

A Conceptual Model and Assessment Template for Capacity Evaluation in Adult Guardianship

Jennifer Moye, PhD,¹ Steven W. Butz, PsyD,¹
Daniel C. Marson, JD, PhD,² Erica Wood, JD,³ and the ABA–APA
Capacity Assessment of Older Adults Working Group³

Purpose: We develop a conceptual model and associated assessment template that is usable across state jurisdictions for evaluating the independent-living capacity of older adults in guardianship proceedings. **Design and Methods:** We used an iterative process in which legal provisions for guardianship and prevailing clinical practices for capacity assessment were integrated, through expert group consensus and external review by legal and health care professionals, to form a conceptual model and template. **Results:** The model and template provide a structure for conducting and documenting a capacity evaluation in guardianship by using six assessment domains of interest to the courts: (a) medical condition, (b) cognition, (c) functional abilities, (d) values, (e) risk of harm and level of supervision needed, and (f) means to enhance capacity. The template also addresses the participation of the person in the guardianship hearing, confidentiality and

privilege issues, and certification by the examiner. An on-line version of the template can be adapted to address specific jurisdictional requirements. **Implications:** A conceptual model and evaluation template provide a useful cross-jurisdictional format for conducting and documenting capacity assessments of older adults in guardianship proceedings. The template may be particularly useful to clinicians for providing courts with information to support limited guardianship orders.

Key Words: Capacity, Competency, Dementia, Guardianship

This work was funded by a grant from The Borchard Foundation Center on Law and Aging and The Charles H. Farnsworth Trust. We are grateful to the 17 clinicians who provided insightful comments on an initial draft of the evaluation template. We thank the members of the ABA–APA Assessment of Older Adults Project Working Group, including Barry Edelstein, Greg Hinrichsen, David Powers, and Charles Sabatino; the National College of Probate Judges (NCPJ); the American Bar Association (ABA) Commission on Law and Aging; and the American Psychological Association (APA), including the Committee on Aging, the Committee on Legal Issues, and the Division of Clinical Neuropsychology. We extend special thanks to the judicial advisory panel convened for this project: Hon. Steve M. King of Texas, Hon. Gary Cassavechia of New Hampshire, and Hon. John N. Kirkendall of Michigan, and the members of the NCPJ Executive Board. Staff support was provided by Deborah DiGilio and Donna Beavers at the APA and Jamie Philpotts at the ABA. We thank two anonymous reviewers who provided a helpful critique of earlier drafts of this article.

The evaluation template described here is available online at www.abanet.org/aging or www.apa.org/PI/aging, and it can be modified according to jurisdictional needs for use by the judiciary, not-for-profit organizations, provided that the use is for noncommercial purposes. Dr. Butz is now with Comprehensive Geriatric Services, Baltimore, MD.

Address correspondence to Jennifer Moye, VA Medical Center, 940 Belmont Street, Brockton, MA 02301. E-mail: jennifer.moye@va.gov

¹VA Boston Healthcare System and Harvard Medical School, Boston, MA.

²Department of Neurology and Alzheimer's Disease Research Center, University of Alabama at Birmingham.

³American Bar Association, Commission on Law and Aging, Washington, DC.

As our population ages, increasing numbers of older adults will experience functional loss associated with neurocognitive and neuropsychiatric diseases (Quinn, 2004). In some cases these individuals will become subject to guardianship proceedings, in which a judge may appoint a guardian to make decisions on behalf of a person determined to lack the capacity to make those decisions. Guardianship is intended to protect a vulnerable adult, but it also results in a substantial loss of rights for that individual (Zimny & Grossberg, 1998).

Clinical Evaluation in Adult Guardianship

Judicial determination of capacity is a crucial component of all guardianship proceedings. Each state, through its statutes and case law, sets forth legal definitions and procedural requirements for determining an individual's capacity (Anderer, 1990; Sabatino & Basinger, 2000). There is enormous variability in the role, scope, and format of clinician capacity assessment in these provisions. Currently, 30 states require a clinical evaluation of capacity prior to guardianship proceedings, 15 states leave this decision to the discretion of the court, and 5 states provide no statutory

direction. Statutes in only 23 states provide guidance concerning the information needed in a clinical evaluation for guardianship (Mayhew, 2005).

In recent years, the concept of capacity in guardianship has moved away from a global, “all or none” construct toward a more finely tuned, functional definition (Moye, 2003; Sabatino & Basinger, 2000). For example, in principle, a person may lack the capacity to handle financial affairs but still retain the capacity to make health care decisions or to vote in elections. In response, the idea of “limited guardianship” has emerged, in which judges craft orders to match the functional strengths of the individual: preserving autonomy in areas of retained capacities and delegating to limited guardians those areas of lost capacity (National Guardianship Network [NGN] Members, 2004). Hence, clinical evaluations are increasingly complex and increasingly crucial to preserving the autonomy and rights of older adults. The Uniform Guardianship and Protective Proceedings Act (UGPPA; National Conference of Commissioners on Uniform State Laws, 1997), a model statute for adult guardianship, recommends detailed functional evaluation by physicians, psychologists, or other qualified professionals, but it does not describe what is meant by “functional evaluation.” Currently, 16 states require functional assessment in guardianship (Mayhew, 2005).

