not be interpreted as a sign of dishonesty. Developing a wide-ranging understanding of all possible cultural pitfalls is clearly unreasonable. However, a simple openness to the idea that culture may impact how a client appears and interacts with his or her counsel goes a long way toward bridging this gap. The examples above are demonstrative and fail to encompass the myriad ways culture affects interactions. Generally, practitioners who reach out to a friend or colleague who shares a similar cultural background as the client will obtain a wealth of information on how to best serve the client's needs.

IX. [16.71] A BRIEF OVERVIEW OF NEUROIMAGING

With continued technological advancements, medical professionals have increasing access to diagnostic tools that show the brain in progressively greater detail. The ability of neuroimaging to identify the exact location within the brain a stroke occurred or the overall degree of brain atrophy (*i.e.,* shrinkage) of an individual suffering from Alzheimer's disease is unparalleled. However, as useful as neuroimaging is for treatment planning and diagnosis, it lacks the richness of information about day-to-day functioning and competency that neuropsychological evaluation can offer. Said another way, the most detailed 3-D image of the brain's structure does not speak to an individual's functional abilities to perform a given task. Practitioners certainly will see brain imaging referenced in the medical records of their clients. But it is certainly unfair to expect practitioners to have more than an understanding of the existence of these clinical tools.

The remainder of this section is intended as a reference for practitioners, who are forgiven if they choose not to read it word for word. The two essential ideas are as follows:

a. For the purpose of questions of competence, neuroimaging does not directly assess a person's functional abilities. The structure or interconnectivity of the brain relates to competence, but imaging is insufficient to determine day-to-day ability.

b. When many neuroimaging records directly bear on the question at hand, the practitioner would be well-served by retaining a neuroradiologist.

The first type of brain imaging is known as structural brain imaging, which can be thought of as measuring the shape of the brain or identifying areas where something atypical happened. The primary types of structural brain imaging include computed tomography scans (sometimes erroneously referred to by their older name, "CAT scans") and magnetic resonance imaging (MRI). These methods take a static picture of the shape of the brain and do a tremendous job of revealing a growing tumor, a bleed within the brain or surrounding tissues, stroke, vascular changes, and so on.

CT scans use X-rays to create a three-dimensional image of the brain within the skull. CT scanning is an inexpensive and quick method of brain imaging. MRI uses, among other things, the properties of the water in our bodies, which, when magnetized, allows special sensors to create a much more detailed, static picture of the brain than CT scanning can. Despite the differences in the level of detail, CT scanning is not inferior to MRI. Rather, the type of imaging ordered is based on which type is most likely to reveal the brain features of concern. Structural brain imaging makes up the vast majority of brain imaging utilized for medical purposes.

The second type of brain imaging, known as functional brain imaging, does not image the shape of the brain but rather measures the degree to which different areas within the brain are metabolically active (*i.e.,* how much work they are doing). In part because of the expense, functional imaging is used less frequently than structural imaging, so the legal practitioner is less likely to see these types of reports. However, because functional imaging is much more sensitive to "seeing" subtle changes that cannot be seen on an MRI or CT scan, they are particularly useful for substantiating brain injuries following accidents, for instance. This class of imaging includes

a. positron emission tomography (PET) scans;

b. single-photon emission computed tomography (SPECT) scans;

c. functional magnetic resonance imaging (fMRI);

d. diffusion tensor imaging (DTI) (a type of fMRI); and

e. quantitative electroencephalography (qEEG).

While their ability to show the physical shape of the brain is lower, they excel at showing how well different areas of the brain are working.

Functional brain imaging holds great promise in identifying diseases well before they become so severe that they change the brain enough to be noticed by the individual or structural imaging is likely to pick them up. Advances in this area of medicine allow clinicians to identify how an individual's "brain state" relates to his or her specific form of psychological or neurologic illness. This allows more tailored treatments to be provided. SPECT scans, PET scans, and especially qEEGs are being used in new and innovative ways to help identify which subtype of depression an individual suffers from. Once this kind of data is collected, clinicians have a much deeper understanding of why the patient is feeling the way he or she does and a much more biologically driven idea of how best to treat a given disorder.

The most common forms of functional imaging that the attorney is likely to see are PET and SPECT scans, both of which are closely related in terms of the underlying technology. They use special sensors to pick up trace amounts of radiation emitted from a fairly harmless radioactive tracer, or "radioligand," the examinee takes before scanning. Between SPECT scanning and PET scanning, the latter produces much more detailed images. However, fMRI and DTI produce the most staggeringly precise images — accompanied by a staggeringly high price tag.

A particularly good imaging modality for use in the courts is qEEG or "brain mapping." This imaging modality's efficacy is well supported in the literature and can shed light on various brain processes with great detail. It is also reasonably inexpensive and is becoming progressively more available. This diagnostic procedure readily shows how well one part of the brain communicates with others and how active different regions are. Generally, it has a great deal of sensitivity to subtler changes in brain function.

Not all brain abnormalities are revealed in all types of brain imaging. For example, it is not uncommon for nothing definitive to show up on a CT scan done when a patient is taken to the emergency department after a fall. Practitioners should not be surprised when clear areas of concern are revealed by an MRI ordered by a neurologist at a follow-up appointment. On the other hand, even with a high-quality MRI, there may be nothing of concern found, *i.e.,* an "unremarkable finding." However, with functional imaging such as PET scanning or qEEG, areas of concern that explain the patient's symptoms often emerge quickly. In short, attorneys must recognize that a "clean" CT scan does not necessarily mean there are no problems.

One useful aspect of imaging is gauging the degree of progression of a disease such as Alzheimer's disease. Alzheimer's disease also demonstrates a different pattern of brain atrophy than vascular dementia, making imaging useful for differential diagnosis. It is, however, entirely unclear from these images what a person can and cannot do in terms of activities of daily living or whether the individual is able, for example, to understand the implications of entering into a contract.

Clinicians are unlikely to make statements about a patient's capacity based on brain imaging and interview alone. While brain imaging tools do an excellent job of quantifying the structural integrity or levels of brain activity, they do not directly assess the day-to-day abilities of the person who owns that brain.

X. [16.72] RULES OF EVIDENCE AND ADMISSIBILITY

Effective January 1, 2011, Illinois largely adopted the Federal Rules of Evidence, though there are a few notable differences. Per Fed.R.Evid. 401, evidence is "relevant" if it has any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. It is within a trial judge's discretion to determine what is relevant. When dealing with complex scientific or medical evidence, all courts in Illinois must adhere to the rules. Probate courts tend to take a more relaxed view on admissibility, given the wide discretion granted to judges. However, a skilled attorney familiar with the Rules of Evidence can be a formidable opponent when questionable medical or scientific evidence is at issue.

A. [16.73] Applying the *Frye* Standard to Neuropsychological Evidence

Each jurisdiction has its own gauge for determining when scientific evidence is credible and should be admitted. Illinois applies the *Frye* standard from the decision in *Frye v. United States,* 293 F. 1013 (D.C. Cir. 1923), which requires that expert scientific evidence be based on "generally accepted" scientific principles. Under the *Frye* standard, "[a] court may determine the general acceptance of a scientific principle or methodology in either of two ways: (1) based on the results of a *Frye* hearing; or (2) by taking judicial notice of unequivocal and undisputed prior judicial decisions or technical writings on the subject." *People v. McKown,* 226 Ill.2d 245, 875 N.E.2d 1029, 1034, 314 Ill.Dec. 742 (2007). However, "[t]he application of the *Frye* standard is limited to scientific methodology that is considered 'new' or 'novel.' " 875 N.E.2d at 1036. Therefore, one seeking to challenge scientific evidence should be prepared to show that it is not settled as a generally accepted principle.

A major criticism of the *Frye* standard is that something could be widely accepted, despite having been largely discredited by the scientific community. By virtue of decisions like *McKown, supra,* the party seeking to challenge such evidence through a *Frye* hearing will have the burden of showing that the evidence is no longer settled or accepted. This often puts the court in a difficult position. Further, what does "generally accepted" mean? What degree of acceptance or percentage of the relevant scientific community must agree before something is considered credible?

In states that have adopted the newer *Daubert* approach, there is a greater emphasis on validation and measurability. *See Daubert v. Merrell Dow Pharmaceuticals, Inc.,* 509 U.S. 579, 125 L.Ed.2d 469, 113 S.Ct. 2786 (1993). In *Daubert,* the U.S. Supreme Court found that the Federal Rules of Evidence expressly overturned *Frye.* The Court held that the Federal Rules of Evidence supplanted this standard of "general acceptance" in 1975. In particular, Fed.R.Evid. 702 reads:

> **If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.** 113 S.Ct. at 2794, quoting Fed.R.Evid. 702.

The *Daubert* Court even went as far as to express that "[n]othing in the text of [Fed.R.Evid. 702] establishes 'general acceptance' as an absolute prerequisite to admissibility." *Id.* Given Illinois' adoption of the Federal Rules of Evidence, there is a strong possibility that, eventually, Illinois will adopt the *Daubert* standard or some limited variation thereof. Until that day, Illinois appellate courts sometimes find themselves relying on bits and pieces of *Daubert* to identify the best available evidence. Consider the following discussion from Illinois' Fourth District:

> **Although Illinois has not adopted the *Daubert* standard for admission of scientific opinion testimony, the Supreme Court's discussion regarding what constitutes "scientific knowledge" can still inform our analysis of what constitutes scientific opinion testimony. In *Daubert,* the Court noted that the words "scientific" and "knowledge," respectively, imply "a grounding in the methods and procedures of science" and "more than subjective belief or unsupported speculation." The Court added that to qualify as " 'scientific knowledge,' an inference or assertion must be derived by the scientific method." [***Daubert, supra,*** 113 S.Ct. at 2795.**] Thus, in short, "a scientific expert is an expert who relies on the application of scientific principles, rather than on skill or experience-based observations, for the basis of his opinion." *Carmichael v. Samyang Tire Inc.,* 131 F.3d 1433, 1435 (11th Cir. 1997).** *Harris v. Cropmate Co.,* 302 Ill.App.3d 364, 706 N.E.2d 55, 60 – 61, 235 Ill.Dec. 795 (4th Dist. 1999).

Of distinct importance, Illinois courts applying the *Frye* standard have still specifically required that evidence be based on valid and measurable scientific principles rather than "experience-based observations." *Id.* When considering the quantity of information physicians often have access to when signing a physician report in guardianship proceedings, it raises questions about whether such evidence should even be regarded as meeting either the *Frye* or *Daubert* standards. Nevertheless, Illinois retains the *Frye* test for expert opinion evidence.

Therefore, guardianship, probate, and even personal injury attorneys seeking to admit neuropsychological evidence should confer with their retained experts to identify prevailing literature, measurements, and tests that are generally accepted within the field. When an attorney questions whether an expert is using measurements and tests for a generally accepted purpose, it may form the basis for an initial objection to that expert's reports or testimony. When a physician, nurse practitioner, or even psychiatrist is called to testify regarding the degree of capacity or cognitive decline, the cautious attorney may do well to consider moving for a *Frye* hearing to test what scientific measures were used to reach the conclusion proffered.