Current clinical assessment in guardianship proceedings has received considerable criticism. Capacity evaluations for guardianship have been found to be “sketchy” and “substandard,” with written descriptions that provide limited functional data and include conclusory findings (Bulcroft, Kielkopf, & Tripp, 1991; Dudley & Goins, 2003; Moye, et al., in press), often resulting in plenary orders. In part, clinicians have lacked conceptual models and instruments for assessing capacity in guardianship. Clinicians may accordingly be confused about the conceptual basis and standards for incapacity; for example, they may believe that an action that goes against medical advice, or that neurological or psychiatric diagnosis itself, indicates incapacity (Ganzini, Volicer, Nelson, & Derse, 2003). In the absence of specific training on capacity standards, judgment agreement between physicians has been near chance (57% agreement; $\kappa = 0.14$; Marson, McInturff, Hawkins, Bartolucci, & Harrell, 1997).

Need for a Unifying Capacity Model and Assessment Template in Guardianship

There is currently a pressing need for a practice model that can help inform capacity determinations across jurisdictions and that is understandable to both legal and health care professionals. However, communication between legal and health care professionals is hindered by the different language used in respective disciplines for similar concepts. Because of this, a coalition from the National Academy of Elder Law Attorneys, the National Guardianship Association, and the National College of Probate Judges has recommended dialogue between legal and medical professionals about diminished capacity and the creation of

templates for multidisciplinary assessments of capacity (NGN, 2004). Such templates should be founded ideally on a conceptual model of capacity evaluation in guardianship that integrates sound legal approaches to capacity within guardianship with best practices in clinical capacity assessment. In this article we respond directly to the recommendations of national guardianship organizations by describing the development of a conceptual model and evaluation template for assessing capacity in guardianships of older adults.

Methods

Specific Aims

Our goals in the project were to develop (a) a conceptual model for capacity evaluation of older adults in guardianship proceedings that is understandable to clinical and legal professionals and usable across jurisdictions, and (b) an assessment template that operationalizes this framework for clinical evaluation. The model and template are not intended as a practice standard, but rather as a tool that clinical and legal professionals may find useful in communicating about capacity and that would improve the quality and consistency of clinical evidence. We restricted the project to capacity evaluation within the guardianship process, as approaches to capacity determination vary according to the specific legal capacity in question. In addition, the project focused only on older adults with late-onset neurological or psychiatric illness, excluding mental retardation and developmental delay, as some states have separate statutes and evaluation proceedings for adults with these latter diagnoses.

Definitions

Guardianship.—In some jurisdictions, *guardianship* encompasses decisions regarding the person and the estate; in other states, *guardianship* is used for the person only, whereas *conservatorship* is used for the estate; other jurisdictions apply these terms differently. In this project we follow UGPPA conventions in which the guardianship model and template will refer to guardianship as involving decisions regarding the person (an adult), with financial decision making included as one relevant functional domain.

Capacity.—The term *capacity* is used in both clinical and legal settings. In legal settings, it may refer to a lawyer’s assessment of a client’s ability to conduct legal transactions—or to a judicial determination of a person’s legal abilities to make decisions or perform certain functions. In clinical settings, it refers to a clinician’s opinion of a person’s abilities to make decisions or perform certain functions. Although a clinical capacity opinion is not a legal finding, it often serves as important evidence in legal proceedings.

Table 1. Stages of Development of Capacity Evaluation Model and Template

Step	Description
1.	Review of Legal Models for Capacity Evaluation in Guardianship
1.1	State-by-state review of statutory definitions of incapacity in guardianship. Summary: Four components are commonly found and vary from state to state: disabling condition, functional behavior, cognition, and necessity for guardianship in avoiding endangerment (Sabatino & Basinger, 2000).
1.2	State-by-state review of statutory requirements for capacity evaluation in guardianship. Summary: 23 states require information on the medical condition, 11 on cognition, and 16 on functional strengths; 13 require that the clinical evaluation note the prognosis; 16 require recommendations for care or less restrictive alternatives; 10 require information on medications (Mayhew, 2005).
1.3	Comparison with national probate court standards Summary: Information is required on diagnosis, prognosis, limitations and current condition, level of supervision or assistance needed with personal care and decisions, and whether current medication affects demeanor and ability to participate in proceedings (Commission on National Probate Court Standards and Advisory Committee on Interstate Guardianships, 1993).
2.	Review of Clinical Models for Capacity Evaluation in Guardianship
2.1	Grisso Model Summary: The model includes a causal component (e.g., the condition causing the deficits); functional characteristics (e.g., understanding, knowledge, beliefs, and abilities); and the interactive component (e.g., congruency between the person's abilities and the supports or demands in the environment; Grisso, 2003).
2.2	VA Model Summary: The model recommends an assessment of current medical conditions, noting the existence of acute or treatable conditions, cognitive functioning, mental health factors, specific functional abilities, and an interview to assess "values, goals, and preferences." These data are considered in light of environmental demands and possible interventions (Department of Veterans Affairs, 1997).
3.	Development of a Conceptual Model for Capacity Evaluation Summary: Six key domains of capacity assessment found consistently in legal and clinical sources were identified—medical diagnosis, cognition, everyday function, values and preferences, level of risk and supervision needed, and means to enhance capacity.
4.	Review of Existing State Forms for Capacity Evaluation Summary: Twelve existing court templates for capacity evaluation in adult guardianship were found by searching state court Web sites and by solicitations on elder law listserves. Templates varied widely, from being essentially a series of blank lines (e.g., MA) to being a detailed check-off form with more than 100 check boxes (e.g., CA).
5.	Development of the Capacity Evaluation Template Summary: A model assessment template was developed that merged the conceptual model developed in Step 3 with useful formats identified in Step 4.
6.	Review of Model and Template
6.1	Review by representatives of legal and clinical organizations Summary: Members of (a) the ABA Commission on Law and Aging, (b) the National College of Probate Judges Executive Board, and (c) the APA Committee on Aging, Committee on Legal Issues, and Division of Clinical Neuropsychology provided feedback on the model and template.
6.2	Review by Practicing Clinicians Summary: Seventeen clinicians (6 physicians and 11 psychologists) representing 12 states (AL, CA, CT, CO, FL, MA, MI, MN, NC, PA, VA, UT) provided feedback on the template. Most (92%) said they would use the template; and most said the form would be practical to complete (median of 5 on a 6-point scale with 1 = not practical and 6 = very practical).
6.3	Revision of model and template Summary: The working group considered feedback and made revisions based on group consensus.