B. [16.74] Foundations and Authentication

Even the most impressive experts are useless if testimony or reports are not admitted into evidence. Although the Federal Rules of Evidence are often relaxed in probate and guardianship proceedings, counsel should be careful to prepare for challenges to admission. Attorneys in guardianship practice often present physician and neuropsychological reports directly to the judge and begin arguing about the contents. While some judges may permit this loose and informal manner of introducing a respondent's mental competence, the proper way to admit an item into evidence is to first lay a foundation.

This chapter is not intended to offer a comprehensive guide to evidence, as a number of fine resources serve that function. See, *e.g.,* Richard L. Miller II, LAYING FOUNDATIONS FOR INTRODUCING EVIDENCE (IICLE®, 2022). The steps are generally as follows:

1. Mark exhibit for identification.

2. Describe the exhibit.

3. Show the exhibit to opposing counsel.

4. Provide the court with a copy.

5. Lay the foundation:

    a. What is the document?

    b. Have you seen it before?

    c. Can you explain how you prepared it?

    d. What is the purpose of this report?

    e. Did you speak with [the party] in preparing the report?

6. Authenticate:

    a. Is the exhibit complete?

    b. Is it a true and accurate copy or representation?

In bench trials, guardianship hearings, and other proceedings, most of which occur in front of a judge only, this completes the process because the judge can now consider the evidence in his or her findings. In a jury trial, however, the evidence must also be published to the jury. In either case, once the proper foundation has been laid, the witness may be questioned in more detail about the evidence.

The two biggest problems for attorneys seeking to admit neuropsychologists' reports are laying a foundation and failing to authenticate the report properly. Even in relaxed proceedings, as long as the Rules of Evidence apply, attorneys ought to be mindful of the requirement that a document cannot speak alone. In most cases, except when otherwise stipulated, there will need to be a human witness who can testify to the document. This credible witness can verify that the document is a true and accurate copy, replication, or representation of what it is intended to prove.

For instance, if one is seeking to introduce a neuropsychological report that says an alleged adult with a disability lacks decision-making capacity for financial matters, the author of the document should be called to testify. If opposing counsel attempts to introduce a document without authentication or foundation, consider whether it makes sense to require the proponent to produce a witness to do so.

XI. [16.75] ETHICAL TIPS RELATING TO DIMINISHED CAPACITY

Issues involving cognitive impairment are a concern throughout elder law practice. They are also increasingly seen in divorce proceedings involving older couples, injury cases involving head traumas and concussions, and even licensure disputes involving older professionals whose abilities to perform their jobs may be limited because of cognitive decline.

As fiduciary disputes and estate contests become more prevalent, the careful practitioner will do well to maintain awareness of issues involving diminished capacity. For instance, an attorney may become aware of potential issues with a client's ability to execute estate planning documents because the client repeatedly has difficulty recalling the names of family members or cannot recall which bank he or she uses. In such a situation, the careful and ethical practitioner should consider advising the client to undergo a consultation with a neuropsychologist before completing the estate planning. This protects not only the client but also the attorney from potential liability.

Rule 1.14(a) of the Illinois Rules of Professional Conduct of 2010 (RPC) states that "[w]hen a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client." However, "[w]hen the lawyer reasonably believes that the client has diminished capacity . . . and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including . . . seeking the appointment of a guardian ad litem, conservator or guardian." RPC 1.14(b).

Therefore, if a client retains the services of an attorney and that attorney begins to suspect declining mental capacity, not only is it responsible for the lawyer to request an assessment, but in many ways, any continued representation may require it. After all, if the threshold question is whether the attorney "reasonably believes" the client cannot act in his or her own interests, then there must be a way to verify how the attorney reached that conclusion. In other words, how can you reasonably believe your client is incompetent? What legitimate scientific or objective steps have you taken to qualify that determination? Unless the attorney is also trained to perform such an evaluation, an argument could be made that the attorney is bound to seek such an informed determination before proceeding.

Likewise, concerned family members may contact an attorney about obtaining guardianship over an elderly loved one. Sometimes these relatives will arrive at appointments without the loved one, or if the person is present, the relative may answer all questions or attempt to lead all discussions. Often, the elderly client may direct the attorney to just do whatever the younger relative directs or may avoid providing answers directly to the attorney. These may be genuine signs of love, affection, and warranted trust among family. However, in many cases, they are warning signs that the elderly person has become dependent on others because of failing memory or difficulty making decisions. Worse, they can be signs of undue influence, neglect, or even outright financial exploitation. It is often challenging to differentiate which of these three scenarios is most prominent in each individual case.

Questions of capacity can come up even after a person dies. The key issue in many will and trust contests is whether the decedent had proper testamentary capacity at the time of executing estate planning instruments. Unfortunately, most of these cases involve the decedent's capacity at a time in the past, possibly even decades prior to litigation. This can make reliable analysis of the person's past mental capacity very difficult. Nevertheless, a qualified expert may be able to reconstruct a picture of a person's mental capacity based on medical records, interviews with relatives, and mental health treatment records, provided sufficient information is available.

The credibility and value of testimony vary widely depending on the age of the information, the amount and quality of past medical records, and corroboration from former treating professionals. In each situation, a consultation with an experienced neuropsychologist can be essential to proving one's case.

Sections 16.76 – 16.78 below should serve as a simple guide for some of the key warning signs that could get an attorney in trouble ethically if not dealt with in a timely fashion.

A. [16.76] Red Flags Suggesting the Need for Further Evaluation

Despite having no formal training in diagnosing individuals with cognitive or emotional symptoms, attorneys are typically in a good position to recognize when their clients should be referred for evaluation. This is because attorneys often conduct the same discussion with many clients and cover the same questions and information. Having similar conversations with multiple clients gives attorneys a good baseline of what level of comprehension and participation can be expected. Often, just recognizing that a client's thinking is atypical in some way is more than sufficient to initiate a conversation with a professional about whether it makes sense to assess the client's capacity.

One should also never forget to listen to "gut" instincts. Initial impressions and unsettling feelings can be a healthy starting place for avoiding ethical concerns. It does not matter if four different physician reports all say an individual is competent. Counsel's experience and intuition should not be underestimated. The reality is that most attorneys spend far more time with their clients than most physicians do, which puts them in an excellent position to pick up on things others may have missed. If in doubt, make a quick phone call to a neuropsychologist or other qualified professional and bounce observations and gut reactions off him or her to see if it makes sense to request a formal evaluation. It would be a mistake for the practitioner to diagnose or exercise clinical judgment. Ultimately, the practitioner is the one taking the risk if he or she proceeds to represent an incompetent party.

B. [16.77] Practical Tips and Resources for Dealing with Diminished Capacity

The American Bar Association (ABA) has terrific resources concerning capacity assessment for legal practitioners. These are frequently updated and can provide excellent information and updates on issues involving diminished capacity on a national level. See ABA, *Adult Capacity and Assessment,* www.americanbar.org/groups/law_aging/resources/capacity_assessment.

There are many behaviors that cognitively impaired people may exhibit. Here are a few examples:

1. In conversation, responses to questions may be vague or dance around the point.

2. A cognitively impaired person might use indefinite statements or vacillate between seemingly disparate responses.

3. When presented with a question, the cognitively impaired client may arrive at different conclusions on different days.

4. Your client may be lucid and coherent during one interaction yet incapable of rational conversation during another meeting.

5. Your client may have bizarre or paranoid beliefs about others that do not change when presented with information proving the contrary.

Often, an individual who does not have the information being requested may feel as though he or she ought to know. In responding to the request, the individual may pretend to know or seem to make something up to avoid or deflect the question entirely. This process of seeming to "make up" a logical response is referred to clinically as "confabulation" and should not be mistaken for lying. It is a process whereby, among other things, an individual can save face by providing reasonably logical, though generally incorrect, information.

Another phenomenon involves the individual with diminished capacity looking to others for answers. In some situations, it will be rather clear cut, such as when a client looks at one of his or her children to provide the answer. Other situations are less clear cut, such as when one spouse, who is more cognitively intact, has grown accustomed to unconsciously "filling in the gaps" for his or her spouse. At other times, the more intact spouse may be able to predict what his or her loved one is about to say and preemptively finish the other's sentences without prompting. Scenarios like these are common in most marriages and are not necessarily cause for concern. However, further assessment may be warranted when they become frequent enough that the practitioner wonders what the client's position is or notices that a loved one is doing the bulk of the speaking.

An individual whose mental abilities have declined to the point at which questions emerge concerning competence is likely to experience problems in other parts of his or her life. For instance, when the practitioner is working with a client with financial limitations, it is usually safe to assume that the same cognitive decline affecting his or her fiduciary duties may affect other areas

of the person's life. Because of the more generalized impact of cognitive decline on activities of daily living, looking at other areas of that person's functioning may provide good cues to the attorney about the questions at hand. Outwardly visible signs of the individual's decreased functioning may include

1. a generally disheveled appearance;

2. a lack of hygiene;

3. a misunderstanding of his or her medical issues;

4. difficulty remembering to pay bills; and

5. getting lost on the way to the practitioner's office, even after visiting numerous times.

If there is one tip the authors can share that will be of perhaps the most use, it would be to slow down and use your own faculties to observe the individual. Whether it is a client, a litigant, or an adult with a potential disability in a court proceeding, the most important thing an attorney can do is to observe first and speak next.

Using expressions like, "I'd like to know if I was clear when I explained that. Would you please repeat back to me what I just said?" is hard to beat in assessing a client's level of understanding and ensuring that practitioners express themselves clearly. Given the requirements of RPC 1.14, attorneys may find it useful to create a quick reference tool like the one in §16.111 below or some other client assessment tool to help direct their thinking about whether a potential client has the requisite capacity to engage their services.

C. [16.78] Attorneys with Diminished Capacity

For a profession that is always looking out for others, attorneys are notoriously poor about watching out for their own mental and physical health concerns. On April 11, 2014, the American Bar Association's Commission on Lawyer Assistance Programs (CoLAP) released its Working Paper on Cognitive Impairment and Cognitive Decline (Working Paper), www.americanbar.org/content/dam/aba/administrative/lawyer_assistance/ls_colap_working_paper_on_cognitive_imp.authcheckdam.pdf. Recognizing that an increasing number of attorneys are practicing well into their later years, even past the point at which they may be experiencing cognitive decline themselves, the Working Paper provides Lawyer Assistance Programs with a sample worksheet to help identify attorneys who may be suffering from diminished capacity. In fact, the Working Paper even provides suggestions on how one attorney might speak to another attorney about potential declining abilities.

For attorneys who believe a fellow member of the bar may be showing signs of declining cognitive abilities, it can be a challenging and sensitive matter. No one enjoys the thought of challenging a colleague's ability to do a job effectively. Still, there may be ethical implications for attorneys who know of a problem and fail to report it. This can indeed create a difficult ethical quandary.

The ABA Committee on Ethics and Professional Responsibility offers some guidance. "Impaired lawyers have the same obligations under the Model Rules as other lawyers. Simply stated, mental impairment does not lessen a lawyer's obligation to provide clients with competent representation." ABA Comm. on Ethics & Prof'l Responsibility, Formal Op. 03-429 (June 11, 2003). Therefore, an attorney is not relieved of ethical and competency duties just because his or her mental capacity is waning. The opinion also finds, however, that "partners in the firm and lawyers with comparable managerial authority in professional corporations, legal departments, and other organizations deemed to be a law firm make 'reasonable efforts' to establish internal policies and procedures designed to provide 'reasonable assurance' that all lawyers in the firm, not just lawyers known to be impaired, fulfill the requirements of the Model Rules." *Id.*

The ABA Committee on Ethics and Professional Responsibility has also found that

> **a lawyer who believes that another lawyer's known violations of disciplinary rules raise substantial questions about her fitness to practice must report those violations to the appropriate professional authority. A lawyer who believes that another lawyer's mental condition materially impairs her ability to represent clients and who knows that that lawyer continues to do so, must report that lawyer's consequent violation of Rule 1.16(a)(2), which requires that she withdraw from the representation of clients.** ABA Comm. on Ethics & Prof'l Responsibility, Formal Op. 03-431 (Aug. 8, 2003).

For further reading on the subject of attorney cognitive decline, see the ABA's webpage concerning Intervention and Impairment Assistance, www.americanbar.org/groups/professional_responsibility/resources/lawyersintransition/interventionandimpairmentassistance.

XII. [16.79] WORKING WITH NEUROPSYCHOLOGISTS

The legal system has discovered the probative value of neuropsychological evaluations, and this increased reliance on neuropsychologists within the courts is driving up demand within a group of properly trained clinicians that is not expanding at nearly the same rate. The first step in selecting a neuropsychologist is to check credentials and ensure that the individual's background, training, and experience are consistent with the questions he or she will be asked to address. If no colleague can refer a good neuropsychologist directly, a good first step is to request the potential neuropsychologist's curriculum vitae. The most widely accepted definition of the training one needs to undergo to consider oneself a neuropsychologist comes from what is referred to as the Houston Conference Guidelines. See H. Julia Hannay et al., *Proceedings of the Houston Conference on Specialty Education and Training in Clinical Neuropsychology,* 13 Archives of Clinical Neuropsychology 157 (Special Issue 1998).

The main information from the Houston Conference Guidelines is whether the individual completed a two-year postdoctoral residency in clinical neuropsychology supervised by an established clinical neuropsychologist. Please note that the State of Illinois does not presently regulate the designation of "Neuropsychologist," though Illinois does license the designation "Clinical Psychologist." As a result, there is no legal prohibition on any licensed clinical psychologist advertising himself or herself as a neuropsychologist, even without meeting the Houston Conference Guidelines definition.

Moreover, the neuropsychologist's specialization(s), undergraduate education, and master's degree should be considered. Specialization in either forensic psychology or neuropsychology is a good sign that someone has additional specialized experience doing the kinds of evaluation that counsel requests. Additionally, obtaining a master's degree in forensic psychology before pursuing a doctoral degree is a good indicator of appropriateness as well. However, it should be noted that master's degree programs in forensic psychology have not existed very long, and this should not be used to rule out a good candidate.

The settings in which the neuropsychologist has trained and practiced should also be considered. Much like evidence of an attorney's early judicial clerkship for an appellate court may strongly suggest he or she would be a competent appellate advocate, clinical practice settings that allow the neuropsychologist the opportunity to perform substantive forensic neuropsychological evaluations early in his or her career is preferable.

Finally, while board certification for physicians is commonplace, it is much less common among psychologists and neuropsychologists. The most recent numbers reveal approximately four percent of licensed clinical psychologists have pursued board certification. The largest proportion of those who have pursued board certification have done so in clinical psychology. However, while more and more clinical neuropsychologists and forensic psychologists are also pursuing board certification, this potentially beneficial additional step cannot be expected in the same manner it is for consulting physicians.

A. [16.80] What Type of Expert?

When deciding to "refer" a patient to a neuropsychologist for evaluation, it is important to establish early on whether the clinician will be serving as purely a treating provider under Illinois Supreme Court Rule 213(f)(2) or a retained and controlled expert under S.Ct. Rule 213(f)(3). The distinction cannot be overstated. An expert who merely treats an injury has a different relationship, both legally and in terms of credibility in these types of cases. Importantly, there are several ways that a neuropsychologist can get involved in the case. The distinctions may have a great impact on payment and scope of care.

First, if the primary purpose of the evaluation is to establish care, provide diagnostic clarification or help plan treatment for the patient, this would be considered "medically necessary." In these instances, commercial insurance or Medicare is a viable payment option. If, on the other hand, the primary questions to be addressed involve those before the court, this is unlikely to be considered "medically necessary." The reader can clearly see where there will be overlap between these categories, but in general, if an attorney requests an evaluation that includes an ostensibly clinical question, it is not practical to suggest health insurance be billed. This is discussed further in §16.103 below.

Next, the attorney may accept a new client who has been seeing a neuropsychologist for care. This is a much clearer example of a treating professional under Rule 213(f)(2). On the other hand, sometimes an attorney will choose to consult with a neuropsychologist confidentially, simply to self-educate and prepare for a case. These types of consulting experts are generally not discoverable and are allowed to remain confidential.

Finally, there are times when an attorney will retain a neuropsychologist to testify in court. This person's identity must be disclosed per Rule 213(f)(3). A witness who is retained to be a testifying expert generally will not render direct care. Rather, he or she is solely reserved for the purpose of explanatory expertise.

B. [16.81] Engaging a Neuropsychologist

Once a qualified neuropsychologist has been identified, it should be kept in mind that clinicians appreciate clear direction from their referral sources about what questions need to be answered. The batteries of tests that neuropsychologists administer are very flexible and can be used to shed light on a vast number of concerns. Providing a clear list of questions to be addressed in the evaluation allows the neuropsychologist to structure the process surrounding addressing the nuances of these questions.

The attorney will want to phone the neuropsychologist before making the referral to see if it is an appropriate fit. This discussion should reference the attorney's observations about the client, medical information that bears on the question (if available), concerns the family has mentioned, and so on. It is also important that the neuropsychologist is briefed on the legal issue to have a good sense of the complexity of the decisions that the individual will be required to make. Providing the relevant statutes and caselaw is also important. Evaluators who work in this arena regularly are likely familiar with most of the relevant law, but the practitioner must ultimately ensure this. It also makes sense to mention the idea of having a phone conversation following the receipt of the completed report to explain anything that is less than clear.

Matters relating to payment also need to be discussed. Some neuropsychologists require an advance retainer, and a minority may be comfortable submitting a bill to the estate. In the latter circumstance, it is important that the appropriate court order is obtained before formally engaging the expert's services and that the expert is identified, by name, in the court order. Even fewer evaluators will be open to billing commercial medical insurance to assess a legal matter, as was described in §16.103 below.

One of the best ways to determine any examiner's skills in answering questions for the courts is to discuss key terms, legal decisions, court decisions, orders, statutes, regulations, element tests, or similar legal theories that would clarify the specific standards to be applied. Neuropsychological batteries may be adapted to use specific questions or tests to elicit the information contemplated by the components of relevant statutes or case decisions. At times, this same battery of tests, interviews, etc., can address legal questions that evolve with time. Still, it is preferable to pose all relevant questions to the neuropsychologist at the outset. During this kind of conversation, either the attorney or examiner will likely conclude whether this is a viable process to continue.

It is good practice to follow up on these initial phone calls with a brief letter outlining matters discussed and the particular questions that must be addressed. The neuropsychologist likely took notes during the phone call as well. Still, because of the differences between questions that are relevant to a neuropsychologist and questions that are legally relevant, it makes sense to reiterate exactly what needs to be addressed.

C. [16.82] Preparing the Client for Neuropsychological Testing

No responsible litigator would allow his or her client to walk into a deposition unprepared. Likewise, it is worthwhile for attorneys to take time to prepare their clients for evaluation. While a neuropsychological evaluation is not an adversarial proceeding like a deposition, the evaluation can have sweeping consequences. This is especially so when large estates are on the line or careers and reputations are at stake. Always remember that the evaluation could reveal that a previously high-performing and successful individual with decades of achievements is legally incompetent, information that may become available in public court filings. Therefore, take time to explain the process to the individual in advance.

The existence of validity indicators (see §16.40 above), as well as the myriad other methods neuropsychologists use to detect inconsistent or insufficient levels of effort, should serve as a reminder to the attorney and client that the process is a scientific determination and not something to attempt to "game."

There is a real benefit to emphasizing to the client the importance of exerting his or her best effort in the process and being open and honest during the interview and testing. All too often, individuals may be simply nervous about the possibility that the examiner may discover something minor that reflects poorly on him or her. At times, this causes examinees to answer a questionnaire, for instance, with the intent of appearing to be free of even the kinds of flaws to which most people readily admit. The result can be that someone with only minimal emotional difficulties will appear dishonest or "covering up" something. This, ultimately, can blow up in the examinee's and attorney's faces because there is a report in existence that seriously discredits their position.

Neither the pattern of presenting an overly positive image of oneself nor putting insufficient effort into testing necessarily renders the evaluation invalid. In fact, some level of bias in how examinees approach testing is normal. However, when an examinee approaches testing this way, it complicates the testing and report-writing process. It also has the potential to reflect poorly on the examinee.

D. Understanding the Neuropsychologist's Evaluation

1. [16.83] Organization of Neuropsychological Evaluations

Neuropsychological reports vary in terms of length, comprehensiveness, quality, and the degree to which they are understandable by non-clinicians. There also will be some degree of uniformity in terms of the general sections included or the areas assessed.

Most good neuropsychological reports are fairly accessible by the non-clinician who takes the time to read them, recognize what the individual parts represent, do a little bit of research, and ultimately obtain a brief consultation from the neuropsychologist for the remaining unanswered questions. Even in the best of cases, however, the level of complexity of the clinical constructs at hand challenges the neuropsychologist's ability to explain his or her conclusions clearly. Alternatively, the neuropsychologist may have preconceived notions about what the reader already knows, which can limit the report's clarity. This latter scenario necessitates a consultation with either the original neuropsychologist who performed the evaluation or a consultant to ensure the attorney has a good working understanding of the report to call into question its weaknesses.

Unfortunately, some neuropsychological evaluations are poorly written, are too brief, or rely too much on technical jargon. Additionally, it is not always going to be clear to legal practitioners whether a specific legal construct has been addressed, and if it has been, the wording of the conclusions may be unnecessarily vague. In such situations, having a consultant review the report and advise you on his or her understanding of its conclusions, strengths, and weaknesses may be advisable. Often, the origins of this problem are what is expected within the general medical community versus what the legal community would prefer. Most of those brief, jargon-y reports are comprehensible by other referring providers and adequately answer the clinical questions posed.

2. [16.84] How Test Performances Are Described

Understanding neuropsychological test performance descriptors is essential for practitioners engaging with neuropsychological evaluations. This section describes the meanings of many terms that practitioners will encounter in the body and the data table of the report.