Approach

The conceptual model and assessment template for capacity in adult guardianship were developed as part of a dialogue between legal and clinical professionals in the American Bar Association (ABA) Commission on Law and Aging and American Psychological Association (APA) Assessment of Capacity in Older Adults Work-

ing Group (American Bar Association Commission on Law and Aging and American Psychological Association, 2005, 2006). From the APA, members from the Committee on Aging, as well as experts in the field identified by those members, participated; support and input was received from the APA Committee on Legal Issues and other member groups as detailed in Table 1. From the ABA, staff attorneys from the Commission on

Table 2. Aspects of Cognitive Functioning Important to Assess in a Capacity Evaluation

Domain	Description
1. Sensory acuity	Detect visual, auditory, tactile stimuli
2. Motor skills	Demonstrate the nature and extent of gross and fine motor skills
3. Attention	Attend to a stimulus and concentrate over brief time periods
4. Working memory	Attend to material over short time periods and hold ≥ 2 ideas in mind
5. Short-term memory	Encode, store, and retrieve information
6. Long-term memory	Remember information previously stored
7. Understanding	Comprehend written, spoken, or visual information (also called receptive language)
8. Communication	Express self in words, writing, or signs (also called expressive language)
9. Arithmetic	Understand basic quantities; make simple calculations
10. Verbal reasoning	Compare 2 choices to reason logically about outcomes
11. Visual-spatial reasoning	Perceive visual-spatial relations and solve visual problems
12. Executive function	Plan for the future, demonstrate judgment, and inhibit inappropriate behavior

Law and Aging participated, as well as expert elder law attorneys identified by the staff members. A judicial advisory panel composed of three representatives from the National College of Probate Judges also participated. The working group was initiated after it was recognized that both psychologists and lawyers are asked increasingly to evaluate the capacity of older adults and were seeking guidance in this process.

We developed the model and template in six phases as described in Table 1. After careful review of legal provisions in every state, and of prevailing clinical models, we developed a conceptual model of capacity assessment in guardianship. Similarly, after reviewing existing court forms, we created an assessment template. This was reviewed by members of relevant legal and clinical organizations, and practicing clinicians, and we modified it on the basis of feedback received in an iterative process. At each stage described in Table 1, group members or outside reviewers developed and reviewed aspects of the model and template. We reviewed concerns and criticism during regular conference calls and occasional in-person meetings, and we made changes to the model and template based on group discussion and consensus.

Conceptual Model

The final conceptual model includes six elements as subsequently described here.

Medical Condition That Produces Functional Disability

Documentation of the relevant medical diagnoses is a key element in capacity determination, as it is an important causative factor explaining any functional disability (e.g., dementia as “causing” a problem managing medications). Historically, many state statutes used the vague term *mental disability* as a sufficient disabling condition, and some opened a very wide door by including *advanced age* and the catch-all or *other cause*. Such amorphous and discriminatory labels invited overly subjective judicial determinations. Therefore, it is important to determine the specific problems causing any observed cognitive or functional disability.

Twenty-two states use specific categories of disease (e.g., “mental illness,” “physical illness,” or “chronic use of drugs or alcohol”). However, the exact extent to which courts are seeking and obtaining information on specific, well-characterized psychiatric or neurologic disorders is unknown. A wide range of neurological and psychiatric conditions may impact capacity with aging, such as Alzheimer’s disease or other forms of dementia, stroke, Parkinson’s disease, traumatic brain injury, schizophrenia, and bipolar disorder (Dymek, Atchison, Harrell, & Marson, 2001; Kim, Karlawish, & Caine, 2002; Moye, Karel, Azar, & Gurrera, 2004).

Some conditions—such as delirium or depression (McAvay et al., 2006)—may be temporary and reversible, and as they improve so too could capacity. Legal and judicial professionals may not be aware of the specific prognoses associated with different diagnoses. Thus, a listing of the current medical diagnoses is not sufficient. A description of the prognoses, an indication that temporary causes of mental impairment have been ruled out, and consideration of the impact of medications and other mitigating factors (such as stress from a recent death) are important in documenting the cause of any functional impairment.

Cognition

Cognitive functioning is an equally important element in capacity determination, as cognitive dysfunction associated with neurocognitive illness is associated with diminished capacity (Gurrera, Moye, Karel, Azar, & Armesto, 2006; Marson, Chatterjee, Ingram, & Harrell, 1996). The UGPPA defines cognitive impairment associated with incapacity as existing in an individual who “is unable to receive and evaluate information or make or communicate decisions” [§102 (5)]. Cognitive functioning is a component of statutory standards for capacity in many states (Sabatino & Basinger, 2000). Cognitive domains relevant to capacity evaluation and commonly assessed in neuropsychological or cognitive assessment (Lezak, Howieson, & Loring, 2004) include those described in Table 2. Although psychiatric and emotional disturbance is not necessarily a cause of capacity impairment, the extent to which severe psychiatric and emotional disturbance

Table 3. Aspects of Emotional and Psychiatric Functioning Important to Assess in a Capacity Evaluation

Domain	Description
1. Disorganized thinking	Having rambling thoughts, or nonsensical or incoherent thinking
2. Hallucinations	Seeing, hearing, or smelling things that are not there
3. Delusions	Believing things that are not true against reason or evidence
4. Anxiety	Having uncontrollable worry, fear, and anxious thoughts or behaviors
5. Mania	Having very high mood, disinhibition, sleeplessness, or high energy
6. Depressed mood	Having sad or irritable mood
7. Lack of insight	Having an inability to acknowledge illness and accept help
8. Impulsivity	Acting without considering the consequences of behavior
9. Noncompliance	Refusing to accept help

impair cognitive functioning is critical to know (Grisso & Appelbaum, 1995) and is detailed in Table 3.