Neuropsychologists utilize various scores such as T-Scores, Z-Scores, Standard Scores, Scaled Scores, and the like. Because percentiles are statistics most familiar to the general public, this description will focus on percentile ranges. A percentile "rank" conveys the relative standing of an individual's performance compared to a normative sample (*i.e.,* a reference group of typically functioning individuals). For instance, the 50th percentile signifies an average performance, whereas the 95th percentile places an individual in the top 5 percent of the population. Significantly, practitioners should understand that single test performance rarely carries significant meaning. The neuropsychologist's main task during test interpretation is identifying patterns that align with known diagnoses and impairments in daily life. Understanding the process of pattern matching to differentiate between various disorders is well beyond the scope of this chapter. Interested readers are referred to Muriel D. Lezak et al., NEUROPSYCHOLOGICAL ASSESSMENT (5th ed. 2012).

"Nominative descriptors" are more than labels; they transform numerical scores into meaningful categories reflecting human cognition's complexity. Spanning from "Grossly Impaired" to "Very Superior," these categories narrate an individual's cognitive abilities and challenges. They provide a shorthand for understanding ability.

Grasping these descriptors is like learning the syntax of a specialized language. Each term carries connotations and fits into a broader context, contributing to a comprehensive interpretation. See below for the precise definitions, percentile equivalents, and practical applications of these terms. In brief, understanding these nominative descriptors — and the categories of cognitive performance they denote — can significantly demystify a report or a consultation with a controlled expert. Percentile ranges are summarized from Esther Strauss et al., A COMPENDIUM OF NEUROPSYCHOLOGICAL TESTS: ADMINISTRATION, NORMS, AND COMMENTARY (3d ed. 2006).

Nominative descriptors are intended to denote discrete ranges of ability. The order of descriptors below represents a continuum from what might be colloquially described as exceptionally strong on one end to being so limited in ability that the individual is unable to function on the other end. The following are the terms attorneys are most likely to see:

a. "Very Superior" performance reflects a range above the 97th percentile, indicating outstanding cognitive abilities.

b. "Superior" ranges from the 91st to 97th percentile, denoting above-average functions.

c. "High Average" falls within the 75th to 90th percentile, representing slightly above-average abilities.

d. "Average" typically falls within the 25th to 75th percentile, the expected cognitive norm. This is a normal, healthy, typical area of ability that the majority of people fall into relative to their same-aged peers.

e. "Low Average" is usually between the 17th and 24th percentile, slightly below average.

f. "Borderline" refers to the 6th to 16th percentile range, potentially indicative of difficulties but not impairment.

g. "Impaired" generally falls in the 3rd to 5th percentile range, suggesting significant difficulties.

h. "Grossly Impaired" (or "Markedly Impaired") falls below the 3rd percentile, indicating severe dysfunction.

Practitioners may also encounter terms unconnected to measured ability that relates to another aspect of test administration:

a. "Invalid" does not correlate to a percentile range, referring instead to compromised results. This term may be seen in instances including when a test is administered incorrectly, when an interruption broke the examinee's focus during testing, or when an examinee exerted insufficient effort for the resulting data to be accurate.

b. "Valid" indicates that test results accurately reflect cognitive abilities without a specific percentile alignment. It may simply mean that the results of a test of effort suggest the examinee exerted sufficient effort that other concurrently administered tests can be considered valid.

c. "Not Administered" (or "N/A") denotes a test was not conducted, thus lacking a percentile equivalent.

3. [16.85] Components of an Evaluation

Regardless of whether you are working with a clear document or one of questionable value, a good place for practitioners to start involves a rudimentary understanding of the individual components of a typical neuropsychological evaluation. In the service of this, the following descriptions of the common sections are provided:

Referral information. This section is devoted to the reasons the referral came about and commonly gives a brief synopsis of the concerns assessed for.

Informed consent for evaluation. In contrast to a clinical neuropsychological evaluation, a forensic neuropsychological evaluation generally includes information related to the patient consenting for evaluation and the limits of confidentiality. This section generally outlines what was explained and any relevant responses made by the examinee. It should be noted that when competence is being evaluated, the neuropsychologist is obligated to explain the methods and procedures that will be used as well as any risks or benefits to the patient but is not specifically required by either Illinois law (see 740 ILCS 110/3(c)) or the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct, www.apa.org/ethics/code, to disclose that the evaluation is being performed to assess that individual's competence. Specifically, Standard 9.03(a)(3) of the Psychologist's Code of Conduct states that consent is implied when "one purpose of the testing is to evaluate decisional capacity."

Legal background. This section is self-explanatory. It provides a brief background of the legal matter at hand and demonstrates that the neuropsychologist was reasonably aware of the legal rationale for the individual being evaluated.

Background information. This section reviews the course of the present illness and other medical history. It includes information on the individual's subjectively reported cognitive functioning, psychological functioning, social functioning, and historical educational attainment. A review of the available medical records may appear here or in a separate section. In the well-written neuropsychological evaluation, all reportable symptoms that ultimately meet the criteria for the diagnoses rendered will be present in this section. Practitioners may want to consult §16.71 above for a brief overview of the brain imaging modalities referenced in this section.

Behavioral observations. This section includes information about the individual's appearance and demeanor during testing and a statement about issues impacting the validity of the data collected (other than specific tests of validity).

Tests administered. Somewhere in the evaluation, a list of tests administered to the individual should be provided. Some clinicians choose to include this list in the body of the evaluation, and some prefer to provide a table at the end of the report that includes the names of the tests administered, the scores, and the performance ranges the scores fall into.

Summary of test results. For ease of understanding, the same information provided in the table of tests administered is also provided in prose form in this section. This section brings to life what those individual tests measure and what the scores mean. For non-clinicians, reading this section often will be the most challenging part. Practitioners may want to reference §16.110 below, a glossary of medical and neuropsychological terminology commonly used in these evaluations.

Conclusions, summary, or impressions. In this section, practitioners will find a summary of the testing data, interview information, and medical information thought to be most relevant to the ultimate conclusions and diagnoses drawn. This section generally includes the neuropsychologist's rationale for his or her conclusions and how the patient meets the criteria for a given diagnosis. This section also may reference competing diagnoses that were ruled out. Some forensic neuropsychologists prefer separate sections addressing clinical conclusions and conclusions about legal matters, but this is variable.

Diagnosis. This section is self-explanatory. However, diagnoses themselves can be confusing. In part, this is because two diagnostic systems may be used:

a. the American Psychiatric Association's DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, TEXT REVISION (5th ed. 2023); and

b. the World Health Organization's INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS (ICD-10) (10th ed. 2016), commonly referred to as the ICD-10 or, more simply, ICD.

One or more diagnoses may be made in this section, and these diagnoses will always include an alphanumeric code and a prose description. ICD and DSM codes overlap a great deal, though the names of the specific diagnoses may differ subtly or significantly between the two diagnostic systems. For example, an individual who had a stroke causing significant cognitive disability but not behavioral changes (*e.g.,* aggression) might be diagnosed according to ICD-10 convention as "F01.50. Vascular Dementia, without behavioral disturbance." This same individual would be diagnosed using the DSM-5-TR system as "F01.50. Major Neurocognitive Disorder, due to Vascular Disease, without behavioral disturbance." In this instance, the diagnosis code remained the same, but the name of the disorder changed. The best bet is to search for the alphanumeric diagnosis code in both DSM and ICD databases if there is confusion. Additionally, a limited number of diagnoses are included in one system but not the other. Brief descriptions of diagnoses that will commonly come to the attention of legal practitioners can be found in §§16.43 – 16.60 above. Still, there are obvious benefits to returning to the original source to obtain a comprehensive understanding of a given disorder.

Recommendations. In clinical neuropsychological evaluations, the recommendation section will focus on strategies to help the patient utilize his or her remaining strengths to help make up for any weaknesses. Clinical recommendations sections also commonly include a list of additional services (*e.g.,* seeing a psychiatrist, obtaining speech therapy, seeking assisted living) that would be beneficial. In short, recommendations from clinical evaluations will center on how the patient or his or her family can improve the patient's global functioning. In forensic evaluations, recommendations may be more limited and focus on services to help improve the concerns that originally came before the court. These forensically oriented recommendations may include many of the above but are less focused on improving global functioning and more centered on managing forensic concerns. Additionally, recommendations can be offered to help the attorney mitigate some of the cognitive limitations experienced by the client if the client is ultimately thought to be marginally competent. Lastly, some neuropsychologists will recommend the need for guardianship or respond to the court's questions in the recommendations section rather than in the aforementioned conclusions section.

4. [16.86] Credibility of the Evaluation

The presentation or discrediting of opinions provided in a neuropsychological evaluation is a multifaceted process. It requires a keen understanding of both legal principles and neuropsychological practices. While a clinician's evaluation may provide valuable insights, the attorney must critically assess whether these insights directly relate to the legal questions of the

case. This involves a nuanced consideration of the relevance, methodology, and limitations of the neuropsychological evaluation, highlighting the intricate interplay between law and psychology in the assessment of elder competence. The discussion in §§16.87 – 16.92 below is intended to orient practitioners to some common factors; the number of possibilities for how a report can be supported or discredited is vast. Armed with this primer, practitioners are well-advised to retain their own consulting expert to help explain the intricacies of what is valid and invalid about a given report.

a. [16.87] Was the Evaluation Clinical or Forensic in Nature?

Identifying the original purpose of the evaluation is paramount. Clinical evaluations are designed to answer medical questions and guide treatment and are rarely tailored to answer legal questions. In a forensic evaluation, the examiner would take a different approach and employ different processes and tests to appropriately address the court's concerns. Rather than one being better or worse, it is a matter of apples versus oranges. A clinician who performed a clinical evaluation may be reluctant to opine on matters he or she did not assess for. An attorney might challenge a clinical evaluation's relevance in court, while a forensic assessment would typically be more legally defensible.

b. [16.88] Was the Clinician Aware That Questions of Competence Were Before the Court?

If the clinician was unaware of the legal questions surrounding competence during evaluation, his or her assessment would be unlikely to consider those issues. When a patient is referred by another medical professional for an evaluation, there generally is a "referral question." Meeting the standard of care entails focusing on those questions and, from a practical standpoint, cannot be so wide-ranging that it can be applied ex post facto to answer all other questions.

Sometimes the findings of a clinical evaluation demonstrate such a level of impairment that the clinician could comfortably opine on a topic he or she had not directly assessed. More times than not, however, complex questions about a person with that level of impairment would not be contested.

In short, if the original intent of the evaluation was such that it did not consider the matters the expert later opines on, the foundation of the expert's opinion can be attacked, casting doubt on the validity of the opinion. Conversely, practitioners may seek to show how the neuropsychological findings indirectly inform the legal matters at hand.

c. [16.89] How Much Time Was Devoted to the Evaluation?

The thoroughness of any evaluation can greatly affect its credibility. An evaluation that appropriately assesses cognitive functioning sufficient to answer clinical referral questions might take five hours of face-to-face testing and interview. That same five hours of time is unlikely to allow an examiner to complete testing, interview around more questions, review additional records, interview additional collateral information sources, consult with attorneys, and administer tests specific to competency.

d. [16.90] Who Performed the Evaluation?

Forensic psychology and neuropsychology have grown increasingly sophisticated and specialized. The complex and sometimes prolonged nature of administering tests has sparked a debate regarding who should conduct them: licensed psychologists, psychometrists (also called "testing technicians"), or psychologists in training. Psychometrists are individuals trained in administering and scoring psychological tests but are not licensed psychologists. Relatedly, it is common for psychologists who are in training (and therefore not licensed) to do evaluations. The latter two groups differ in training and ethical obligations, but a licensed clinical psychologist or neuropsychologist supervises both.

While there is no fundamental ethical prohibition against using a non-licensed trainee or testing technician, several concerns arise. There is also greater hesitancy among many clinicians to use non-licensed individuals to perform testing. This is because the interpretation of results, especially in a forensic context, requires an understanding not only of the particular test but also of broader psychological principles, the individual's background, and potential implications in the legal system. Practitioners are well-advised to consider who performed the testing and scoring of tests, as questions of the validity of the testing can be raised, especially when discrepancies arise.

The reader should also be aware that many of the statements in §§16.91 and 16.92 below come from writings related to clinical psychology or clinical neuropsychology, which have related but significantly different concerns when compared to the expectations of forensic evaluations.

Of note, when presenting forensic evaluations, it should be clear who conducted the testing, allowing for potential scrutiny and ensuring ethical transparency. See Shane S. Bush et al., ETHICAL PRACTICE IN FORENSIC PSYCHOLOGY (2d ed. 2019). Similarly, the examinee should be made aware of the training status of the individual conducting testing with him or her.

(1) [16.91] Benefits of psychometrists and psychologists in training

The benefits of utilizing psychometrists and psychologists in training to administer neuropsychological evaluations include the following:

Efficiency and practicality. In some settings, particularly when there are large numbers of patients or tight schedules, using psychometrists or psychologists in training can be more practical.

Expertise in administration. Psychometrists specialize in test administration. With consistent training and a focus on administration rather than interpretation, they might offer a desirable level of consistency.

Cost-effectiveness. In some cases, employing a psychometrist or psychologist in training might be more cost-effective than using a licensed psychologist for test administration. This can make assessments more accessible to a broader range of individuals and allow the examiner more time to consult with attorneys, review records, and write reports.

(2) [16.92] Drawbacks of psychometrists and psychologists in training

The drawbacks of utilizing psychometrists and psychologists in training to administer neuropsychological evaluations include the following:

Validity and reliability of data. Psychometrists, though trained, might not have the depth of knowledge and experience that licensed psychologists possess. The same is true of psychologists in training. This can potentially result in mis-administrations or misinterpretations.

Psychologist detachment. There is a risk that the psychologist might become detached from the primary data collection process when this process is assigned to another individual. Direct interaction with the individual being tested often provides the psychologist with nuances and observations that cannot be captured through scores alone. See Randy K. Otto and Kirk Heilbrun, *The practice of forensic psychology: A look toward the future in light of the past,* 57 American Psych. 1, pp. 5 – 18 (2002). These observations can be pivotal in forensic settings in which understanding the broader context and subtle cues can significantly impact the final evaluation.

Ethical considerations. The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct, www.apa.org/ethics/code, dictates that psychologists take responsibility for the work performed by those under their supervision. Using psychometrists means psychologists must ensure that these technicians adhere to the same high ethical standards. This includes ensuring that non-licensed individuals undergo thorough training and regular refresher courses. Their role should be strictly confined to test administration and scoring, refraining from interpretation or feedback.

While there is an inherent risk when using psychometrists and psychologists in training in forensic psychology and neuropsychology, it is not an insurmountable one. The critical factor remains the stringent adherence to ethical guidelines, comprehensive training, and close supervision. Attorneys should be aware that experts who utilize psychometrists and psychologists in training may be opening themselves up to greater scrutiny.

5. [16.93] Defining Terms

Understanding the terminology used in a neuropsychological report cannot be overstated. All medical reports range between complex and unreadable; practitioners may consider hiring a controlled expert to assist in understanding the various reports.

Practitioners will encounter terms and phrases that may have specific clinical meanings that make little sense. Other terms may have meanings that are clear only to that particular examiner. At times, phrases may appear to have clear meanings but ultimately mean something quite different. And sometimes clinicians just make poorly written statements. Being able to discern which phrase belongs to which category is nearly impossible. Some of these categories, however, are discussed in the §§16.94 and 16.95 below.

a. [16.94] Clinical Terms of Art

Medical professionals often use terms with precise definitions within their field, but these might be completely foreign to legal practitioners. For example, words like "aphasia" (loss of ability to understand or express speech) or "executive dysfunction" (difficulties in managing cognitive processes) may appear in neuropsychological evaluations. Without clear communication with the expert evaluator, these terms could be misinterpreted, leading to a failure to understand the nuances of the client's condition. Further complicating practitioners' (and the general public's) understanding of terminology, a great deal of inaccurate information is available regarding the meaning of particular terms in popular culture. For instance, "executive functioning" has a very specific clinical definition, which bears little resemblance to the way it is used in social media.

The onus falls on the expert evaluator to translate these clinical terms into language that can be easily understood by the nonmedical audience. However, such translations can lose nuances critical in a legal context. Sometimes, the translations themselves could be clearer. And, of course, not all examiners write clearly in the first place. Open dialogue between the attorney and the examiner can thus be instrumental in ensuring that legal arguments are constructed on a robust understanding of the clinical findings. See also §16.84 above. Some common terms and phrases with specific clinical meanings are as follows:

1. clinically significant;

2. significant impairment;

3. mild impairment;

4. borderline intellectual functioning;

5. variability in performance;

6. "Test rendered invalid because . . .";

7. "Examinee could not participate meaningfully in testing because . . ."; and

8. "The patient functions within the mildly mentally deficient psychometric range of intelligence."

To the non-clinician, many of these phrases will raise questions, such as:

1. Should I be concerned about "mild impairments?" They are mild, right?

2. Is "variability in performance" a good or a bad thing?

3. Is an "invalid performance" on a test bad or irrelevant?

4. When you wrote the phrase "the patient functions within the mildly mentally deficient psychometric range of intelligence," did you put those words into a bowl, toss them in the air with salad servers, and then reassemble them into your report?

Of note, the sample in item 4 *does* have specific meaning to another neuropsychologist, even though it will inevitably cause practitioners to raise an eyebrow. Some definitions of these terms can be found in §16.84 above or §16.110 below. However, the larger point of this section is to raise awareness of meaningful statements that convey no meaning at first glance. In both law and psychological practice, the devil is in the details.

b. [16.95] Differentiating Vague Language from Gibberish

Differentiating between substantive phrases in expert reports and statements that are vague or amorphous is similar to separating the wheat from the chaff when both wheat and chaff look the same. If a report describes the examinee globally as demonstrating "neural dysfunction," it sounds like it must be a real thing. However, the phrase is actually so broad as to be meaningless. Similarly, the phrase "neuroatypical" has exploded onto the scene in recent years. Even though it sounds medical-y, you would be hard pressed to find a widely accepted definition of the term. Other phrases, such as "Has some degree of impairment in . . ." demonstrates a remarkably low degree of specificity. Last, "May benefit from some assistance with managing finances" might make you scratch your head and think, "Gee, I could benefit from assistance managing mine too." In this example, vague language may also come from the clinician not being comfortable with opining on certain matters or a belief that making nonspecific statements will limit the likelihood he or she will anger the patient or his or her family. In short, obtaining clarification whenever there are complex terms is necessary to assess the results of the evaluation and the examiner's opinion.

6. [16.96] When Evaluations Come to Different Conclusions

Often practitioners are puzzled when one report comes to one conclusion and another provider's report says something completely different. At times, situational factors surrounding the two reports hint at why they differ, but it is usually unclear. Common factors that lead to reports with disparate conclusions include timeline and information sources.

Timeline. In assessments of cognitive functioning, the time frame in which the assessment is conducted plays a pivotal role in the results. Cognitive disorders progress at varying rates, with some exhibiting rapid decline. Consequently, evaluations conducted at different time periods may yield disparate conclusions. For instance, individuals with Alzheimer's disease (a progressive neurodegenerative disorder) may experience significant declines in cognitive functioning over a short period. Conversely, someone who has multiple sclerosis may sometimes have a cognitive deficit that fades with time or turns into a different deficit. Practitioners should be mindful that even a difference of a few months between evaluations can lead to inconsistencies in the findings. This temporal variance is akin to photographing a river after a spring rain and then again six months later after a hot summer. It is the same river but looks completely different.

Information Sources. Another contributing factor to divergent conclusions in neuropsychological evaluations can be the sources of information available to the evaluator. Evaluators may rely on various data, including medical records, caregiver reports, and assessments by other professionals. Discrepancies between evaluators' conclusions may arise if different sets of information are made available or if they place differing emphases on specific sources. For example, one evaluator might prioritize medical history, while another might place more weight on

caregiver reports. A third evaluator may have no access to caregiver perspectives at all. The intentions of family members who bring their loved one in for assessment — and their preferred outcome of the assessment — are also very important. Many neuropsychologists refer to their process of evaluating as putting pieces of a puzzle together. Access to a greater variety of puzzle pieces (*i.e.,* information sources) can lead to a more complete and accurate picture. Conversely, missing pieces may lead to gaps or misinterpretation, creating potential disparities between two evaluations.

7. [16.97] Examinee Factors: Emotional State and Willingness To Participate

The examinee's emotional state and willingness to participate or exert full effort on the day of evaluation can significantly impact the findings. An individual's performance on a cognitive test may fluctuate based on factors such as anxiety, depression, and motivation. For instance, imagine a situation in which two adult children are bringing their father in for an evaluation that he is apprehensive about. This worry or sense of helplessness may both decrease his eventual performance. Additionally, if, while driving to the evaluation, the two children angrily complain that their third sibling avoids taking Dad to medical appointments, the stress of all of this will reduce performance. Often, the validity of neuropsychological reports is discussed in terms of the examinee's intentional effort to perform poorly, but there are also many situations in which stress, and not intent, causes lower performances.

8. [16.98] What Neuropsychological Evaluations Represent the "Gold Standard"?

The process of choosing specific tests for neuropsychological evaluation is both an art and a science. Many practitioners may be surprised that there is no "gold standard" for one type of case. This is because a "type of case" is defined very differently from one person to the next. From the viewpoint of practitioners, a 70-year-old who was in a car accident may be a different type of case from a 70-year-old with possible vascular dementia. To a neuropsychologist, many of the same tests given to the first patient should also be given to the second. This is because, in both instances, the clinician would still need to know about the cognitive domains outlined in §16.37 above. Depending on the particular symptoms the examinee exhibits, known as his or her "clinical presentation," and the referral question, adding some additional tests may be relevant. However, most clinicians maintain a core battery of tests that examinees receive. How a clinician assembles his or her battery of tests is akin to how a chef chooses the knife he or she uses. One chef might choose an eight-inch knife for a given task, while another prefers a ten-inch knife. Using a paring knife would certainly raise some eyebrows, but no one would bat an eyelash about an eight-inch versus a ten-inch knife. In short, the "battery of tests" an examiner chooses comes from a blend of professional judgment, scientific principles, practical considerations, and personal experience.