Everyday Functioning

Everyday functioning is perhaps the most salient element in capacity determination, as ultimately the court is interested in what the individual can and cannot do. For instance, can the person make major or minor health care decisions, including end-of-life decisions? Can he or she make property management choices, placement decisions, and choices about personal lifestyle? Can the person make decisions necessary to enable him or her to live independently?

Until recently, the everyday functioning tests found in state laws were fairly vague and subjective, such as “incapable of taking care of himself” (The General Laws of Massachusetts, 1999); “unable to provide for personal needs and/or property management” (N.Y. Mental Hygiene Law, 1999); or “incapable of taking proper care of the person’s self or property or fails to provide for the person’s family” (Ohio Revised Code, 1999). Many states have now set a higher and more objective bar for weighing functional behavior by focusing only on one’s ability to provide for one’s “essential needs,” such as “inability to meet personal needs for medical care, nutrition, clothing, shelter, or safety” (Idaho Code, 1999; Minnesota Statutes Annotated, 1998; N. H. Revised Statutes Annotated, 1999).

Functional assessment is a common component of gerontological assessment and an essential component of dementia diagnosis (Loewenstein & Mogosky, 1999). Clinicians often categorize functional abilities into the activities of daily living, or ADLs (e.g., grooming, toileting, eating, transferring, and dressing) and the instrumental activities of daily living, or IADLs (e.g., abilities to manage finances, health, and functioning in the home and community). We note the specific categories of functioning identified by the working group and judicial advisory panel as especially relevant to guardianship proceedings in Table 4.

Table 4. Components of Everyday Functioning Relevant for Adult Guardianship

Domain	Description
1. Care of self	Maintain adequate hygiene, bathing, dressing, toileting, and dental activities Prepare meals and eat for adequate nutrition Identify abuse or neglect and protect self from harm
2. Financial	Protect and spend small amounts of cash Manage and use checks Give gifts and donations Make or modify will Buy or sell real property Deposit, withdraw, dispose, and invest monetary assets Establish and use credit Pay, settle, prosecute, or contest any claim Enter into a contract, commitment, or lease arrangement Continue or participate in the operation of a business Employ persons to advise or assist self Resist exploitation, coercion, undue influence
3. Medical	Give or withhold medical consent Admit self to health facility Choose and direct caregivers Make or change an advance directive Manage medications Contact help if ill or in medical emergency
4. Home and community life	Choose or establish abode Maintain reasonably safe and clean shelter Be left alone without danger Drive or use public transportation Make and communicate choices about roommates Initiate and follow a schedule of daily and leisure activities Travel Establish and maintain personal relationships with friends, relatives, coworkers Determine degree of participation in religious activities Use telephone Use mail Avoid environmental dangers and obtain emergency help
5. Civil or legal	Retain legal counsel Vote Make decisions about legal documents

Individual Values, Preferences, and Patterns

A consideration of the individual’s values and preferences, although not explicit in most guardianship statutes, has a pivotal and intrinsic role in the process of capacity determination. The inclusion of values as an explicit and equally important element in capacity determination is an innovation of this model. Choices that are linked with lifetime values are rational for an individual even if outside the norm. A person’s, race, ethnicity, culture, and religion may impact individual values and preferences (Blackhall, Murphy, Frank, Michel, & Azen, 1995; Hornung et al., 1998).

The importance of individual values is highlighted in

Table 5. Values Relevant for Adult Guardianship

Area	Example Questions
1. Values about guardianship	Does the person want a guardian? If yes, who does the person want to be guardian?
2. How decisions are made	Does the individual prefer that decisions be made alone or with others?
3. Habitation	Where does the person want to live? What is important in a home environment?
4. Goals and quality of life	What makes life good or meaningful for an individual? What have been the individual's most valued relationships and activities?
5. General concerns	What overarching concerns drive decisions—e.g., concern for the well-being of family, for preserving finances, for avoiding pain, for maintaining privacy; desire to be near family; living as long as possible?
6. Cultural and religious views	What are the individual's strong likes, dislikes, hopes, and fears? Are there important religious beliefs or cultural traditions that impact decisions?

several key clinical and legal sources. The seminal 1982 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research defined capacity to include "the possession of a set of values and goals," which is foundational to comparing alternatives in decision making. Similarly, the ABA's Model Rules of Professional Conduct (American Bar Association, 2003) for lawyers describe factors to be balanced in the determination of capacity to include "the consistency of a decision with the known long-term commitments and values of the client" (rule 1.14, comment 6). In addition, the VA Capacity Assessment Guideline (Department of Veterans Affairs, 1997) recommends a clinical interview to determine "the patient's beliefs and values on the specific capacity issues in question" (p. 10).

Knowledge of values is important not only in determining capacity but also in the guardian's ongoing decision making and in development of any guardianship plan—the set of proposed steps the guardian will follow in providing for care of the incapacitated person. The UGPPA provides that a guardian must "consider the expressed desires and personal values of the [individual] to the extent known to the guardian" (§314(a)). We describe some core values identified by the working group that may affect the individual's preference for who is named guardian, as well as preferences that underlie medical decisions, financial decisions, and living arrangements, in Table 5.