9. [16.99] Comprehensiveness of the Evaluation

The length of time spent performing the evaluation determines what kinds of conclusions can be drawn. One gross distinction is between a "screening battery" and a full battery of tests. A screening battery comprises a concise set of tests that provide a quick and general assessment of cognitive function. It can help identify major cognitive deficits without delving into the specific

details of the impairment. It trades shorter administration times for decreased comprehensiveness. On the other hand, a full neuropsychological evaluation includes a comprehensive array of tests tailored to explore various cognitive domains in detail. This extensive assessment can provide a deeper understanding of an individual's cognitive strengths and weaknesses.

The choice between these two methods depends on several factors, detailed in §§16.100 and 16.101 below.

a. [16.100] Examinee Considerations

A full neuropsychological evaluation can take several hours, requiring sustained attention and effort. Because of the demands the testing places on examinees, achieving a balance between obtaining complete information and the comfort of the examinee is of paramount importance. If the examinee's capacity for prolonged testing is limited, either due to fatigue or cognitive impairment, a brief screening battery may be more suitable. Similarly, physical health and medical conditions (*e.g.,* chronic pain, fatigue syndromes) also limit the examinee's ability to engage in a full evaluation. In these instances, a brief screening battery is preferred. Screening batteries are also more appropriate when severe cognitive impairments become apparent from the outset of testing. In short, when it becomes clear that an examinee cannot complete a full battery, there is benefit in obtaining a rough estimate of all cognitive domains. Essentially, having less comprehensive data in all areas of functioning is preferable to in-depth data in only two or three domains. It is possible (and sometimes the only option) to write a report based solely on an interview with the examinee, collateral interviews, and records review.

b. [16.101] Examiner Considerations

A comprehensive evaluation is more important if the report will be closely scrutinized, such as in cases in which there is a high probability the examiner will be called to testify. Additionally, if there are questions about cognitive abilities and concerns about emotional factors (*e.g.,* depression or behavioral concerns), examiners may be reluctant to assess both areas briefly. Another consideration is financial. Because private insurance and Medicare do not generally reimburse clinicians for evaluating questions that are not "medically necessary," referrals originating in the court system often need to self-pay. In these instances, finding examiners who will do comprehensive evaluations inexpensively can be difficult.

E. [16.102] Issues Related to Payment — Caveat Emptor

One issue that often emerges is the cost of neuropsychological testing and who will pay for it. It is important to get an idea early on from the neuropsychologist about what he or she expects the cost to evaluate to be, as not every case will justify the expense. Like any expert service, an attorney must make these decisions prudently so as not to spend a client's money carelessly. However, the sheer amount of information obtained through a neuropsychological evaluation is substantial, and it takes a remarkable amount of time to collect and process that data, conduct the interviews, review past treatment records, and write the ultimate report. When all is said and done, a comprehensive forensic neuropsychological evaluation is likely to take on the order of 20 or more hours to complete. Because of the cost of these extensive evaluations, practitioners may want to consider whether the evaluation costs outweigh the expected benefits in a particular case. These hours break down as follows:

Patient interview and review of collateral information sources	3 – 4 hours
Review of medical and (limited) legal records	1+ hours
Administering neuropsychological and psychological tests	5 – 6 hours
Scoring and interpreting data	1 – 2 hours
Writing the final report	7 – 9 hours

For attorneys, a "case" may include stages like intake, gathering evidence, pleadings, discovery, depositions, and ultimately a trial, settlement, or other resolution. An attorney would be hard-pressed to refer to the "case" as any single element; rather, it is a process with many moving parts. Much the way legal matters proceed through stages, the neuropsychologist's "case" is the patient. To the attorney, the "evaluation" is but one piece of the bigger case — an expert's report or a deposition to take — but to the clinician performing that evaluation, it is, in its own right, a "case," which has a beginning, middle, and end.

Once an attorney appreciates the distinction between sending a client for what seems like a "doctor visit" for an isolated, single event and for a formal evaluation of competence, the value becomes clearer. With comprehensiveness of evaluation comes a price. Beyond the figures above, there is also time spent discussing the evaluation results with the attorney, the individual, and his or her family. Independent of the hourly rate of the particular neuropsychologist, this kind of specialty evaluation is not going to be particularly cost-effective in smaller guardianships or injury cases with lower values or limited insurance coverage. However, a neuropsychological evaluation may be the best option when substantial assets or a great deal of contention exist between the various stakeholders.

F. [16.103] Dealing with Billing and Insurance Rules

Sometimes attorneys request that a neuropsychologist bill private insurance or Medicare, but this is often not an option. Medicare rules, as well as the contractual relationship all psychologists have with commercial group health insurance companies, specifically prohibit a neuropsychological evaluation (or any other service, for that matter) from being paid by insurance if it cannot be demonstrated that it is medically necessary. In the most basic sense, if an attorney is seeking out a neuropsychologist to perform an evaluation, that evaluation will not be deemed medically necessary by an insurance company.

In other situations, an attorney may suggest that the client request a referral for a neuropsychological evaluation through the client's primary care physician. This only creates the appearance of propriety. Beyond this, whichever neuropsychologist the physician ultimately refers the client to will generally perform a clinical neuropsychological evaluation rather than a forensic neuropsychological evaluation. That clinical neuropsychologist is unlikely to understand that legal questions must be answered. Subsequently, his or her reports will be geared toward answering the referring doctor's questions and not questions relevant to the courts. Additionally, being unaware of the intentions of family members (who may be exerting undue influence on the examinee) will

tend to nudge the results of this evaluation in the direction that the family member prefers. Finally, should a neuropsychologist be called to testify and it is revealed that he or she violated the law or breached an insurance contract in order to be paid, that clinician's credibility may be significantly compromised.

To be clear, it is important to distinguish clinical evaluations performed during clinical "treatment" versus evaluations performed on "consultation" or for a forensic or legal purpose. Regarding the relevance of the final evaluation, a clinical neuropsychological evaluation is a very different type of evaluation than a forensic neuropsychological evaluation.

In typical clinical evaluations, when a referring doctor's questions are less threatening (*e.g.,* what type of dementia is this person exhibiting?), there is less need for validity indicators that a forensic evaluation commonly includes. There is simply less potential for the examinee to be motivated by secondary gain. Additionally, clinical evaluations place less emphasis on collecting and verifying collateral information. This includes additional interviews with multiple loved ones or caretakers. There is also less need to examine other medical records with a fine-toothed comb. Instead, clinical evaluators can focus on the most relevant or available records. Last, only some clinical neuropsychological evaluations address questions of competence because addressing these questions commonly requires additional testing and interviews, and most neuropsychologists are reluctant to take on the liability of answering questions for which they have not specifically assessed. In short, performing an appropriately detailed forensic neuropsychological evaluation that can effectively resist being discredited in court simply takes more time than a clinical evaluation.

G. [16.104] A Note on Illinois Supreme Court Rule 213(f)

As mentioned in §16.1 above, a neuropsychological evaluation can have wide applicability in other areas of practice beyond elder law and guardianship. For instance, consider head traumas (see §16.51 above) that might occur during an auto accident or a hypoxic brain injury (*i.e.,* carbon monoxide poisoning or drownings). These conditions immediately impact an individual's cognitive functioning and can increase the likelihood of eventually developing dementia if they occur in an otherwise healthy adult. Lawyers who practice in the realm of personal injury and medical malpractice may find neuropsychological evidence quite effective at demonstrating how an injury has diminished a person's overall functionality.

XIII. [16.105] CONFIDENTIALITY RULES

One of the more challenging considerations to deal with in practice is the intersection between the legal and ethical rules that bind attorneys as opposed to the ethical and legal obligations that bind health professionals. Both groups have many of the same goals but conflicting effects. After all, the attorney's role in litigation is typically to obtain as much favorable evidence as possible to prove a client's case or disprove that of an opponent. This may mean issuing written discovery, sending out subpoenas, obtaining deposition testimony, or battling other parties over what is even discoverable.

Anyone who has handled cases involving medical testimony is keenly aware that physicians, psychologists, and other clinicians can be extremely reluctant to release information about their patients, even when presented with subpoenas and court orders. Attorneys often see this as obstructionism or an attempt to thwart their efforts. In some cases, this may be true. More commonly, however, clinicians simply react to their own ethical obligations and limitations. Consider for a moment the two most critical privacy laws that govern the release of all protected health information (PHI) by any clinician — the Health Insurance Portability and Accountability Act of 1996 and the Mental Health and Developmental Disabilities Confidentiality Act, discussed in §§16.106 and 16.107 below, respectively. PHI generally includes health records, billing statements, and any part of a patient's mental health records or charts that may contain things like social security numbers, dates of birth, medical conditions, and the like.

A. [16.106] Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub.L. No. 104-191, 110 Stat. 1936, was created for a wide range of purposes. The overarching goal of HIPAA was to govern the availability and scope of health insurance plans. This complex federal statute covers many issues, but for clinicians being asked to provide commentary on patient diagnoses and records, one particular provision is very important:

> **A covered entity or business associate may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.** 45 C.F.R. §164.502(a).

The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule), 45 C.F.R. pt. 160, pt. 164 (subpts. A, E), goes on to explain what constitutes a covered entity, what counts as protected health information, and what exceptions are permitted. These can feel like a moving target for healthcare providers, as they are subject to amendment, revision, and countless court decisions interpreting them. Attorneys working in this area should familiarize themselves with the general rules and exceptions for disclosing PHI. Be prepared to exercise some flexibility to make the provider comfortable that you have obtained the necessary legal authority to get such records. Ideally, consent from the patient is the best option. Even then, be prepared to make sure your documentation is perfect.

Often healthcare providers are cautious about providing or discussing patient medical records because the Privacy Rule also provides a private right of action for violators. 45 C.F.R. §160.402 provides the mechanism for obtaining civil money damages for violations of the Privacy Rule. This is a greater threat to the provider than aggravating an attorney by not turning over records; therefore, when weighing options, the clinician generally will err on the side of caution.

B. [16.107] Mental Health and Developmental Disabilities Confidentiality Act

In Illinois, there are protections applicable to mental health records in addition to those protected by the Health Insurance Portability and Accountability Act of 1996 (see §16.106 above). The Illinois General Assembly created the Mental Health and Developmental Disabilities Confidentiality Act (MHDDCA), 740 ILCS 110/1, *et seq.,* to further protect the value and efficacy of the provider-patient relationship by ensuring even stricter standards for the disclosure of medical records and information that pertain specifically to mental health treatment.