Risk of Harm and Level of Supervision Needed

Most state statutes require that the guardianship is necessary to provide for the essential needs of the individual or that the imposition of a guardianship is the least restrictive alternative for addressing the proven substantial risk of harm to the individual (Sabatino & Basinger, 2000). The principle of the least restrictive alternative means that clinical interventions, such as elder services, technological assistance, or case management, and legal mechanisms, such as durable powers of attorney or health care proxies, have been ruled out as alternatives to the problems identified in the guardianship petition (Wilber, 1996).

An analysis of risk is not merely a consideration of the condition and its effects; it also takes into account the environmental supports and demands of the individual (Grissio, 2003). Strong social and environmental supports may decrease a person's risk whereas lack of supports may increase it. For example, it may make a real difference whether the person has a caring family, is in a supervised setting, or is surrounded by a familiar community network (Lawton, 1982). The level of supervision recommended by the clinician and the legal interventions determined by the judge must match the risk of harm to the individual and the corresponding level of supervision required to mitigate such risk. In some cases, the risk of harm is low and the need can be addressed through a less restrictive alternative or limitation to guardianship. In other cases, less restrictive alternatives have failed or are inappropriate, and a plenary guardianship is necessary to protect the well-being of the elder.

Means to Enhance Capacity

Guardianships are intensely intrusive legal interventions. Nevertheless, in the best of situations, guardianship will protect the individual's well-being, promote his or her values, and maximize the individual's functioning. Clinical and legal professionals must therefore be vigilant in finding ways to enhance capacity, and thus eliminate the need for or limit the scope of the guardianship. These include practical accommodations (such as vision aids, medication reminders), as well as medical, psychosocial, or educational interventions (such as physical or occupational therapy, counseling, medications, or training). The mere existence of a physical disability should not be a ground for guardianship, because most physical disabilities can be accommodated with appropriate medical, functional, and technological assistance directed by the individual (Hommel, 1996).

Clinical recommendations for intervention bear upon many aspects of the guardianship process (Quinn, 2004). These recommendations may indicate how to maximize participation in the hearing, such as with auditory amplification or documents in large type. Further, if improvement of capacity is possible with

treatment for underlying conditions, clinical recommendations may guide the judge in deciding when to hear the case again. For example, if the patient is in a postoperative delirium but decisions must be made about care (in the absence of next of kin, etc.), then a judge may want to review the need for the guardianship after the delirium clears. Similarly, if a guardianship is sought involving treatment for an acute psychotic disorder, a judge may want to review the need for guardianship after treatment. Finally, clinical recommendations may directly inform the guardian's plan of care.

Assessment Template

The final version of the model template is shown in Appendix A. In the model template we attempt to balance comprehensiveness with efficiency. Borrowing from formats on existing templates, the model uses a combination of headings with space for narrative description and check boxes to provide at-a-glance summaries. The template has sections for each of the six model elements. The diagnostic section includes a place to list the physical and mental diagnoses, the medications and whether they may impact functioning, and both reversible and mitigating factors that may cause confusion. The cognitive section has three broad categories: (a) general level of alertness or consciousness, (b) cognitive abilities, and (c) impact of emotional and psychiatric factors. The everyday functioning section is broken into ADLs and four IADLs. Finally, there are sections on values and preferences, risk of harm and level of supervision needed, and treatments. A seventh section provides a place for the clinician to comment on the individual's attendance at the hearing. A final certification section provides space for the clinician to describe his or her discipline, the approach used in completing the form, whether the individual was informed about privilege, and any tests used. Because clinicians and courts may have specific jurisdictional requirements, we have made an online version of the template available in word processing format (www.abanet.org/aging or www.apa.org/PI/aging), with permission given to modify the form according to local practice needs. Supplemental forms are available online to describe the specific areas described in Tables 2–5.

Discussion

Older adults are increasingly subject to guardianship proceedings (Quinn, 2004), and this number is expected to rise in coming decades with the ever-growing geriatric population. Legal and clinical concepts of capacity under guardianship have evolved to recognize that individuals may manifest discrete functional strengths and weaknesses, and that courts should carefully match these functional abilities through the use of limited guardianship or less restrictive alternatives to guardianship (NGN Members, 2004). The avoidance of guardianship when not necessary, and the

successful application of limited guardianship when appropriate, depends largely upon the provision of expert clinical testimony to the courts by clinicians. Clinical reports are of extremely high consequence, particularly in courts that do not utilize court investigators or counsel for the allegedly incapacitated person, especially given that the subject of the petition is rarely present at the hearing (Moye, Mlinac, Wood, Wood, & Edelstein, 2006).

Historically, physicians provided clinical documentation for adults in guardianship proceedings. Currently, 23 states provide for the involvement of psychologists or other mental health professionals (Mayhew, 2005). Such testimony is often in the form of a written report in which the clinician describes the patient's clinical status to the court. Ultimately, the guardianship order, and resulting retention or removal of individual rights, hinges on the quality of information provided by the clinician and others who testify to the individual's abilities.

The task for the health care professional of providing information to the courts is onerous. There are competing demands on clinical time and unclear sources of payment for clinical evaluation for the purposes of guardianship. Often petitioners who are family members may ask the clinician to provide the written report as part of usual care. When additional evaluation is needed, state courts tend to have limited funds, if any, for such evaluation.

It may be challenging for clinicians to translate and organize clinical knowledge into a format usable by the courts. Clinical and legal professionals approach the concept of capacity from different conceptual frameworks (i.e., medicine vs the law) and utilize different terminology. Clinicians may not be knowledgeable about legal processes and provisions, whereas lawyers and judges may be similarly ignorant about the meaning of clinical diagnoses and tests. Judges may not be clear about what information they need to construct limited guardianship orders and to establish appropriate monitoring plans.

Templates for guardianship evaluation that are meaningful to clinicians and courts may provide one cost-effective approach addressing these challenges (NGN Members, 2004). In this article we describe an effort by a team of psychologists, lawyers, and judges to develop a conceptual model and template that is mindful of both statutory frameworks and clinical concepts; is cross-jurisdictional; and responds to the NGN recommendations. We propose a six-part conceptual model for capacity evaluation in adult guardianship: (a) medical condition that causes functional disability, (b) cognition, (c) everyday functioning, (d) values and preferences, (e) risk of harm and level of supervision needed, considering environmental supports, and (f) means to enhance capacity.

Although more elaborate frameworks can be utilized, this six-part model describes a minimal set of factors important to the court that reflects statutory frameworks, prevailing probate court standards, and existing clinical models for capacity in guardianship. The template operationalizes this model for clinicians

and the courts and offers a way to unify thinking about capacity across jurisdictions. We also hope the template may help to make the process of crafting limited orders more feasible.

The template focuses specifically on the assessment of the allegedly incapacitated person by the clinician. It is not meant to supplant the total investigatory process by the court or other components of testimony the court may hear and consider in determining guardianship. For example, ideally a guardianship case is screened before it is heard to determine the triggering factors, the social situation (e.g., are there reliable family or friends that would be both available and willing to provide support or assistance), and the potential appropriateness of using less restrictive alternatives to guardianship (such as durable powers of attorney, in-home assistance, or elder services; American Bar Association Commission on Law and Aging and American Psychological Association, 2006). The template includes a place for the evaluator to describe the social system and to note whether less restrictive alternatives may be appropriate to address the needs identified in the clinical evaluation. We hope the template can improve communication between health care professionals and the courts about the clinical evaluation process, but the template, in and of itself, cannot solve all the concerns that have been identified in the adult guardianship process, such as lack of screening, inadequate funding of court investigators, and insufficient monitoring, to name a few (Quinn, 2004).

The template aims to guide and record a clinical evaluation, but it is not in itself intended as rating scale or psychological test. It relies on the inherent reliability and validity of the underlying assessment process by the clinician. For example, it presumes that any neuropsychological test results used to support descriptions of cognition are appropriately administered (i.e., when the individual is as medically stable as possible; adjusting for the individual's educational and language background; etc.).

Limitations

Because the template is not a test, it is not subject to usual psychometric reliability and validity analyses. The utility of the template rests in its responsiveness to the legal and clinical frameworks noted, and the review process described. Limitations to the model and template include that it was developed as a collaborative process between the American Bar Association and American Psychological Association. Although we attempted to obtain input from multiple disciplines and from those outside these associations, the model and template could reflect disciplinary biases within members of these organizations.

We encourage examination and revision of the template to improve its comprehensiveness, efficiency, and flexibility. For example, a next step may be for some courts to pilot the template to determine its practicality (e.g., will clinicians complete it?) and usefulness (e.g., does it help the court?), and to

compare cases that did or did not use the template. Continuing interdisciplinary collaboration between clinical and legal professionals will be vital to deepening our understanding of the concept of capacity, improving the capacity assessment process, and protecting the autonomy and rights of older adults with diminished capacity.

References

- American Bar Association. (2003). *Model rules of professional conduct*. Washington, DC: Author.
- American Bar Association Commission on Law and Aging and American Psychological Association. (2005). *Assessment of older adults with diminished capacity: A handbook for lawyers*. Washington, DC: Author.
- American Bar Association Commission on Law and Aging and American Psychological Association. (2006). *Determining capacity of older adults in guardianship proceedings: A handbook for judges*. Washington, DC: Author.
- Anderer, S. J. (1990). *Determining competency in guardianship proceedings*. Washington, DC: American Bar Association.
- Blackhall, L. J., Murphy, S. T., Frank, G., Michel, V., & Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. *Journal of the American Medical Association, 274*, 820–825.
- Bulcroft, K. A., Kielkopf, M. R., & Tripp, K. (1991). Elderly wards and their legal guardians: Analysis of country probate records in Ohio and Washington. *The Gerontologist, 31*, 156–164.
- Commission on National Probate Court Standards and Advisory Committee on Interstate Guardianships. (1993). *National probate court standards*. Williamsburg, VA: National College of Probate Judges and National Center for State Courts.
- Department of Veterans Affairs. (1997). *Clinical assessment for competency determination: A practice guideline for psychologists*. Milwaukee: Department of Veterans Affairs National Center for Cost Containment.
- Dudley, K. C., & Goins, R. T. (2003). Guardianship capacity evaluations of older adults: Comparing current practice to legal standards in two states. *Journal of Aging and Social Policy, 15*, 97–115.
- Dymek, M. P., Atchison, P., Harrell, L., & Marson, D. C. (2001). Competency to consent to medical treatment in cognitively impaired patients with Parkinson's disease. *Neurology, 56*, 17–24.
- Ganzini, L., Volicer, L., Nelson, W., & Derse, A. (2003). Pitfalls in the assessment of decision-making capacity. *Psychosomatics, 44*(3), 237–243.
- Grisso, T. (2003). *Evaluating competences* (2nd ed.). New York: Plenum Press.
- Grisso, T., & Appelbaum, P. S. (1995). The MacArthur Treatment Competency Study III: Abilities of patients to consent to psychiatric and medical treatment. *Law and Human Behavior, 19*, 149–174.
- Gurrera, R. J., Moye, J., Karel, M. J., Azar, A. R., & Armento, J. C. (2006). Cognitive performance predicts treatment decisional abilities in mild to moderate dementia. *Neurology, 66*, 1367–1372.
- Hommel, P. A. (1996). Guardianship reform in the 1980's: A decade of substantive and procedural change. In M. Smyer, K. W. Schaie, & M. B. Kapp (Eds.), *Older adult's decision-making and the law* (pp. 225–253). New York: Springer.
- Hornung, C. A., Eleazer, G. P., Strothers, H. S., Wieland, G. D., Eng, C., McCann, R., et al. (1998). Ethnicity and decision-makers in a group of frail older people. *Journal of the American Geriatrics Society, 46*, 280–286.
- Idaho Code § 15-5-101 (a)(1); (1999).
- Keith, P. M., & Wacker, R. R. (1992). Guardianship reform: Does revised legislation make a difference in outcomes for proposed wards? *Journal of Aging and Social Policy, 4*, 139–155.
- Kim, S. Y. H., Karlawish, J. H. T., & Caine, E. D. (2002). Current state of research on decision making competence of cognitively impaired elderly persons. *American Journal of Geriatric Psychiatry, 10*, 151–165.
- Lawton, M. P. (1982). Competence, environmental press, and the adaptation of older people. In M. P. Lawton, P. G. Windley, & T. O. Byerts (Eds.), *Aging and the environment: Theoretical approaches* (pp. 33–59). New York: Springer.
- Lezak, M. D., Howieson, D. B., & Loring, D. W. (2004). *Neuropsychological assessment* (4th ed.). New York: Oxford University Press.
- Loewenstein, D. A., Mogosky, B. J. (1999). The functional assessment of the older adult patient. In P. Lichtenberg (Ed.), *Handbook of geriatric assessment* (pp. 529–554). New York: Wiley.
- Marson, D. C., Chatterjee, A., Ingram, K. K., & Harrell, L. E. (1996). Toward a neurologic model of competency: Cognitive predictors of capacity to consent in Alzheimer's disease using three different legal standards. *Neurology, 46*, 666–672.
- Marson, D. C., McInturff, B., Hawkins, L., Bartolucci, A., & Harrell,

- L. E. (1997). Consistency of physician judgments of capacity to consent in mild Alzheimer's disease. *The American Geriatrics Society*, 45, 453-457.
- Mass. Gen Laws Ann. ch. 201 §6, (1999).
- Mayhew, M. (2005). Survey of state guardianship laws: Statutory provisions for clinical evaluations. *Bifocal*, 26, 1-19.
- McAvay, G. J., Van Ness, P. H., Bogardus, S. T., Zhang, Y., Leslie, D. L., Leo-Summers, L. S., et al. (2006). Older adults discharged from the hospital with delirium: 1-year outcomes. *Journal of the American Geriatrics Society*, 54, 1245-1250.
- Minn. Stat. Ann § 525.54, subd. 2 (1998).
- Moye, J. (2003). Guardianship and conservatorship. In T. Grisso (Ed.), *Evaluating competencies* (2nd ed., pp. 309-390). New York: Plenum Press.
- Moye, J., Karel, M. J., Azar, A. R., & Gurrera, R. J. (2004). Capacity to consent in dementia: Empirical comparison of three instruments. *The Gerontologist*, 44, 166-175.
- Moye, J., Mlinac, M., Wood, E., Wood, S., & Edelstein, B. (2006). Challenges in guardianship of older adults: Results of a tri-state study. *Journal of the National College of Probate Judges*, 3, 1-3.
- Moye, J., Wood, E., Edelstein, B., Wood, S., Bower, E. H., Harrison, J. A., et al. (2007). Statutory reform is associated with improved court practice: Results of a tri-state study. *Behavioral Sciences and the Law*, 25, 425-436.
- National Conference of Commissioners on Uniform State Laws. (1997). Uniform Guardianship and Protective Proceedings Act. Retrieved June 6, 2003, from <http://www.law.upenn.edu/bl/ulc/fnact99/1990s/ugppa97.htm>
- National Guardianship Network Members. (2004). National Wingspan Implementation Session: Action Steps on Adult Guardianship Progress. Retrieved January 6, 2005, from <http://www.naela.com>
- N. H. Rev. Stat. Ann. § 464-A:2(XI) (1999).
- N.Y. Mental Hygiene Law §81.02(b) (1999).
- Ohio Revised Code Ann. §2111.01(D) (1999).
- President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. (1982). *Making health care decisions* (Vol. 1). Washington, DC: U.S. Government Printing Office.
- Quinn, M. J. (2004). *Guardianship of adults: Achieving justice, autonomy, and safety*. New York: Springer.
- Sabatino, C. P., & Basinger, S. L. (2000). Competency: Reforming our legal fictions. *Journal of Mental Health and Aging*, 6, 119-143.
- Wilber, K. H. (1996). Alternatives to guardianship revisited: What's risk got to do with it? In M. Smyer, K. W. Schaie, & M. B. Kapp (Eds.), *Older adult's decision-making and the law* (pp. 213-224). New York: Springer.
- Zimny, G. H., & Grossberg, G. T. (1998). *Guardianship of the elderly: Psychiatric and judicial aspects*. New York: Springer.

Received December 15, 2006
 Accepted March 15, 2007
 Decision Editor: Linda S. Noelker, PhD

APPENDIX A, GUARDIAN EVALUATION TEMPLATE ON FOLLOWING PAGES 600-603

Submit an Abstract to The Gerontological Society of America for the 61st Annual Scientific Meeting

November 21-25, 2008
 National Harbor, MD



The Call for Papers and the online
 abstract submission form will be
 available January 2008.

**Abstract Deadline:
 Friday, March 14, 2008**

Visit
www.agingconference.com
 for continuously updated annual meeting information!

State of County of	THIS SECTION TO BE COMPLETED BY THE COURT	XXX Court of Justice XXX Division
In the Matter of:		File No.
Definition of Incapacity in the State of ___:		

Note: Text boxes appear in online form and will expand to the size of the text.

1. PHYSICAL AND MENTAL CONDITIONS

A. List Physical Diagnoses:

Overall Physical Health: Excellent Good Fair Poor

B. List Mental (DSM) Diagnoses:

Overall Mental Health: Excellent Good Fair Poor

Overall Mental Health will: Improve Be stable Decline Uncertain

If improvement is possible, the individual should be re-evaluated in _____ weeks.

Focusing on the mental diagnose(s) most impacting functioning, describe relevant history:

C. List all Medications:

<u>Name</u>	<u>Dosage/Schedule</u>
<input style="width: 100%; height: 20px;" type="text"/>	

These medications may impair mental functioning: Yes No Uncertain

D. Reversible Causes.

Have temporary or reversible causes of mental impairment been evaluated and treated? Yes No Uncertain

Explain:

E. Mitigating Factors.

Are there mitigating factors (e.g., hearing, vision or speech impairment, bereavement, etc.) that cause the person to appear incapacitated and could improve with time, treatment, or assistive devices?

Yes No Uncertain

Explain:

2. COGNITIVE AND EMOTIONAL FUNCTIONING

A. Alertness/Level of Consciousness

Overall Impairment: None Mild Moderate Severe Non Responsive

Describe:

B. Memory and Cognitive Functioning

Overall Impairment: None Mild Moderate Severe

Describe below or in Attachment

C. Emotional and Psychiatric Functioning

Overall Impairment: None Mild Moderate Severe

Describe below or in Attachment

D. **Fluctuation.** Symptoms vary in frequency, severity, duration: Yes No Uncertain

3. EVERYDAY FUNCTIONING. Describe below or in Attachment the strengths & weaknesses.

A. Activities of Daily Living (ADLs)

Ability to Care for Self (bathing, grooming, dressing, walking, toileting, etc.)

Level of Function: Independent Needs Support Needs Assistance Total Care

Describe:

B. Instrumental Activities of Daily Living (IADLs)

Financial Decision Making (bills, donations, investments, wills, manage assets, resist fraud, etc.)

Level of Function: Independent Needs Support Needs Assistance Total Care

Describe:

C. Medical Decision Making (express a choice and understand, appreciate, reason about health info)

Level of Function: Independent Needs Support Needs Assistance Total Care

Describe:

D. Care of Home and Functioning in Community (manage home, health, telephone, mail, drive, leisure, etc.)

Level of Function: Independent Needs Support Needs Assistance Total Care

Describe:

E. Other Relevant Civil, Legal, or Safety Matters (sign documents, vote, retain legal counsel, etc.)

Level of Function: Independent Needs Support Needs Assistance Total Care

Describe:

4. **VALUES AND PREFERENCES.** Describe below or in Attachment relevant values, preferences, and patterns. Note whether the person accepts/opposes guardianship, goals for where/how life is lived, religious or cultural considerations.

5. **RISK OF HARM AND LEVEL OF SUPERVISION NEEDED**

A. **Nature of Risks.** Describe the significant risks facing this person, and note whether these risks are due to this person's condition and/or due to another person harming or exploiting him or her.

B. **Social Factors.** Describe the social factors (persons, supports, environment) that decrease the risk or that increase the risk.

C. How **severe** is risk of harm to self or others: Mild Moderate Severe

D. How **likely** is it Almost Certain Probable Possible Unlikely

E. **Level of Supervision Needed.** In your clinical opinion:

Locked facility 24-hr supervision Some supervision No supervision

Needs could be met by: Limited Guardianship Less Restrictive Alternative

If checked, Explain:

6. **TREATMENTS AND HOUSING.** The individual would benefit from:

Education, training, or rehabilitation Yes No Uncertain

Mental health treatment Yes No Uncertain

Occupational, physical, or other therapy Yes No Uncertain

Home and/or social services Yes No Uncertain

Assistive devices or accommodations Yes No Uncertain

Medical treatment, operation or procedure Yes No Uncertain

Other: _____ Yes No Uncertain

Describe any specific recommendations:

7. **ATTENDANCE AT HEARING**

The individual can attend the hearing Yes No Uncertain

If no, what are the supporting facts:

If yes, how much will the person understand and what accommodations are necessary to facilitate participation:

8. CERTIFICATIONS

I am a Physician Psychologist Other _____ licensed to practice in the state of _____

Office Address:

Office Phone:

This form was completed based on:

- an examination for the purpose of capacity assessment
 my general clinical knowledge of this patient

Prior to the examination, I informed the patient that communications would **not** be privileged:

- Yes
 No

Date of this examination or the date you last saw the patient:

Time spent in examination:

Other sources of information for this examination:

- Review of medical record
 Discussion with health care professionals involved in the individual's care
 Discussion with family or friends
 Other

List any tests which bear upon the issue of incapacity and date of tests:

--

I hereby certify that this report is complete and accurate to the best of my information and belief. I further testify that I am qualified to testify regarding the specific functional capacities addressed in this report, and I am prepared to present a statement of my qualifications to the Court by written affidavit or personal appearance if directed to do so.

SIGNATURE of CLINICIAN

DATE

Print name

License type, number, and date