A widely cited case on this issue comes from the Illinois First District Court of Appeals, which clarified the purpose for the statute, stating:

> **The statutory privilege is a legislative balancing between relationships which society thinks should be fostered through the shield of confidentiality and the interests served by disclosure of the information in court. The legislature has determined that except for limited purposes, there is more value to encouraging and sustaining that kind of relationship. . . . The beneficent purposes of psychiatry can only be fully realized when the patient knows that what is revealed in the evaluation conferences or communications are free from judicial scrutiny.** *In re Marriage of Lombaer,* 200 Ill.App.3d 712, 558 N.E.2d 388, 393 – 394, 146 Ill.Dec. 425 (1st Dist. 1990).

The penalties for willful violations are even more severe under the MHDDCA than under HIPAA; violations are treated as Class A misdemeanors in Illinois, punishable by up to a year in prison, and penalties can include the plaintiff's attorneys' fees and costs for pursuing an action against the violator. 740 ILCS 110/16.

One key element of the MHDDCA is that the healthcare professional is not permitted to disclose mental health records even in response to a civil subpoena unless accompanied by a court order. 740 ILCS 110/10(d). See also 740 ILCS 110/3(a). This protection even survives the death of the patient. 740 ILCS 110/5(e). However, this protection is not without limitations and exceptions.

One such exception is by court order, and another is consent of the party whose information is requested. In order to gain disclosure by court order, the court must perform an in camera review of the testimony or documents in question and find that the information is

> **relevant, probative, not unduly prejudicial or inflammatory, and otherwise clearly admissible; that other satisfactory evidence is demonstrably unsatisfactory as evidence of the facts sought to be established by such evidence; and that disclosure is more important to the interests of substantial justice than protection from injury to the therapist-recipient relationship or to the recipient or other whom disclosure is likely to harm.** 740 ILCS 110/10(a)(1).

This standard creates a heavy burden for those seeking disclosure or discovery of such information or testimony. In short, this standard requires that the evidence not be available from any other competent source and is so important that it would be better to have it admitted than not. Given the strong legislative policy to the contrary, attorneys should be prepared for an uphill battle getting such information.

C. [16.108] Release of Raw Data and Testing Protocols

In litigation, discovery regarding psychological and neuropsychological raw test data (some portions), test manuals, and test stimuli is complicated. Upon purchasing these kinds of materials from the test manufacturers, psychologists are bound by the test copyright restrictions and additional restrictions. Much like a trade secret, this type of data is closely held by creators. Essentially, a psychologist is ethically and legally obligated not to release these types of

information to unqualified users. "Unqualified users" are individuals who are not formally trained in the scoring and interpretation of such materials. While psychologists are not the only professionals who are considered qualified users, their training in assessment renders them to be the most likely to be qualified to handle this information. The American Psychological Association establishes the most broadly accepted definition of "qualified user":

> **The term assessment qualifications refers to the combination of knowledge, skills, abilities, training, experience, and practice credentials that are deemed desirable for the use of psychological tests and assessment materials. However, the term describes two types of qualifications: (a) generic assessment knowledge and skills necessary for typical uses of tests and (b) specific qualification for the responsible use of tests in specific settings and for specific purposes.** Samuel M. Turner et al., *APA's guidelines for test user qualifications: An executive summary,* 56 American Psych., No 12, 1099 – 1113 (2001).

To be clear, many professions could be considered to have appropriate qualifications to administer and interpret these tests. It is just less likely that other professions will have access to courses commonly offered to psychologists, the time to take these courses, or appropriate supervision as they learn to use them.

Besides ensuring that users are qualified to use these tests, these standards also help maintain what is referred to as "test security." Much like the ACT or LSAT would cease to be of any use if answer sheets were made available widely, psychological and neuropsychological tests become completely useless when available to individuals who are not trained in properly using these materials. First, individuals without training can look at raw patient responses and draw conclusions from them. Still, these conclusions do not have the basis in training and experience they would for a psychologist. This leads to data being misconstrued, often dramatically. Second, unscrupulous individuals with access to this kind of protected information could deconstruct the tests and then understand how to fake a test of effort effectively or, on the other hand, how to appear to be a genius on an IQ test. Finally, neuropsychological test developers have a significant stake in this matter because of the immense resources that go into developing and standardizing their tests. Should these tests become less valid, neuropsychologists will abandon them, and the developers stand to lose a great deal of money due to losing proprietary information.

All of this is not to say that the tools psychologists use can never be critiqued, nor is raw data immune from being checked for errors; it is just essential that these materials be released only to another psychologist or neuropsychologist for this purpose. In addition to the privacy provisions of the Mental Health and Developmental Disabilities Confidentiality Act (see §16.107 above), a second provision deals with releasing these essential test materials.

Under 740 ILCS 110/3(c), raw data and testing protocols are strictly prohibited from disclosure. These are the proprietary, highly protected components of the assessment process that, if widely disseminated, would damage the validity and, ultimately, the usefulness of these tests. It may be helpful to think of raw test data and testing protocols similar to the secret algorithms used by credit reporting bureaus or social media companies. It is one thing to seek a credit report and score and have an expert testify as to what that score says about the consumer. Still, it is quite another thing to order the full disclosure of the secret algorithms that these companies have invented to arrive at the score.

Therefore, when seeking raw test data and/or testing protocols, counsel should seek leave of court to have such information transmitted directly from the clinician who possesses it to the retained expert who can review and interpret the information. *Id.* Nevertheless, such information will almost never be fully disclosed unless the court finds that disclosure would not "compromise the objectivity or fairness of the testing process." *Id.*

The solution to the problem depends on the type of case. In probate and guardianship litigation, a party's mental capacity is often the pivotal issue. In these cases, the attorney seeking these protected materials should seek leave of court to have the requested materials sent directly to its expert who, in turn, can explain and discuss them with the attorney. Although, at first blush, some attorneys may find this a bit restrictive, it is helpful because the attorney gains a better and more thorough understanding of the information sought, preventing the possibility of misunderstanding data or reliance on bad information.

This may not be practical in other types of litigation, specifically medical malpractice matters. Under 735 ILCS 5/2-622(a)(1), an attorney seeking to name a health professional as a defendant based on "healing arts malpractice" must attach to the complaint a certificate of merit by a similarly licensed and trained health professional, which sets forth that he or she has reviewed the allegations against a health provider and found that, based on a review of the records and other materials provided, the case is meritorious.

In Illinois, attorneys are not required to disclose the identity of the health professional signing a certificate of merit. Instead, the attorney signs and files an affidavit swearing under oath that the consultation has occurred and that the health professional, indeed, has signed the certificate of merit. This protects physicians who regularly assist attorneys in pursuing these claims. Therefore, if an attorney is litigating a medical malpractice case and seeks these protected materials, a separate expert may be warranted for the limited purpose of reviewing these materials. Otherwise, disclosing the reviewing physician or other health professional would likely be unavoidable. However, this is an unlikely scenario, given the rarity of neuropsychological malpractice claims.

XIV. [16.109] CONCLUSION

Despite the shroud of mystery surrounding neuropsychology, practitioners are encouraged to remember that methodically collected data about an individual's cognitive and emotional functioning can go a long way to generating reliable and verifiable insights into an individual's capacity. It is true that the vast array of cognitive and psychological disorders that affect a person's capacity can be dizzying. It is also true that neuropsychological evaluations can be challenging to understand. However, the utilization of objective assessments such as neuropsychological testing is becoming more commonplace in the courts simply because of how probative the data is. Practitioners are well advised to consider this form of assessment when existing opinions are vague or the existing expert seems to have provided an insufficient basis for their opinion.

When used properly and in consultation with a trained expert, neuropsychological testing can be a powerful tool for proving a case or protecting clients. The key element of neuropsychological evidence that every attorney should remember is that it builds an objective picture of a person's

overall cognitive abilities. Neuropsychological testing tends to remove preference, prejudice, and personal opinion from the equation and shifts the decision-making process toward data, standards, and unbiased measurement. Once factors impacting mental capacity are formally measured, this evidence can be presented as not just credible evidence but indeed as the strongest evidence available for determining mental capacity in a legal context.

XV. APPENDIX

A. [16.110] Frequently Used Neuropsychological Terms and Common Tests

Adaptive Functioning: Ability to thrive and adjust to changes in one's environment.

Activities of Daily Living (ADLs): Skills such as cooking, shopping, using the telephone, grooming, housekeeping tasks, etc.

Affect: Emotional tone or feeling as seen or experienced by another person.

Agnosia: Sensory deficits causing an inability to identify previously known stimuli.

Aphasia: A newly developed impairment in language processing, object naming, comprehension, reading, writing, etc.

Ataxia: Abnormal, inefficient motor activity impairing coordination and movement.

Attention: Ability to focus and maintain interest. Allows engagement in certain cognitive processes while ignoring others.

Boston Diagnostic Aphasia Examination (BDAE): A comprehensive assessment of different aspects of language, including auditory, visual, and gestural (*i.e.,* talking with one's hands).

Boston Diagnostic Aphasia Examination (BDAE-3): Assesses individual components of the ability to express oneself verbally and understand what others are saying.

Boston Naming Test (BNT-II): Test of language abilities requiring the patient to name increasingly obscure objects. Useful in differentiation between different dementias.

Brief Test of Attention (BTA): A test of attention in which patients are verbally given a string of letters and numbers and are asked to count the letters but ignore the numbers.

Brief Visual Memory Test (BVMT-R): A comprehensive test of an individual's ability to learn visual information (*i.e.,* nonverbal memory).

California Verbal Learning Test (CVLT-4): A comprehensive test of memory for a list of words in which a person is repetitively read and asked to remember a series of words.

Category Test: Part of the Halstead-Reitan Neuropsychological Battery that specifically measures executive functioning and problem-solving skills.

Central Nervous System Vital Signs (CNS-VS) A computerized screening of most domains commonly assessed by neuropsychologists.

COGNISTAT or The Neurobehavioral Cognitive Status Examination: A brief assessment of some cognitive functions.

Cognitive: Mental processes including attention, perception, memory, thinking, and learning. Cognition refers primarily to thinking and figuring out instead of emotions and feelings.

Computed Tomography (CT): Type of X-ray-based brain imaging that results in pictures that provide information on the brain's structure.

Confrontation Naming: Task in which patients name the visual stimulus (a picture of an object). This tests word-finding abilities (*i.e.,* anomia). See Boston Naming Test.

Continuous Performance Test (CPT-3 or IVA+): Attention and vigilance task in which patients detect and respond to one form of stimuli while ignoring other confusing stimuli.

Controlled Oral Word Association Test (COWAT, FAS): Verbal fluency test involving the generation of multiple words, all beginning with a certain letter of the alphabet.

CPT-3: See Continuous Performance Test

Divided Attention: The ability to focus on and track more than one stimulus simultaneously.

Draw-a-Clock Test: Test in which patients are asked to draw the face of a clock set to a certain time. This is a simple test commonly used in dementia differential diagnosis and other cognitive disorders. This is a quick and dirty but useful test.

Electroencephalogram (EEG): Recording of brain electrical activity (brain waves). See also qEEG.

Emotional Lability: Dramatic changes in emotionality, including sudden changes in affect.

Executive Functioning: Includes adaptability, goal-directed behaviors, planning, and problem-solving.

Expressive One Word Picture Vocabulary Test (EOWPVT) A test of expressive language, such as the ability to use language to describe objects you recognize.

FAS: See Controlled Oral Word Association Test.

Fluency: Description of verbal skills including articulation, speed that words are produced, and clarity of sentence structure.

fMRI: See Functional MRI.

Full Scale IQ (FSIQ): Intelligence Quotient score obtained from multiple tests, including verbal and nonverbal abilities, processing speed, and working memory.

Functional MRI (fMRI): A type of functional imaging that provides detailed images representing the level of activity within different brain regions.

Grooved Pegboard or Purdue Grooved Pegboard: A test of fine motor dexterity.

Halstead-Reitan Neuropsychological Battery (HRNB): A comprehensive battery of tests of neuropsychological functioning that has fallen out of favor in recent years.

Hopkins Verbal Learning Test (HVLT): A test of memory for a list of words in which a person is repetitively read and asked to remember a series of words.

Immediate Recall: Remembering information that was given a short time ago as opposed to remembering information that was given some time ago (generally 20 – 30 minutes prior).

Intellectual Assessment: Alternate name for IQ testing (*i.e.,* WAIS). See Full Scale IQ (FSIQ).

Iowa Gambling Test (IGT): A test of executive functioning and decision-making.

IQ: Intelligence Quotient

IVA: See Continuous Performance Test.

Judgment of Line Orientation (JOLO): Test the accuracy of visual perception.

Learning Curve: Visual representation of the progression of learning over several successive trials in which the same information is repeatedly presented.

Leiter International Performance Scale (Leiter-R): A nonverbal assessment instrument that emphasizes visual-perceptual skills and fluid reasoning that assesses intellectual capabilities without the influence of linguistic skills.

Magnetic Resonance Imaging (MRI): Structural brain imaging that results in more detailed images than a CT scan.

Malingering Tests or Tests of Effort or Validity Indicators: Multiple different tests that assess the overall effort expended by the examinee. These measures ensure that other data collected during testing can be considered valid and reliable.

Memory: Learning, storing, and later being able to retrieve information.

Millon Clinical Multiaxial Inventory (MCMI): A comprehensive evaluation of personality style that also assesses overall psychopathology (*e.g.,* depression, anxiety, psychosis) to some degree.

Minnesota Multiphasic Personality Inventory (MMPI): A comprehensive evaluation of personality style and overall psychopathology (*e.g.,* depression, anxiety, psychosis).

Mini-Mental State Examination or Folstein Mini Mental State Examination (MMSE): A brief clinical rating scale (as opposed to a neuropsychological test) used to estimate cognitive functioning.

Motor Control: The ability to efficiently control muscles involved in movement to achieve the desired goal.

Motor Coordination: Includes body movements such as fine motor control (muscles in the fingers and toes) and gross motor control (muscles of the legs and arms).

Neuropsychological Measures: Another name for tasks or tests used to determine cognitive/neuropsychological functioning.

NIH Toolbox: A computer-administered set of neurobehavioral tests that assess cognition, emotion, motor, and sensation.

Percentile: A number representing what percentage of the population's abilities fall below the level of performance of the individual in question.

Personality Assessment Inventory (PAI): A comprehensive evaluation of personality style and overall psychopathology (*e.g.,* depression, anxiety, psychosis).

Performance IQ (PIQ): A total score of nonverbal reasoning abilities derived from intelligence testing.

Positron Emission Tomography (PET): An advanced form of functional brain imaging utilizing a radioactive dye to study areas of metabolic activity within the brain.

Phonemic Fluency: The ability to rapidly produce words beginning with the same sound. See COWAT.

Praxis: The capability of performing skilled movements (using muscles to perform a set of steps).

Perceptual Reasoning Index (PRI): Measures the ability to understand and reason with nonverbal (*i.e.,* visual) information. Part of the Full Scale IQ of the WAIS.

Premorbid Functioning: Level of ability present before illness or injury.

Processing Speed Index (PSI): The speed with which a person can perform simple, repetitive decision-making tasks. Part of the Full Scale IQ of the WAIS.

Quantitative EEG (qEEG): Computerized analysis of brain electrical activity (brain waves) that provides brain images, improves diagnosis accuracy, and improves treatment planning determinations.

Receptive One Word Picture Vocabulary Test (ROWPVT) Level of understanding (reception of language) of what others say to you.

Recognition Memory: Ability to correctly identify previously learned information from a combination of information seen before versus new information.

Repeatable Battery for the Assessment of Neuropsychological Status (RBANS-2): A brief "screening" battery assessing several different areas of cognitive functioning. Particularly convenient because it can be administered at bedside.

Rey Auditory Verbal Learning Test (RAVLT): A test of memory for a list of words in which a person is repetitively read and asked to remember a series of words.

Rey-Osterrieth Complex Figure Test (or Rey Complex Figure Test) (RCFT): Can be given as a relatively poor test of visual memory but is more commonly given as a test of visual-spatial skills, for which it is considered a good measure.

Rorschach Test (*i.e.,* Inkblot Test): A useful clinical tool that can be problematic in forensic settings because of challenges related to the complexity of scoring it.

SDMT: See Symbol Digit Modalities Test.

Semantic Fluency: A test of the ability to generate words from certain categories within a limited time frame, *e.g.,* the ability to name every fruit one can think of.

Sensory Perception: The ability to recognize aspects and important details in one's environment.

Spatial Orientation: Determining an object's location in two- dimensional and three-dimensional space.

Standard Score: A number that indicates how one's ability compares to what is considered average for the individual's age and education level.

Stanford-Binet Intelligence Scale (SBIS): An assessment tool designed to gauge cognitive abilities across various domains, employing verbal and nonverbal tasks to comprehensively measure an individual's intellectual functioning.

Stroop Color-Word Interference Test: A timed test involving reading the color of the ink that a word is written in while ignoring the word itself. For example, when the word "red" is written in green ink, the subject is asked to ignore the word and report the color of the ink. Poor performance indicates difficulty in filtering irrelevant information. See verbal inhibition.

Symbol Digit Modalities Test (SDMT): A key is provided in which symbols are coupled with numbers. On the test, the symbols are provided, and the subject fills in the number that goes with each of those symbols as rapidly as possible. See Processing Speed.

Test of Nonverbal Intelligence (TONI): A standardized examination specifically crafted to evaluate intelligence without reliance on verbal expression, thereby offering a unique perspective on cognitive function, particularly useful for those with language barriers or impairments.

Thematic Apperception Test (TAT): A useful clinical tool that can be problematic in forensic settings because of challenges related to interpreting the results.

TOVA: Test of Variables of Attention. See Continuous Performance Test.

T-Score: Standard score that assumes a normal distribution and has a mean of 50 and a standard deviation of 10.

Tower Test (D-KEFS, Tower of London, Tower of Hanoi): A task assessing problem-solving skills, planning, and organization, all of which are functions of the frontal lobe of the brain. The task involves creating stacks of discs on three pegs while following certain rules.

Trail Making Test: A test consisting of one trail connecting numbers in a dot-to-dot fashion and a second part requiring the individual to alternate back and forth between numbers and letters while connecting the dots. Tests attention and frontal lobe function. This is a very sensitive test of overall brain dysfunction.

Verbal Comprehension Index (VCI): Measures verbal reasoning skills and knowledge of word meanings. Part of the FSIQ of the WAIS.

Verbal Fluency Tests: Speed of generation of words within certain constraints. See also phonemic and semantic fluency.

Verbal Inhibitory Task: See Stroop Color-Word Interference Test

Visual Discrimination: Ability to differentiate one visual stimulus from another. See Judgment of Line Orientation (JOLO).

Visual-Spatial Skills: Understanding the relationships of objects in two-dimensional and three-dimensional space.

Wechsler Adult Intelligence Scale (WAIS): Standardized, comprehensive test of intellectual functioning (*i.e.,* IQ), which can be useful to gauge an individual's ability to understand complex ideas and perform some tasks.

Wechsler Memory Scales (WMS): A comprehensive battery of tests of several different types of memory tests.

Wechsler Test of Adult Reading (WTAR): Test of reading/pronunciation ability. It is also considered a "hold" test (abilities do not change much over time or after most brain insults), so it can estimate someone's previous functioning.

Wide Range Achievement Test (WRAT-4): A comprehensive test of academic abilities, including reading, spelling, and math. The reading subtest is a "hold" test (abilities do not change much over time or after most brain injuries), so it can estimate someone's previous functioning.

Wisconsin Card Sort Test (WCST): A comprehensive test of executive functioning, cognitive flexibility, and "set shifting" (essentially using feedback to learn).

Working Memory Index (WMI): Tests the ability to hold and manipulate simple information. Part of the FSIQ of the WAIS.

Word Retrieval: The ability to identify and utilize a word when needed.

B. [16.111] Attorney's Cheat Sheet for Recognizing Diminished Capacity

The following questions can be effective in helping to screen your client's thinking. No single answer means much in an absolute sense. However, taken together, they will guide you to consider some important areas of functioning.

Before the First Meeting:
- Schedule meeting for the best time of day (earlier = clearer thinking).
- Manage your frustration.
- Schedule much more time.
- Schedule multiple brief appointments.
- Decide whether to interview the client alone vs. with family members

During Meetings:
- Encourage active participation.
- "Can you explain that back to me?"
- Ask open-ended questions. Avoid yes/no.
- Repeat yourself frequently and then summarize. Then ask again later.
- If there are errors, explain again and recheck.
- Simplify and break ideas into smaller chunks.

Light-Duty Assessment:
Orientation
- What day of the week is today?
- What is today's date?
- What town are we in?
- Why are we here today?

Memory
- What did we talk about last time we met?
- What did you watch on television last night? What was the plot?
- If the client watched the news/read a newspaper: What were the main stories?
- What roads did you take to get here?
- Where does your [family member/friend] live?

Judgment
- May I see your checkbook? (Inspect for accuracy of recording and calculation ability.)
- When was the last time you saw your doctor/financial planner? What things did you talk about? (If there was a decision to be made, ask how it was made.)

Things You Might Notice (Cognitive):
- Poor recent memory (*i.e.,* last few days)
- Frequent "tip-of-the-tongue" phenomenon
- Poor attention or losing track of conversation
- Confusion about times or locations
- Inconsistency or over-focus on one subject
- Poor judgment or bizarre deductions
- Poor hygiene/appearance

Things You Might Notice (Emotional):
- Is his or her mood depressed/flat/hopeless?
- Does he or she exhibit impulsive, angry, or inappropriate behaviors?
- Is he or she overly suspicious or downright paranoid?
- Does he or she see or hear things that others do not?

Family Input
- Have the family count pills in bottles to ensure the client is taking medications as prescribed.
- Ask whether there have been hospital admissions (*e.g.,* for dehydration, falls, diabetes management, infections, burns).
- Ask how clean the house is.
- Ask whether the client is consistent in paying bills.
- Ask whether the client is overly confused when using technology.
- Ask about recent dings on cars or moving violations.
- Ask about the client's consistency in attending to medical needs.
- Ask about the presence of bruises or scrapes from falling.
- Ask about alcohol/illicit drug use/Rx drug abuse.

My Notes: