

# A HANDBOOK FOR LAWYERS

## ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY:



American Bar Association  
Commission on Law  
and Aging



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

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**American Bar Association  
Commission on Law  
and Aging**

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**AMERICAN  
PSYCHOLOGICAL  
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## About the American Bar Association Commission on Law and Aging

The mission of the American Bar Association (ABA) Commission on Law and Aging is to strengthen and secure the legal rights, dignity, autonomy, quality of life, and quality of care of elders. It carries out this mission through research, policy development, technical assistance, advocacy, education, and training.

The ABA Commission consists of a 15-member interdisciplinary body of experts in aging and law, including lawyers, judges, health and social services professionals, academics, and advocates. With its professional staff, the ABA Commission examines a wide range of law-related issues, including: legal services to older persons; health and long-term care; housing needs; professional ethical issues; Social Security, Medicare, Medicaid, and other public benefit programs; planning for incapacity; guardianship; elder abuse; health care decision-making; pain management and end-of-life care; dispute resolution; and court-related needs of older persons with disabilities.

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The American Psychological Association (APA) is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Through its divisions in 53 subfields of psychology and affiliations with 59 state, territorial, and Canadian provincial associations, APA works to advance psychology as a science, as a profession, and as a means of promoting health, education, and human welfare. The APA Office on Aging coordinates the association's activities pertaining to aging and geropsychology (the field within psychology devoted to older adult issues). The Committee on Aging (CONA) is the committee within the APA governance structure dedicated to aging issues. Its six expert geropsychologists are selected for three-year terms. Together, the Office on Aging, CONA, and association members promote the health and wellbeing of older adults and their families through expanded scientific understanding of adult development and aging and the delivery of appropriate psychological services to older adults.

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*Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers* represents the first work product of the ABA/APA Assessment of Capacity in Older Adults Project Working Group, established in 2003 under the auspices of the Task Force on Facilitating APA/ABA Relations.

In June 2003, a two-day meeting, *Legal and Psychological Perspectives on Assessment of Capacity in Older Adults: An ABA-APA Dialogue*, brought together a group of attorneys, psychologists, and a probate judge to discuss professional needs. Among the issues identified was a need for a handbook for attorneys on working with older adults with diminished capacity with a focus on attorney assessment. Subsequent to the meeting, the ABA/APA Assessment of Capacity in Older Adults Project Working Group was formed. The group met again in December 2003. At that meeting an outline for the handbook was developed and chapter authors were identified.

Members of the ABA/APA Working Group are: Nancy Coleman, M.S.W, M.A.; Deborah DiGilio, M.P.H.; Barry Edelstein, Ph.D.; Gregory Hinrichsen, Ph.D.; Daniel Marson, J.D., Ph.D.; Jennifer Moye, Ph.D.; Leonard Poon, Ph.D.; David Powers, Ph.D.; Charles Sabatino, J.D.; and Erica Wood, J.D. Daniel Marson and Jennifer Moye contributed case examples. Jennifer Moye was the editor of this handbook.

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# Executive Summary

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With the coming demographic avalanche of Boomers reaching their 60s and the over-80 population swelling, lawyers face a growing challenge: older clients with problems in decision-making capacity. While most older adults will not have impaired capacity, some will. Clear and relatively obvious dementias will impair capacity, and the prevalence of such dementias increases with age. But what about older adults with an early stage of dementia or with mild central nervous system damage? Such clients may have subtle decisional problems and questionable judgments troubling to a lawyer. This handbook offers a conceptual framework and practice tips for addressing problems of client capacity, in some cases with help from a clinician.

Some might argue that without training in mental disorders of aging and methods of formal capacity evaluation, lawyers should not be making determinations about capacity. Yet lawyers necessarily are faced with an assessment or at least a screening of capacity in a rising number of cases involving specific legal transactions and, in some instances, guardianship. Even the belief that “something about a client has changed” or a decision to refer a client for a formal professional capacity evaluation represents a preliminary assessment of capacity.

The 2002 revision of the ABA’s Model Rules of Professional Conduct, Rule 1.14, concerning the client with diminished capacity, recognizes the bind in which this places the attorney, and provides some guidance. The rule triggers protective action when an attorney reasonably believes that a client has diminished capacity, that there is a potential for harm to the client, and that the client cannot act in his or her own interest. However, the critical question is: how does the lawyer reach a reasonable belief that the client has diminished capacity? This handbook seeks to respond.

The handbook represents a unique collaboration of lawyers and psychologists. While it is a joint project of the ABA Commission on Law and Aging and the APA, its applicability is broad. It can be of use to

elder law attorneys, trusts and estates lawyers, family lawyers, and general practitioners. It introduces lawyers to a wide spectrum of mental health professionals, including, but extending beyond, licensed psychologists. Interdisciplinary partnerships between lawyers and clinicians promise more informed approaches for helping older clients meet their legal needs.

The handbook is not a practice standard meant to outline compulsory actions. Instead, it offers ideas for effective practices and makes suggestions for attorneys who wish to balance the competing goals of autonomy and protection as they confront the challenges of working with older adults with diminished capacity. The handbook includes helpful discussion of the following 16 key questions.

**1. What are legal standards of diminished capacity?** (Ch. II, pp. 5 – 8). In everyday legal practice, lawyers need to be familiar with three facets of legal thinking about diminished capacity—standards of capacity for specific legal transactions under statutory and case law; standards of diminished capacity in state guardianship law; and ethical guidelines for assessing capacity, as set out in Model Rule 1.14 and the comments to the rule.

**2. What are clinical models of capacity?** (Ch. III, pp. 9 – 12). While psychologists and other health professionals may use different terms than lawyers, conceptually the clinical model of capacity has striking similarities to the legal model.

**3. What signs of diminished capacity should a lawyer be observing?** (Ch. IV, pp. 13 – 16). There is no single marker of diminished capacity, but there are “red flags” that may indicate problems. Attorneys should be alert to cognitive, emotional, or behavioral signs such as memory loss, communication problems, lack of mental flexibility, calculation problems, disorientation and more, as described.

**Capacity Worksheet for Lawyers (pp. 23 - 26)**

This capacity worksheet helps you identify and organize:

- **Observational signs of diminished capacity.**
- **Mitigating factors affecting capacity.**
- **Transaction-specific elements of legal capacity.**
- **Task-specific factors in evaluating capacity.**
- **Preliminary conclusions about client capacity.**

**4. What mitigating factors should a lawyer take into account?** (Ch. IV, pp. 16 – 17). Factors such as stress, grief, depression, reversible medical conditions, hearing or vision loss, or educational, socio-economic, or cultural background can influence a determination or can call for alternative action—such as a referral to a physician or an adjusted approach to communication.

**5. What legal elements should a lawyer consider?** (Ch. IV, pp. 17 - 18). A lawyer can compare the client’s understanding with each of the elements of capacity set out in statute or case law for the specific transaction or situation at hand. For instance, state law may require that for making gifts, a person must have an understanding of the property dispositions made and the persons and objects of his or her bounty.

**6. What factors from ethical rules should a lawyer consider?** (Ch. IV, pp. 18 – 19). A lawyer must take into account key questions specific to the task at hand (many of which are set out in the Comment to Rule 1.14) concerning the nature of the decision (consistency with long-term values, fairness, irreversibility) and the functioning of the individual (ability to articulate reasoning, variability of state of mind, and appreciation of consequences). The more serious the concerns about the decision and the risk involved, the higher the functioning needed.

**7. How might a lawyer categorize judgments about client capacity?** (Ch. IV, pp. 19 - 20). There is no simple score that will help the lawyer easily to come to a conclusion about client capacity. Rather, it is a professional judgment integrating all of the factors above. It might be helpful to categorize the results in the schema on page vii.

**8. Should a lawyer use formal clinical assessment instruments?** (Ch. IV, pp. 21 - 22). It is generally *not appropriate for lawyers to use formal clinical assessment instruments* such as the Mini-Mental Status Examination (MMSE), as they are not trained in using and interpreting these tests, the information yielded is limited, and the results may be misleading.

**9. What techniques can lawyers use to enhance client capacity?** (Ch. V, pp. 27 – 30). Lawyers can use practical approaches to accommodate sensory and cognitive changes that become more prevalent with age, and to build trust and confidence. Lawyers must be sensitive to age-related changes without losing sight of the individuality of each older client, and must not assume impairments in older clients but be prepared to address these issues when they arise. It is a fine line to walk. The handbook lists many tips to engender trust and bolster decision-making ability, and to accommodate hearing, vision, and cognitive loss. It also describes an approach to strengthen client engagement in the decision-making process.

**10. What are the pros and cons of seeking an opinion of a clinician?** (Ch. VI, pp. 31 - 32). If there are “more than mild problems” a lawyer may find it helpful to seek the independent judgment of a physician or other clinician. Moreover, in cases of ongoing or anticipated family or other conflict a lawyer may seek a formal assessment to preempt future litigation such as a will contest. A referral to a clinician requires client consent, and can be quite traumatic for the client, as well as unsettling for the lawyer-client relationship. Also, it is expensive. However, a formal assessment generally is very valuable in clarifying specific areas of diminished capacity, eliciting advice on strategies to enhance capacity, identifying the need for protective action, justifying concerns to family members, and providing evidence in subsequent depositions or court hearings. The handbook offers ideas for ways to suggest an assessment to clients.

**11. What if the client’s ability to consent to a referral is unclear?** (Ch. VI, pp. 34 – 36). The lawyer could wait until the client is stabilized or has a lucid interval to seek consent—or at least “assent.” Under one possible interpretation of the Model Rules, the

- **Intact. No or very minimal evidence of diminished capacity.**
- **Mild problems. Some evidence of diminished capacity, but insufficient to preclude representation or proposed transaction.**
- **More than mild problems. Substantial evidence of diminished capacity. Warrants consultation with or referral to mental health professional.**
- **Severe problems. Client lacks capacity to proceed with the transaction and the representation.**

lawyer might make a very limited disclosure of otherwise confidential information to seek assistance from a clinician, since this is a “protective action.” The lawyer needs to use good judgment and limit information revealed to what is absolutely necessary. The lawyer should seek a clinical consultation without identifying the client whenever possible.

**12. What are the benefits for the lawyer of a private consultation with a clinician?** (Ch. VI, p. 31). Sometimes a lawyer may seek a consultation with a clinician to discuss and clarify capacity issues before proceeding with representation or with a formal mental health assessment. This approach is private, and does not involve the client or require client consent, as the client is not identified. The consultation is simply professional advice to the lawyer, paid for by the lawyer. It often can save considerable time, money, and angst.

**13. How can a lawyer identify an appropriate clinician to make a capacity assessment?** (Ch. VI, pp. 32 - 33). The most important question in identifying an appropriate clinician is *how much experience the professional has with the assessment of capacity of older adults*. Types of professionals most likely to have such a background include: physicians, geriatricians, geriatric psychiatrists, forensic psychologists and psychiatrists, gero- and neuropsychologists, neurologists, and geriatric assessment teams. Lawyers with a large geriatric clientele may already have—or should develop—such contacts. Lawyers can investigate mental health resources through the local Area Agency on Aging, through local affiliates of the

American Psychiatric Association and American Psychological Association, or through state or local medical societies or university medical centers.

**14. What information should a lawyer provide to a clinician in making a referral?** (Ch. VI, pp. 33 - 36). The care with which the lawyer crafts the referral request will bear directly on the usefulness of the results. A referral letter should clearly set out: client background; reason client contacted the lawyer; whether a new or old client; the purpose of the referral (the legal task to be performed); the relevant legal standard for capacity to perform the task at hand; any known medical and functional information about the client; the living situation and any environmental/social factors that may affect capacity; and client values and preferences. The lawyer should request that the *evaluator contact him/her by telephone before proceeding with any written report*, to determine whether such a report would be useful. A written report might not be advisable if litigation is possible and the assessment provides potential adverse evidence.

**15. What information should the lawyer look for in an assessment report?** (Ch. VII, pp. 37 - 39). While capacity reports differ among clinicians, common elements include: demographic information; legal background and referral questions; history of present illness and any psychosocial history; a statement of informed consent to the evaluation; behavioral observations; tests administered and extent to which the test results are considered valid; a summary of test results with scores and performance ranges; a diagnosis or opinion on the question of capacity for the legal task(s) at hand; and any recommendations for clinical actions to treat symptoms.

**16. How does a clinical capacity evaluation relate to the lawyer’s judgment of capacity?** (Ch. VII, pp. 39 - 41). The ultimate question of capacity is a legal—and in some cases a judicial—determination, not a clinical finding. A clinical assessment stands as strong evidence to which the lawyer must apply judgment taking into account all of the factors in the case at hand.



# I. Importance of Lawyer Assessment of Client Capacity

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## A. Capacity Judgments and Legal Practice

Although lawyers seldom receive formal training in capacity assessment, they make capacity judgments on a regular basis whether they realize it or not. In the context of litigation, capacity may be the sole issue in controversy—such as in a guardianship action or a challenge to a will, trust, or donative transfer based on an allegation of legal incapacity. In this context, the lawyer’s role is fairly straightforward—to advocate fairly but zealously for the conclusion that represents the interests of the party he or she represents.

In non-adversarial situations, such as estate planning or the handling of specific transactions, issues of capacity are confronted more informally in the daily practice setting. In this setting, legal practitioners by necessity make implicit determinations of clients’ capacity at at least two points. First, the lawyer must determine whether or not a prospective client has sufficient legal capacity to enter into a contract for the lawyer’s services. Failing this, representation cannot proceed.

Second, the lawyer must evaluate the client’s legal capacity to carry out the specific legal transactions desired as part of the representation (e.g., making a will, buying real estate, executing a trust, making a gift, etc.). Fortunately, for the typical adult client, the presence of adequate capacity is obvious. Moreover, as a legal and ethical matter, capacity is presumed. It is only when signs of questionable capacity present themselves that a capacity determination becomes a conscious mental process—either one deliberately undertaken or haphazardly muddled through.

Such a practice reality may seem foreign and perhaps a bit alarming to the legal professional not readily familiar with mental health concepts. Lacking training in capacity assessment or other aspects of mental health, the average practitioner may argue that lawyers do not and should not perform capacity assessments. Instead, lawyers should refer any cases of questionable capacity to mental health professionals for assessment. The assertion is true as far as it

### Unavoidable capacity determinations:

1. **Does the client have the capacity to contract for my services?**
2. **Does the client have the capacity to complete the legal transaction?**

**Lawyers need a conceptually sound and consistent process for answering these questions.**

goes—but it only goes so far. To decide whether a formal assessment is needed, the lawyer is *already exercising judgment* about the client’s capacity on an informal or preliminary level. The exercise of judgment, even if it is merely the incipient awareness that “something is not right,” is itself an assessment. It is better to have a sound conceptual foundation and consistent procedure for making this preliminary assessment than to rely solely on *ad hoc* conjecture or intuition.

## B. Increasing Prevalence of Capacity Questions

The incidence of cases in which capacity is an issue will increase substantially in the coming years because of the aging demographic bulge and because of the greater incidence of dementia that accompanies the aging process. The label *dementia* implies no specific cause, nor does it represent an inevitable part of normal aging. However, the prevalence of dementia is estimated to double every five years in the elderly, growing from a disorder that affects 1 percent of persons 60 years old to a condition afflicting approximately 30 percent to 45 percent of persons 85 years old.<sup>1</sup> A wide range of diseases affecting the brain cause dementia, some entirely reversible.<sup>2</sup> Alzheimer’s disease is the most common cause, accounting for 60 percent to 70 percent of dementia cases.<sup>3</sup> New drug therapies are emerging to slow the progress of Alzheimer’s, but it remains incurable and irreversible. For more information on dementia, see Appendix 4.

### C. Model Rule 1.14

The ABA's Model Rules of Professional Conduct (MRPC), as revised in 2002, acknowledge the lawyers' assessment functions, and indeed, suggest a duty to make informal capacity judgments in certain cases. For the first time, the revised rule attempts to give some guidance to lawyers faced with that task. Rule 1.14: Clients with Diminished Capacity, recognizes: first, the goal of maintaining a normal client-lawyer relationship; second, the discretion to take protective action in the face of diminished capacity; and third, the discretion to reveal confidential information to the extent necessary to protect the client's interests.

As set forth above, the trigger for taking protective action in part (b) of the rule is threefold, requiring: the existence of diminished capacity; a risk of substantial harm; and an inability to act adequately in one's own

#### **2002 Revision of MRPC 1.14 Client with Diminished Capacity**

- (a) When 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.**
- (b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken, and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator, or guardian.**
- (c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.**

interest. Lawyers are familiar with assessing risk and identifying what is in one's interest, but usually they are neither familiar with nor trained in evaluating diminished capacity. Even though taking protective action is permissive ("may") and not mandatory, inaction due to uncertainty puts the lawyer uncomfortably between an ethical rock and a hard place.

### D. Legal Malpractice

Legal malpractice is another risk factor that points to the need for a more deliberate attention to capacity issues. The failure to assess a client's capacity has been asserted as grounds for legal malpractice by would-be beneficiaries of a client's largess. For example, a disinherited child may allege in a will contest that a lawyer did not exercise proper care in that he or she failed to determine the testator's capacity to execute a will.

Traditionally, the courts have been reluctant to find lawyers liable for malpractice in these circumstances for two reasons: one, the lack of "privity of contract" between the lawyer and the disinherited third party (i.e., the lack of a legal relationship under which a duty arises); and two, the fact that lawyers' conduct is judged by a standard of care established by the knowledge, skill, and ability ordinarily possessed and exercised by other members of the bar in similar circumstances.<sup>4</sup> Historically, most lawyers did not attempt to assess capacity, so consequently, the standard of practice was quite minimal.

However, the principle of privity has been eroded significantly over the years in case law, and standards of practice continue to evolve as the prevalence of incapacity rises and as a greater awareness of the need to address capacity issues has emerged. Legal malpractice for failure to address capacity questions in appropriate cases is no longer a remote possibility.

This is not to say that every client should be referred out for clinical evaluation. Indeed, there are potentially serious negative consequences to such referrals, including increased costs and time delays and increased mental and emotional stress for the client. However, if there are any signs of diminished capacity, the lawyer is far better off consistently documenting the process of determining that the client does or does not have capacity to engage in the transaction.

## E. Lawyer Assessment of Capacity

How do lawyers properly address capacity issues? The Comment to new Rule 1.14 for the first time gives some guidance in assessing capacity, although the rule itself does not define capacity:

### **Comment 6 to Rule 1.14**

**In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision; variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.**

These factors blend quite naturally with the normal client interview and the counseling conversation. Yet the factors appear in the Comment without any conceptual, clinical, or practical explanation.<sup>5</sup>

The purpose of this handbook is to fill in the conceptual background and to offer systematic steps in making assessments of capacity. The process does not plunge lawyers into the task of clinical assessment. Indeed, these guidelines recommend against conducting clinical psychological screenings, such as the Mini-Mental Status Exam (MMSE), unless one is professionally trained in such testing. Clinical screening tests such as the MMSE are often given too much weight. They do not in themselves provide sufficient evaluation of capacity.

This handbook recommends instead a systematic role for lawyers in capacity screening at three levels. The first level is that of “preliminary screening” of

capacity, the goal of which is merely to identify capacity “red flags.”

The process leads in most cases to one of four conclusions:

1. There is no or very minimal evidence of diminished capacity; representation can proceed.
2. There are some mild capacity concerns, but they are not substantial; representation can proceed.
3. Capacity concerns are more than mild or substantial and professional consultation or formal assessment may be merited.
4. Capacity to proceed with the requested representation is lacking.

The second level of involvement, if needed, involves the use of professional consultation or referral for formal assessment. Such consultation or referral is best accomplished after the lawyer has fine-tuned the referral questions.

The third level of involvement requires making the legal judgment that the level of capacity is either sufficient or insufficient to proceed with representation as requested. Regardless of whether a clinical assessment is utilized, the final responsibility rests on the shoulders of the attorney to decide whether representation can proceed as requested or not, or whether in appropriate cases, protective action under MRPC Rule 1.14(b) is merited.

### **The lawyer's assessment of capacity is a “legal” assessment. It involves:**

1. **An initial assessment component and, if necessary,**
2. **Use of a clinical consultation or formal evaluation by a clinician, and**
3. **A final legal judgment about capacity by the lawyer.**



# II. Legal Standards of Diminished Capacity

This chapter describes legal approaches to defining diminished capacity and incapacity. Read in tandem with the next chapter on the clinical models of capacity, the explanation highlights the similarities and contrasts between the two approaches to capacity.

Historically, the law’s approach to incapacity reflects a long-standing paradox. On the one hand, our legal system has always recognized situation-specific standards of capacity, depending on the particular event or transaction—such as capacity to make a will, marry, enter into a contract, vote, drive a car, stand trial in a criminal prosecution, and so on.<sup>6</sup> A finding of incapacity in any of these matters could nullify or prevent a given legal act. On the other hand, at least until very recently, determinations of incapacity in the context of guardianship proceedings were routinely quite global, absolute determinations of one’s ability to manage property and personal affairs. A finding of incapacity under guardianship law traditionally justified intrusive curtailments of personal autonomy and resulted in a virtually complete loss of civil rights.<sup>7</sup>

**Lawyers need to be familiar with three facets of diminished capacity:**

- **Standards of capacity for specific legal transactions.**
- **Approaches to capacity in state guardianship and conservatorship laws.**
- **Ethical guidelines for assessing client capacity.**

## A. Standards of Capacity for Specific Legal Transactions

The law generally presumes that adults possess the capacity to undertake any legal task unless they have been adjudicated as incapacitated in the context of guardianship or conservatorship, or the party challenging their capacity puts forward sufficient evidence of incapacity to meet a requisite burden of proof. The definition of “diminished capacity” in everyday legal

practice depends largely on the type of transaction or decision under consideration.<sup>8</sup> Depending on the specific transaction or decision at issue, as well as the jurisdiction in which one is located, legal capacity has multiple definitions, set out in either state statutory and/or case law. Lawyers must be familiar with the specific state-based standards.

**Consider state legal standards for the specific transaction at hand. The definition of “diminished capacity” in everyday legal practice depends largely on the type of transaction or decision under consideration.**

As described in Chapter III, the evaluation of capacity by clinicians parallels this legal transaction-specific analysis, but instead of “transactions,” clinicians categorize functions into “domains.”

Examples of common transaction-specific legal standards include the following:

### *Testamentary Capacity*

Typically, the testator at the time of executing a will must have capacity to know the natural objects of his or her bounty, to understand the nature and extent of his or her property, and to interrelate these elements sufficiently to make a disposition of property according to a rational plan.<sup>9</sup> The terminology that the testator must be of “sound mind” is still commonly used. The test for testamentary capacity does not require that the person be capable of managing all of his or her affairs or making day-to-day business transactions. Nor must the testator have capacity consistently over time. Capacity is required at the time the will was executed. Thus, a testator may lack testamentary capacity before and/or after executing a will, but if it is made during a “lucid interval,” the will remains valid.<sup>10</sup> Finally, even a testator who generally possesses the elements of testamentary capacity may have that capacity negated by an “insane delusion” (i.e., irrational perceptions of particular persons or events”) if the delusion materially affects the will.<sup>11</sup>

### ***Donative Capacity***

Capacity to make a gift has been defined by courts to require an understanding of the nature and purpose of the gift, an understanding of the nature and extent of property to be given, a knowledge of the natural objects of the donor's bounty, and an understanding of the nature and effect of the gift. Some states use a higher standard for donative capacity than for testamentary capacity, requiring that the donor knows the gift to be irrevocable and that it would result in a reduction in the donor's assets or estate.<sup>12</sup>

### ***Contractual Capacity***

In determining an individual's capacity to execute a contract, courts generally assess the party's ability to understand the nature and effect of the act and the business being transacted.<sup>13</sup> Accordingly, if the act or business being transacted is highly complicated, a higher level of understanding may be needed to comprehend its nature and effect, in contrast to a very simple contractual arrangement.

### ***Capacity to Convey Real Property***

To execute a deed, a grantor typically must be able to understand the nature and effect of the act at the time the conveyance is made.<sup>14</sup>

### ***Capacity to Execute a Durable Power of Attorney***

The standard of capacity for creating a power of attorney has traditionally been based on the capacity to contract. However, some courts have also held that the standard is similar to that for making a will.<sup>15</sup>

### ***Decisional Capacity in Health Care***

Capacity to make a health care decision is defined by statute in most states under their advance directives laws. Typical of these legal definitions is the following from the Uniform Health Care Decisions Act:

“Capacity” means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.<sup>16</sup>

Decisional capacity in health care is rooted in the concept of *informed consent*.<sup>17</sup> The concept is based

on the principle that a patient has the right to prevent unauthorized contact with his or her person, and a clinician has a duty to disclose relevant information so the patient can make an informed decision. The lack of informed consent is often an issue in medical malpractice claims. Informed consent requires that one's consent to treatment be competent, voluntary, and informed. Capacity is only one element of the test of informed consent. A person may have capacity to make a treatment decision, but the treatment decision will lack informed consent if it was either involuntary or unknowing.

While it is up to clinicians to evaluate a patient's capacity for medical treatment, lawyers need to be knowledgeable about this as well. For example, a lawyer may need to determine a client's capacity to execute an advance directive for health care or to establish in court a client's capacity to make a particular health care decision. The test of capacity to execute a health care directive is generally parallel to that of capacity to contract. However, because the capacity to contract is such a malleable test, depending upon the nature, complexity, and consequences of the act at issue, lawyers and judges have few road signs in seeking an answer to the question of capacity for many of these transactions. Accordingly, the clinical models of capacity discussed in Chapter III help to supplement legal notions with scientifically grounded indicators.

### ***Capacity to Mediate***

In referring a client to mediation or representing a client in a mediation, a lawyer should be familiar with the capacity to mediate. The *ADA Mediation Guidelines* name several factors to be considered by mediators:

The mediator should ascertain that a party understands the nature of the mediation process, who the parties are, the role of the mediator, the parties' relationship to the mediator, and the issues at hand. The mediator should determine whether the party can assess options and make and keep an agreement.<sup>18</sup>

### ***Other Legal Capacities***

A host of other legal acts have specific definitions of capacity articulated and honed by statutes and

courts in different jurisdictions. For instance, lawyers may wrestle with client capacity to drive, to marry, to stand trial, to sue and be sued, or to vote.

## B. Diminished Capacity in State Guardianship Law

State guardianship and conservatorship laws rely on broader and more encompassing definitions of incapacity, a finding of which permits the state to override an individual's right to make decisions and to appoint someone (a guardian or conservator) to act as the person's surrogate decision-maker for some or all of the person's affairs.<sup>19</sup> The criteria for a finding of incapacity differ among the states, but in all states, the law starts with the presumption of capacity. The burden of proof is on the party bringing the petition to establish sufficient diminished capacity to justify the appointment of a guardian or conservator.

The law of guardianship has evolved extensively from its English roots. Originally, the law required a finding that the alleged incapacitated person's status was that of an "idiot," "lunatic," "person of unsound mind," or "spendthrift." Present day notions of incapacity instead use a combination of more finely-tuned medical and functional criteria. Since the 1960s, a common paradigm for the definition of incapacity under guardianship laws has been a two-pronged test that required: (1) a finding of a disabling condition, such as "mental illness," "mental disability," "mental retardation," "mental condition," "mental infirmity," or "mental deficiency"; and (2) a finding that such condition causes an inability to adequately manage one's personal or financial affairs.<sup>20</sup>

Historically the disabling condition prong of the test was quite broad. Many states included "physical illness" or "physical 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 and arbitrary judicial determinations. Over time, states sought to refine both prongs of this test to make the determination of incapacity less label-driven, more specific, and more focused on how an individual functions in society.<sup>21</sup> For example, only a few states still include the pejorative term "advanced age" in their definition.<sup>22</sup>

Likewise, the second prong of the test—inability to manage one's affairs—has been honed by many states to focus only on the ability to provide for one's "essential needs" such as "inability to meet personal needs for medical care, nutrition, clothing, shelter, or safety."<sup>23</sup>

In more recent years "cognitive functioning" tests have emerged in many states to supplement or replace one or both prongs of the traditional test. For example, in the 1997 Uniform Guardianship and Protective Proceedings Act, a cognitive functioning test replaces the disabling condition language in the definition of incapacity:

"Incapacitated person" means an individual who, for reasons other than being a minor, is *unable to receive and evaluate information or make or communicate decisions to such an extent* that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance.<sup>24</sup>

These three tests—disabling condition, functional behavior, and cognitive functioning—have been used by states in a variety of ways.<sup>25</sup> Some combine all three.<sup>26</sup> Most states have added threshold requirements for guardianship intervention—most commonly a finding that the guardianship is "necessary" to provide for the essential needs of the individual (i.e., there are no other feasible options) or that the imposition of a guardianship is "the least restrictive alternative."<sup>27</sup>

### Four varying tests of incapacity under state guardianship law:

- **Disabling condition.**
- **Functional behavior as to essential needs.**
- **Cognitive functioning.**
- **Finding that guardianship is necessary and is "least restrictive alternative."**

**State guardianship laws today *permit or prefer limited forms* of guardianship rather than plenary guardianship.**

In addition to defining the elements of diminished capacity for purposes of guardianship, most state laws have finally recognized that capacity is not always an all or nothing phenomenon, and have enacted language allowing for “limited guardianship” in which the guardian is assigned only those duties and powers that the individual is incapable of exercising. Thus, judges, as well as lawyers who draft proposed court orders, need to understand and identify those specific areas in which the person cannot function and requires assistance. Under the principle of the least restrictive alternative, the objective is to leave as much in the hands of the individual as possible.

### C. Ethical Guidelines for Assessing Capacity

The first chapter of this handbook noted the importance of Rule 1.14 of the Model Rules of Professional Conduct, revised in 2002, which describes the special ethical responsibility of lawyers in representing clients with diminished capacity. It also noted that, although the Model Rules do not define capacity, the Comment to Rule 1.14 identifies

the following factors that the lawyer should “consider and balance” in determining the extent of a client’s diminished capacity:

#### **Comment 6 to Rule 1.14—Capacity Factors**

- **The client's ability to articulate reasoning leading to a decision.**
- **Variability of state of mind.**
- **Ability to appreciate consequences of a decision.**
- **The substantive fairness of a decision.**
- **The consistency of a decision with the known long-term commitments and values of the client.**

These factors are explored further in Chapter IV. The task of the lawyer will be to integrate these factors, along with the state’s specific standards for the legal transaction at hand or the specific criteria for a determination of incapacity under state guardianship law—into a process of preliminary capacity assessment. This challenging task is explored in Chapter IV, after the summary of the clinical model of capacity.



### III. Clinical Models of Capacity

**Why consider the clinical perspective on capacity?**

In most situations, the lawyer will determine that the client has legal capacity and will proceed with the transaction without the need for an assessment by a clinical health professional. For clients who do require a clinical assessment, later chapters of this handbook will discuss how to work with clinicians and interpret clinical reports.

This section summarizes models of capacity from the clinical perspective. A comparison of legal and clinical models of capacity reveals many similarities. A basic understanding of a clinical perspective on capacity may help the attorney to make decisions about a client’s legal capacity.

**Which clinical health professionals evaluate capacity?**

Most often, when a lawyer seeks clinical consultation, the clinician will be a physician, although psychiatrists, psychologists, and other mental health professionals also may evaluate capacity. Clinicians use models of capacity that combine clinical practice standards with law and clinical research. The remainder of this section summarizes key elements of these models, including a general conceptual model for capacity and specific “domain” models of capacity.

**A. General Clinical Model of Capacity**

Regardless of the capacity that is being evaluated, clinicians must address four questions: What is the

**Key Points**

- In most cases, it will not be necessary to consult with a clinician.
- Knowledge of clinical models of capacity can be useful.
- Many legal and clinical concepts of capacity are similar.
- There is an emerging consensus on clinical models of capacity.

diagnosis that is causing the problem? What are the client’s cognitive strengths and weaknesses? What are the client’s behavioral strengths and weaknesses? Who is the client and what is the life situation with which they are contending? A widely cited model of capacity (“the Grisso model”) that is often used by psychologists labels these key components of capacity as causal, functional (cognitive and behavioral), and interactive.<sup>28</sup> These components are similar to those found in legal guardianship standards.

<b>A Comparison of Guardianship Standards and Clinical Models of Capacity</b>	
<u>Legal Model</u>	<u>Clinical Model</u>
<b>Disabling Condition</b>	↔ <b>Causal Component</b>
<b>Cognitive Functioning</b>	↔ <b>Cognitive Functioning</b>
<b>Behavioral Functioning</b>	↔ <b>Behavioral Functioning</b>
<b>Necessity Component—</b>	↔ <b>Interactive Component</b>
What risk of harm?	
Least restrictive alternative?	

**1. Causal Component**

- *Definition of Causal Component*  
The causal component is the diagnosis that is the cause of the incapacity—for example, Alzheimer’s disease or schizophrenia.

- *Relationship to Legal Standard*  
The causal component corresponds to the disabling condition test in guardianship law (Chapter II, B). Information about the likely cause of incapacity is very important information for the attorney. Once the diagnosis is established, it usually indicates the prognosis and likely patterns of symptoms. Usually the most important question is: “will this person get better, stay the same, or get worse?” The diagnosis might

also suggest to the attorney why a given client is frequently changing his or her mind. An answer to this latter question is especially relevant to the Comment to Model Rule 1.14, which asks for consideration of the client's variability of state of mind.

For example, an individual comes into a lawyer's office to change a will but seems confused. Knowledge of the cause of the confusion could help to guide the lawyer's actions. A diagnosis of delirium (a condition in which an individual has marked difficulties focusing, usually caused by a medical problem) indicates that confusion is likely temporary and should clear up with appropriate medical treatment. A diagnosis of depression could suggest that a change of mind may be due to feelings of hopelessness or distorted thinking that should also improve with appropriate treatment. Thus, information on the diagnosis not only names the cause of any impairment, but indicates whether the impairment is temporary or permanent, will get better, worse, stay the same, or will improve with treatment.

**Knowing the diagnosis helps answer:**

- **What is causing the problem?**
- **Is it temporary or permanent?**
- **Will it get better or worse?**
- **Could it improve with treatment?**
- **What treatment could help?**
- **Is there is no clinical impairment or illness?**

- **Assessment of Causal Component**

The diagnosis will almost always be one found in the *Diagnostic and Statistical Manual of Mental Disorders – IV (DSM-IV)*,<sup>29</sup> which lists and describes currently recognized psychiatric disorders. A psychiatric diagnosis is made after reviewing current and past problems and medical information (e.g., labs, brain scans). Of course, a clinician may determine that there is no diagnosable illness and that the person's current decisions (even if they represent a change from past decisions) reflect an appropriate, considered choice that is consistent with the individual's values.

## 2. Cognitive Functioning

- **Common Cognitive Problems**

An individual may have cognitive problems with attention, memory, understanding or expressing information, reasoning, organizing, planning, or other areas. These problems could be caused by a cognitive disorder, such as dementia, or a psychiatric disorder such as schizophrenia.

- **Relationship to Legal Standard**

This cognitive element of capacity is found in guardianship law, particularly based on the 1982 or 1997 Uniform Guardianship and Protective Proceedings Act, which emphasize an individual's ability to "receive and evaluate information or make or communicate decisions" or "sufficient understanding or capacity to make/communicate decisions."

- **Assessment of Cognition**

Cognitive symptoms are assessed by clinicians through clinical interview and/or formal testing.

## 3. Functional Behavior

- **Importance of Functional Behavior**

Many traditional clinical assessments end once the person's diagnosis and cognition are assessed (e.g., a typical neuropsychological or neurological assessment). But, when legal capacity is questioned, it is important to have specific, direct information about the individual's abilities for the capacity in question, be it making a will, making a medical decision, living at home, driving, or any other task.

Information about cognitive and functional performance together explains the person's capacity for the transaction in question. For example, in evaluating the capacity to manage finances, information about both memory and abilities to pay bills may be relevant. It is important to consider both pieces of information. Sometimes an individual can demonstrate how to do something during clinical examination but poor memory makes it impossible to remember the task at home. Conversely, a person may have trouble on a standard memory test (e.g., remembering a list of words), but is quite able consistently to name a health care proxy despite the memory problem.

- *Relationship to Legal Standard*

This functional element of capacity is found in guardianship law in clauses that describe the need to adequately manage one’s person or property. The element is also found in all types of transaction-specific legal standards that characterize the specific skills or abilities necessary for the transaction at hand.

- *Assessment of Functional Behavior*

Functional behavior is assessed through the reports of family members, direct observation, and/or performance-based testing. More and more clinicians turn to functional instruments—also called capacity instruments—to do such assessments. Capacity instruments are described in Appendix 3.

#### 4. Interactive Component

- *Definition of Interactive Component*

Some lawyers may object to the clinical model thus far, arguing: “But I have known my client for years, and what is being requested is consistent with his values even though he may look a little confused,” or “But in this situation, naming a reliable and conscientious adult child as an agent under a durable power of attorney is such a low risk that it doesn’t matter if my client cannot pass your tests.”

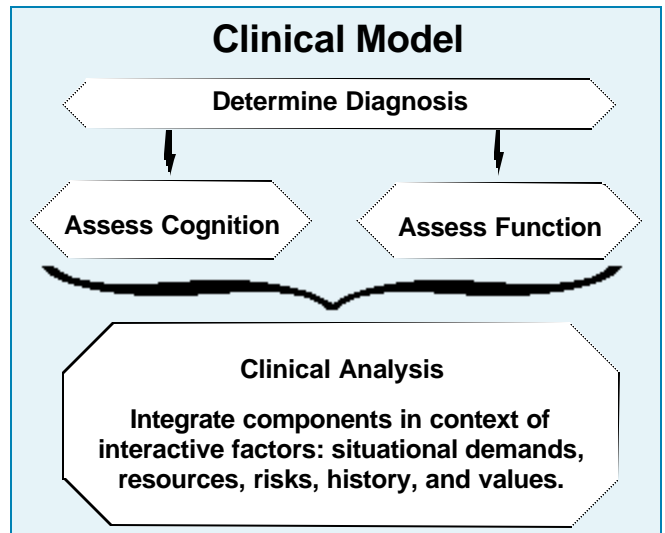
These contextual factors (e.g., the history, the risk in the situation) are also part of a clinical model of capacity and a good clinical evaluation of capacity. The so-called *interactive* component of capacity takes into account personal, physical, psychosocial, and situational demands placed on the individual. The interactive component also incorporates the resources available to the individual, risks of the specific situation, and the person’s values and preferences. The outcome of a clinical evaluation of capacity is never merely a diagnostic statement or report of test results, but an integration of these with the particulars of the client’s life and situation.

- *Relationship to Legal Standard*

The interactive component is clearly recognized in legal concepts of capacity, particularly in statutory pre-conditions for guardianship that require a finding that guardianship is the least restrictive alternative given the person’s circumstances.

- *Assessment of Interactive Factors*

The interactive component is assessed through direct questioning (of the client and, if appropriate, family) about the situation, the person’s resources, history, values, preferences, and knowledge of the services and clinical interventions tried (e.g., bill paying services or treatment for depression). The clinician may need to speak to the lawyer and other sources to gather information about interactive factors.



#### B. Specific Domain Models of Capacity

Just as the law has transaction-specific models of legal capacities, clinicians also recognize “domain”-specific models of capacities. The word “domain” is used to connote a cohesive area of cognitive or functional behavior.

##### *Consent Capacity*

A widely accepted taxonomy of the functional abilities needed for medical decision-making capacity is: Understanding, Appreciation, Reasoning, and Expression of Choice.<sup>30</sup>

Understanding is the ability of the individual to comprehend diagnostic and treatment-related information.

Appreciation refers to the ability to relate the treatment information to one’s own situation. In usual clinical practice, appreciation translates into the client’s belief that a well-considered medical diagnosis is valid and that treatment may be beneficial.

Reasoning is the ability to evaluate treatment alternatives by comparing risks and benefits in light of one's own life. Sometimes reasoning is defined by the ability of the client to provide "rational reasons" behind a treatment choice.

Expressing a choice is the ability to communicate a consistent decision about treatment.

### ***Financial Capacity***

An often-used model of the functional abilities important for financial capacity examines knowledge, skills, and judgment.<sup>31</sup>

Knowledge for finances involves the ability to describe facts, concepts, and events related to financial activities such as knowledge of currency, bank statements, investments, and other personal financial data.

Skills involve the ability to demonstrate practical procedures and routines important for financial management such as making change and writing checks.

Judgment involves the ability to make reasonably sound financial decisions in novel or ambiguous social situations, such as being sensitive to fraud, invulnerable to coercion, and prudent in making investments.

### ***Independent Living***

For many older adults with dementia, a critical assessment concerns whether the individual is safe to live independently. A model for assessing the abilities important for independent living focuses on a range of key skills and judgment.

Skills important to demonstrate for independent living have been described as "instrumental activities of daily living" (IADL). IADLs involve the ability to manage the home, health, money, transportation, meals, and communication.

Judgment relates to insight and decision-making essential to independent living, such as ability to handle emergencies, compensate for areas of incapacitation, exhibit motivation for daily life, and minimize risk to self and others.<sup>32</sup>

These domain models have been especially important in guiding researchers in their development of tests that assess specific functional behaviors and guide actual clinical assessments.

## IV. Lawyer Assessment of Capacity

Lawyers must make capacity judgments in their everyday practice. There are at least two aspects to such assessments. First, the attorney must determine whether the prospective client has sufficient legal capacity to enter into a contract for the attorney's services. Second, the attorney must evaluate the client's legal capacity to carry out the specific legal transaction(s) under consideration. In either instance, the attorney must conduct an analysis of the legal elements of the capacity at issue in relation to the client's presenting cognitive and emotional abilities.

**This chapter describes each of the following steps that the lawyer should take in a thorough analysis of client capacity:**

- A. Observe and interpret signs of diminished capacity;**
- B. Evaluate understanding in relation to the specific legal elements of capacity for the transaction at hand;**
- C. Consider the degree of risk to the client and the ethical factors set out in the Comment to Rule 1.14;**
- D. Complete the legal analysis;**
- E. Document capacity observations; and**
- F. Take appropriate actions in response.**

This chapter outlines the lawyer's task of observation, legal analysis, and capacity judgment. For many, if not most clients, these will be the only necessary steps, because clinical consultation or assessment will not be needed to reach a firm conclusion about capacity. The next chapter directly supplements this discussion by ensuring that clients are judged under circumstances that support and enhance their capacity. The remaining chapters describe the process of obtaining and using an informal clinical consultation or a formal clinical assessment, should the lawyer believe that step is necessary prior to forming a final conclusion about legal capacity.

The process described below focuses on key signs and factors to consider in a legal assessment of capac-

ity. The process outlined is meant to structure and record observations leading to a legal judgment that is sufficiently comprehensive in scope, systematic in process, accountable if challenged, and documented.

Furthermore, the process is geared to blend in naturally to the case interview process, rather than adding a whole new costly element. When used with the worksheet at the end of this chapter, the process systematizes and documents what the lawyer already does implicitly. The worksheet is designed to be used by the lawyer either during the client interview as a note-taking device, or immediately afterwards as an analytic tool.

### A. Observing Signs of Possible Diminished Capacity

There is no single indicator that provides a consistent, clear signal that an older adult is functioning with diminished capacity. However, there are markers that, when considered together, may reflect diminished capacity. These signs should not be taken in and of themselves to be proof of diminished capacity. Instead, they may indicate a need for further evaluation of capacity by an independent professional if the signs are present in sufficient number and/or severity.

In noting potential signs of incapacity, it is important to keep in mind that the focus is on decisional abilities rather than on cooperativeness or affability. It may be challenging to disentangle one's reactions to a client's interpersonal style from observations of the client's cognitive, emotional, or behavioral problems.

#### **Observe with the following in mind:**

- Focus on decisional abilities, not cooperativeness or affability.**
- Pay attention to changes over time; history is important.**
- Beware of ageist stereotypes.**
- Consider whether mitigating factors could explain the behavior.**

It can also be difficult to determine the meaning of cognitive, emotional, or behavioral anomalies in a new client. However, if a client is a returning one, it is critical to consider the history of interactions and pay attention to changes in functioning. A baseline of what is typical for any particular person is extremely helpful in assessing current decisional abilities. Be sensitive to gradual or sudden changes in functioning among returning clients.

Finally, it is useful to be sensitive to societal stereotypes about aging, commonly termed “ageism.” Aging stereotypes may be positive, idealizing old age; or negative, perhaps including the assumption that aging and diminished capacity are synonymous. Such beliefs could influence an appraisal of capacity. Hopefully, awareness of the possible signs of incapacity will help the lawyer to be more objective.

During the course of an interview, the attorney should be aware of specific cognitive, emotional, or behavioral anomalies that serve as “red flags.” These may indicate possible neurological or psychiatric illness that could diminish capacity. Most of the red flags will be observed during the interview or reported by third parties such as family members. It will not be necessary (and in most cases not appropriate) to use psychological screening instruments during preliminary capacity assessments.

During and immediately after a client interview, the attorney can document the signs observed, and also make notations about the nature and severity of these signs on the worksheet following this chapter.

**PART A OF WORKSHEET**

**Observational signs of diminished capacity:**

- Cognitive signs**
- Emotional signs**
- Behavioral signs**

**Mitigating factors may alter weight of observations.**

*Possible Cognitive Signs of Incapacity*

*1. Short-term Memory Loss*

A client quickly may forget information discussed in the interview, repeating the same statements or ask-

ing the same question multiple times, with no indication that she or he has done so more than once. Also, while the client can discuss events from 10 years to 20 years ago, there may be more difficulty describing events of the past few days or weeks. For example, the client may be able to engage in brief casual conversation, such as a five-minute conversation about the weather or sports, but have trouble going beyond that in detail and begin to repeat questions already asked or forget your name or the purpose of the visit. The ability to engage in such small talk can lead family who live out of town to say that an impaired older adult “sounds just fine on the phone.”

*2. Communication Problems*

A great deal can be learned by observing how the client uses language and communicates ideas. For example, a client may have repeated difficulty finding a particular word or naming common items even if they can talk about the item. For example, she may say “I brought my thing with the papers in it” instead of “I brought my notebook.” A common “cover” tactic for older adults with memory or communication problems is to defer to others excessively when asked direct questions, perhaps saying “My wife handles all the appointments, you’d have to ask her if we went,” or “I hardly ever call my own phone number; my son would remember because he uses it.”

Clients who are asked direct questions may have trouble staying on the topic, frequently shifting to discussion of unrelated issues, or moving erratically or nonsensically between topics. Such problems can indicate trouble organizing thoughts such as is found in frontal dementia or in thought disorder (e.g., psychotic thinking). Repeated difficulty finding words and vague or disorganized language may indicate an inability to communicate a clear decision or to comprehend important or relevant information.

*3. Comprehension Problems*

It is important to explore the client’s comprehension of information with other than yes/no questions. For example, difficulty repeating back or paraphrasing simple concepts is indicative of problems in comprehension. Repeated questioning could indicate poor memory or it could indicate poor comprehension. Many people with poor memory can paraphrase infor-

mation immediately, while individuals with poor comprehension will have trouble even with this.

#### 4. *Lack of Mental Flexibility*

A client may lack the capacity to understand or even acknowledge multiple alternatives or viewpoints other than her or his own, or have difficulty comprehending and adjusting to changes. This is different from simply being stubborn in that someone who is stubborn can typically acknowledge that other perspectives exist, and can provide reasons for not choosing them. For example, a stubborn person may not want to change a will for particular reasons, whereas an older adult lacking in mental flexibility may exhibit a general fear of making any changes for very vague reasons.

#### 5. *Calculation Problems*

A client may have very basic difficulties with simple math problems that are far worse than expected given the level of education. An example of this is someone with a college degree who makes an error in adding dollar amounts together, or lines up columns of numbers incorrectly while adding or subtracting. The client may also present signs suggesting impairment in financial management abilities more broadly, e.g., lack of awareness of current financial assets or debts.

#### 6. *Disorientation*

Disorientation can occur relative to space, time, or location. For example, a long-time client may have difficulty navigating through the attorney's office building spatially or may get lost driving to the office even if he or she has been there several times over many years (spatial orientation). Once there, the client may not be able to identify where he or she is (orientation to place). The client may also not be aware of what time it is or what year it is, perhaps making references to events from several years ago as if the events were current (orientation to time).

### ***Possible Emotional Signs of Incapacity***

#### 1. *Significant Emotional Distress*

A client may be persistently emotionally distressed during an interview or across interviews, beyond typical emotions expected given the circum-

stances, such that the individual's emotional state makes it very difficult to address the relevant legal questions. For example, the client may appear extremely anxious, tearful, or seem depressed and appear to have no energy and respond very slowly to questions.

#### 2. *Emotional Lability/Inappropriateness*

Rather than a steady emotional state, a client may also either show an extremely wide range of emotions during an interview (perhaps moving quickly from laughter to tears). Alternatively, a client may express feelings that seem highly inconsistent with what he or she is discussing (laughter when discussing death of a spouse, tears of distress while professing to be happy).

### ***Possible Behavioral Signs of Incapacity***

#### 1. *Delusions*

Delusions are beliefs that are unlikely to be true, such as a belief that neighbors or the government are spying on oneself. Delusional thinking may be manifest more generally in expressions of feeling frightened or unsafe. Presence of delusions may call into question the extent to which decisions are founded on sound reasoning. For example, some delusional nursing home residents occasionally stop eating because of beliefs that their food is being poisoned. However, apparent delusions that seem more reality-based may warrant further exploration. Older adults commonly have concerns about relatives or facility staff stealing money or possessions from them, which unfortunately may be more reality based.

#### 2. *Hallucinations*

Hallucinations are sensory experiences in the absence of physical stimuli that could be responsible for such experiences, such as hearing voices that no one else can hear. They are often auditory or visual, but can involve the other senses: smell, touch, and/or taste. An example is an older adult who seems to be having a conversation with another person who is not there. As with delusions, hallucinations may call into question the extent to which a decision is reality-based. However, it should be noted that high functioning older adults who are recently widowed and grieving sometimes report hearing a deceased spouse

call their name or briefly seeing their image. Also, significant hearing or vision problems can place an older adult at risk for sensory misperceptions. When combined with isolation and anxiety, such misperceptions may appear hallucinatory or delusional in quality.

3. *Poor Grooming/Hygiene*

Individuals who are experiencing cognitive difficulties or serious emotional problems may not brush their hair, shave, or shower regularly, or have other grooming issues. For example, along with irregular bathing or shaving, a relatively common behavior among older adults with dementia is to wear multiple layers of clothing, perhaps several shirts or multiple pairs of pants. Attention to the appearance, clothing, and smell of a client gives clues to possible mental status changes.

***Functioning Beyond the Office***

Observations in the office setting are obviously quite limited. If the lawyer has the ability to interview clients in their home setting, there is a definite advantage in being able to see some of their functioning in their natural and familiar environment. The lawyer may in the natural course of contact with clients—and family members with whom your client has permitted communication—learn other information about the client’s level of functioning at home, particularly with respect to “activities of daily living,” (ADLs) and “instrumental activities of daily living” (IADLs).

Such information may or may not be relevant to capacity. For example, an inability to write checks to pay the bills may be merely a physical deficit (and thus have nothing to do with decisional capacity), or it may be a result of failing to remember payment obligations or how to understand a bill (and thus be quite relevant to capacity for certain legal tasks). In any case, any additional information regarding client functioning in the home and community rounds out the total picture of the client’s abilities and deficits. The worksheet on page 23 provides a space for recording any such information about the client’s functioning beyond the office setting.

***Undue Influence***

Capacity assessment focuses on the fit between the individual’s cognitive, functional, and decisional

ADLS	IADLS
Dressing	Grocery shopping & meal preparation
Bathing	Driving
Toileting	Housework
Eating	Managing money
Walking	Managing medication
Transferring between bed/chair	Using telephone & mail

abilities and the complexity and risk of the legal transaction at hand. On the other hand, undue influence refers to a dynamic between an individual and another person. It is certainly more challenging to assess such a dynamic, but there are certain factors to assess with the elderly client to gauge whether undue influence is at work. Lawyers might attend to whether the elderly client appears fearful, isolated, overly dependent or vulnerable, or seems overwhelmed by or unaware of financial information.<sup>33</sup> It is also useful to determine the history of the relationship between the elderly client and any person who appears to be in a position of power: is it a long-term trustworthy relationship or is it a family member, caregiver, or acquaintance who has more recently become a “new best friend.”

***Mitigating/Qualifying Factors in Assessing Signs of Diminished Capacity***

In addition to noting potential signs of incapacity, there are a number of mitigating or qualifying factors that may influence observed signs. In most cases, the attorney will need to ask some follow-up questions to determine whether these mitigating factors are playing a role. If found, these factors indicate a need for alternative action, be it a referral to a physician, adjusting the approach to communication, or waiting until another time when the client is functioning better.

1. *Stress; Grief; Depression; Recent Stressful Events*

A client may at times seem confused, unable to pay attention to instructions, or unable to make decisions. It is important to ascertain stresses in the client’s life that could cause anxiety, depression, or inability to act. These potential signs of diminished capacity could go away when the transient stresses are alleviated.



Consider these **mitigating factors** that may be addressed to enhance capacity:

- **Stress, grief, depression, recent events**
- **Reversible medical factors**
- **Normal fluctuations in mental ability and fatigue**
- **Hearing and vision loss**
- **Education**
- **Socio-economic background**
- **Cultural and ethnic traditions**

## 2. *Reversible Medical Factors*

Signs of disorientation and confusion could be due to a host of medical conditions and medication factors that are reversible. Some common causes are related to medications: adverse medication reaction, interactions among too many medications (polypharmacy), and taking medications incorrectly. Also, older adults can be extremely sensitive to dietary insufficiency—inadequate nutrition, hydration, and deficiency in certain vitamins in the diet can lead to temporary cognitive changes. Further, persistent pain may impact cognition. A referral to a physician or geriatrician (physician specializing in older adults) prior to further action may be indicated.

Indeed, if the client has not had a complete physical in the past year, referral is always worthwhile.

## 3. *Normal Fluctuations in Mental Ability in Older Adults*

Normal mental status varies over the time of day depending on the situational stresses and available energy for the older client. Clinicians have learned to test older clients in mid-morning when the client is most alert, since fatigue could cause lower performances.

## 4. *Hearing and Vision Loss*

Losses in hearing and vision are normal in aging. Diminished functioning in the senses should not be generalized to mental incapacity. The amount of peripheral loss varies from person to person. Older adults learn ways to compensate for these losses. However, problems in hearing and vision could some-

time present a picture that the older client cannot attend, focus, or provide appropriate responses to questions. Suggestions for accommodating sensory changes are provided in the next chapter.

## 5. *Individual Differences and Variability Considerations*

Mental abilities can be influenced by a person's education, life and job-related experiences, and sometimes socio-economic background. The styles and strategies used in mental performances can be further influenced by the client's gender, personality, lifestyle choices, value system, and eccentricities. In addition, cultural and ethnic traditions in approaching personal, family, and medical issues may vary. From this perspective, the range of cognitive functions that is considered normal among older adults is large. These individual differences are important and need to be taken into account in evaluating potential mental capacity of older clients.

## B. Evaluating a Client's Understanding in Relation to Legal Elements of Capacity

Observation of signs of diminished capacity is only an initial step for the attorney evaluating a client's capacity. The next and more substantive step is to evaluate the client's legal capacity for the proposed transaction or situation at issue. This requires a direct comparison of the client's understanding with each of the functional elements of capacity set out in statute or case law for the transaction or situation at hand.

### PART B OF WORKSHEET

- **Note the legal elements of capacity for the particular task at hand—e.g., testamentary capacity, contractual capacity, and donative capacity.**
- **Compare client's understanding, appreciation, and functioning with the relevant legal elements.**

Testamentary capacity, again, can serve as the illustrative case example. Although a client may

demonstrate signs of diminished capacity in introductory remarks and discussion, the real heart of the capacity issue involves the attorney’s judgment as to whether the client can satisfy the legal elements (usually four) constituent to making a will:

- Can the client describe what a will is?
- Does the client know the “objects of his/her bounty”—i.e., his/her natural heirs?
- Does the client know the nature and extent of his/her assets?
- Can the client describe a basic plan for distributing these assets to his/her heirs?

The client’s decisional process will be implicit and intuitive, as well as explicit and conscious. The attorney’s role is to present information, answer and ask questions, gently probe and query, and weigh client responses and thought processes. In addition, with client consent or in accordance with the rules of ethics, the attorney could solicit information from family members and other collateral sources, including fellow professionals. The decisional process may occur over the course of one or several meetings with the client. Ultimately, the attorney must form a judgment about the client’s understanding of the respective legal elements of the transaction at issue, and regarding the client’s capacity overall to undertake the transaction(s) at issue (in this example, to execute a will), or the client’s capacity to care for self or property under the elements set out in the state guardianship law.

### C. Considering Factors from Ethical Rules

Not only must the lawyer assess the client’s understanding of the legal transaction, but also take into consideration the factors set out in the Comment to Rule 1.14 of the MRPC. The new rule and comment have not been adopted everywhere, yet they merit consideration because of their authoritative source.

The factors addressed in the comment derive from recommendations of a 1993 National Conference on Ethical Issues in Representing Older Clients<sup>34</sup> and, in particular, from an article on representing clients with questionable capacity prepared for the conference by Peter Margulies.<sup>35</sup> Margulies describes six factors—five of which Comment 6 to Rule 1.14 expressly refers to.

### PART C OF WORKSHEET

#### The Margulies/Fordham criteria:

1. **Ability to articulate reasoning behind the decision.**
2. **Variability of state of mind.**
3. **Appreciation of consequences.**
4. **Substantive fairness of decision.**
5. **Consistency with lifetime values.**
6. **Irreversibility of the decisions.**

1. *The client’s ability to articulate reasoning leading to a decision.* The client should be able to state the basis for his or her decision. The stated reasons for the decision should be consistent with the client’s overall stated goals and objectives.
2. *Variability of state of mind.* Margulies defines this factor as the extent to which the individual’s cognitive functioning fluctuates.
3. *Ability to appreciate consequences of a decision.* For example, does a client recognize that without a given medical decision, he or she may physically decline or even die—or without a legal challenge to an eviction, he or she may be without a place to live.
4. *The substantive fairness of the decision.* Margulies maintains that while lawyers normally defer to client decisions, a lawyer nonetheless cannot simply look the other way if an older individual or someone else is being taken advantage of in a blatantly unfair transaction. To do so could defeat the very dignity and autonomy the lawyer seeks to enhance, and thus fairness is one element to balance. Of course, judging fairness risks the interjection of one’s own beliefs and values, so caution is required.

Yet, the reality is that when the desired legal plan conforms to conventional notions of fairness—e.g., equitable distribution of assets among all children—or the plan is consistent with the lawyer’s long-standing knowledge of the client and family, then capacity concerns wane propor-

tionately. Capacity may be diminished but adequate for a legal transaction deemed to be very low risk in the context of conventional fairness.

5. *The consistency of a decision with the known long-term commitments and values of the client.* The decision normally should reflect the client's life-long or long-term perspective. This will be easier to determine if the lawyer-client relationship is long-standing. At the same time, individuals can change their values framework as they age. The distinction is important.
6. *Irreversibility of the decision.* This factor is listed in the Margulies article but not in the Comment to Rule 1.14. Margulies notes that "the law historically has attached importance to protecting parties from irreversible events," and that "doing something that cannot be adjusted later calls for caution on the part of the attorney."<sup>36</sup>

Of these six factors, the first three are "functional" in the sense that they reflect the cognitive functioning of the individual. These may be supported by observation of the signs of diminished capacity described previously. The latter three are "substantive" in that they look at the content and nature of the decision itself. Under the Margulies approach, the latter three factors may be thought of as substantive "levers" that modulate a kind of sliding scale of capacity. The greater the concerns under the latter three substantive variables (fairness, consistency with commitments, irreversibility), the greater the level of functioning demanded under the first three variables (ability to articulate reasoning, variability of state of mind, and appreciation of consequences).<sup>37</sup> In other words, the higher the risk (as measured by the client's own values, the finality, and fairness), the more one must probe to ensure decisional capacity.

The Margulies paradigm has no direct evidence-based validation in the psychological or medical literature, although the paradigm is consistent with the psychological models previously described in Chapter III, emphasizing functional and interactive (i.e., substantive) aspects of capacity. The paradigm rests upon Margulies' ethical analysis of the threshold for protective action, enhanced by an appreciation of the reali-

ties of legal counseling. A key strength is that the factors Margulies enumerates blend quite seamlessly with the kind of issues that lawyers would typically discuss in counseling clients. In that respect, the factors are very user-friendly for lawyers and amenable to easy documentation in the lawyer's notes. A careful weighing and balancing of these factors along with the specific elements of legal capacity for the transaction at hand will assist the lawyer to make a preliminary judgment of capacity.

#### D. Performing the Legal Analysis and Categorizing the Legal Judgment

In making a capacity judgment at this stage (without resorting to clinical consultation or formal assessment), an attorney will need to weigh all the data obtained up to this point as a whole. The completed worksheet summarizes the lawyer's observations regarding cognitive, emotional, and behavioral functioning; the presence of any mitigating factors affecting the observations; the client's decisional functioning in comparison to the applicable legal tests; and task-specific factors recommended under the Margulies/Fordham approach.

With these data, the lawyer should make a categorical assignment of the fit between the client's abilities and the legal capacity at issue. Unfortunately, there is no simple score that will help the attorney easily to arrive at a conclusion. The conclusion is ultimately a professional judgment that is aided by the systematic consideration of signs of incapacity, the client's understanding of the legal transaction, and the factors laid out in the Model Rule. In integrating these sources of data to form a conclusion, the attorney may consider the capacity classification schema in the box on the next page.

If the attorney feels uncertain as to whether the observed problems represent "mild" versus "more than mild" issues, this would be an indication to consult with a clinician as described in Chapter VI.

#### E. Documenting the Capacity Judgment

As in other client matters, the attorney should document his or her observations and assessment regarding client capacity. The worksheet provides that

**PART D OF WORKSHEET**

**Capacity Conclusions**

**Intact**

**No or very minimal evidence of diminished capacity.**

**Mild problems**

**Some evidence of diminished capacity, but insufficient in attorney's judgment to preclude representation or proposed transaction.**

**More than mild problems**

**Substantial evidence of diminished capacity sufficient to warrant attorney consultation with mental health professional, or referral of client for a formal professional assessment of capacity.**

**Severe problems**

**Client lacks the capacity to proceed with the transaction and the representation.**

- Videotaping may, in fact, exaggerate the client's deficits in decisional capacity.
- Unless the attorney videotapes all clients, the fact of videotaping may itself be used to raise doubts of capacity.
- The videotape cannot be edited to remove portions for any reason without risking ethical or legal violation of evidence tampering prohibitions.

**F. Taking Actions Following Informal Capacity Assessment**

Following a preliminary capacity assessment, an attorney may need to weigh different courses of action. In the majority of cases, presumably there will be no issues of diminished capacity and the attorney can proceed with the legal representation without further concern. In the case of "mild problems" with capacity, the attorney may want to consider referring the client for a *geriatric medical evaluation* to ensure there are no medical problems which may be transiently affecting capacity and for which resolution could remove any lingering concerns.

In cases involving "more than mild problems" with capacity, the attorney also should consider a general geriatric work-up. However, in such cases it is likely that capacity issues will persist and will require either a formal referral to a *clinician* for capacity assessment or at least attorney consultation with a clinician for guidance and clarification. After taking such external steps, the attorney then can decide the best course of action concerning the representation.

In situations where "severe problems" with capacity exist, further representation by the attorney may be problematic. Withdrawal from direct representation, taking all reasonable steps to protect the client's interests, or seeking to advance the client's interests through representation of another party (e.g., a family member), may be indicated. If a client-lawyer relationship already exists before capacity becomes an issue, then protective action may be ethically appropriate under Model Rule 1.14(b).

A formal evaluation of capacity by a clinician will be useful in supporting these actions. Communication with the client about the capacity issues, as well as with family members and significant others where

documentation, although it may be advisable to further summarize key observations, conclusions, and reasonings in a case note, either in the space provided at the end of the worksheet or elsewhere in a case summary. In cases where the additional steps of consultation with a mental health professional or referral for formal assessment are necessary, the worksheet provides a first level of assessment. Once additional steps are taken (as described in Chapters VI and VII), the lawyer should document further analysis, judgment, and final disposition in the case file.

***Videotaping As Documentation?***

The question is often asked whether videotaping of the client completing a legal transaction, such as a will signing or being questioned just before the transaction, is a good idea. Experienced practitioners have come to different conclusions on this question. In selected cases, videotape evidence of a client explaining his or her reasons behind a particular dispositive provision can provide a deterrence to a contest. But, there are several arguments against videotaping the client's execution of a document:

### **Possible Action Steps Following Preliminary Assessment**

#### **Intact Capacity**

- Proceed normally

#### **Mild problems**

- Proceed normally
- Consider medical referral or
- Informal mental health consultation or
- Formal capacity assessment

#### **More than mild problems**

- Proceed with great caution
- Consider medical referral or
- Informal mental health consultation or
- Formal capacity assessment

#### **Severe problems**

- Formal capacity assessment
- Decline representation or withdraw
- Protective action if appropriate

appropriate, may be warranted in most of these cases to protect the client's legal interests and to reduce the risk of exploitation.

#### **G. Caution Against Lawyer Use of Psychological Instruments**

Cognitive screening instruments have enjoyed wide acceptance and use in clinical settings, mainly because of their brevity and simplicity in administering, scoring, and interpreting. Several brief mental status questionnaires have been developed, the most popular of which is the 30-item Mini-Mental Status Examination (MMSE), although others are widely used, too. See the Cognitive Screening tests in Appendix 3.

The MMSE provides a quick but blunt assessment of overall cognitive mental status. It assesses orientation, attention, registration and immediate recall, language, and the ability to follow simple verbal and written commands. It provides a total score that places

the individual on a 30-point scale of cognitive function. In clinical settings, the MMSE has been used to detect impairment, follow the course of an illness, monitor response to treatment, screen for cognitive disorders in epidemiological studies, and follow cognitive changes in clinical trials.

While this handbook argues that lawyers regularly engage in the legal assessment of capacity and should do so in a systematic manner, for a variety of reasons addressed below, it is generally not appropriate for attorneys to use more formal clinical assessment instruments, such as the MMSE.

#### ***Lack of Training***

Lawyers generally do not have the education and training needed to administer these tests. Many factors must be taken into consideration when administering and interpreting psychological tests. A few examples include: limits to the validity and reliability of tests; impact of mental status, education level, environmental variables (e.g., lighting, noise), fatigue, sleep deprivation, and sensory deficits on test results; and impact of social and cultural issues on performance.

#### ***Limited Yield***

For an attorney, the information yield of psychological screening instruments is very limited, compared with other sources of relevant information. At best, screening test scores will indicate that further psychological evaluation is needed, which could often be better determined on the basis of careful observation and a thorough interview.

#### ***Over-Reliance***

There is a danger of over-reliance on single test scores. Single test scores can unfortunately appear to be objectively and numerically precise. A multidimensional approach to clinical assessment is considered the gold standard for formal assessment. Decisions should not be made on the basis of a single test score.

#### ***False Negatives and False Positives***

Screening exams such as the MMSE pose a risk of producing both false positives and false negatives in conclusions about mental deficits related to relevant tasks. For example, a client with mobility problems (e.g., arthritis) may have a reduced MMSE score relat-

ed to difficulty drawing pentagons or folding a paper. This deficit has little relevance to the ability to prepare an advance directive. Such a conclusion would be a “false positive.” On the other hand, an individual who demonstrates excellent performance on the MMSE (knows the date, has good memory) but has a specific focused and unfounded delusion about a family member, which represents an acute psychosis, may lack testamentary capacity despite the high score. This is a “false negative.”

#### ***Practice Effects***

When cognitive screening tests are used more than once, familiarity with the test can improve perform-

ance, even though one’s cognitive functioning has not improved.

#### ***Lack of Specificity to Legal Incapacity***

In a number of studies, cognitive screening alone has been found lacking sensitivity or specificity to many decisional tasks, such as medical decision-making.<sup>38</sup> It is likely to be much more relevant to evaluate the client’s understanding of the specific legal elements of capacity for the transaction at hand and consider the factors laid out in this chapter. Such an approach is much more consistent with a normal attorney-client interview and will likely be more defensible in the event of a malpractice claim.

# Capacity Worksheet for Lawyers

Source: *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, by the ABA Commission on Law and Aging and the American Psychological Association (2005).

Please read and review the handbook prior to using the worksheet.

**Client Name:** \_\_\_\_\_ **Date of Interview:** \_\_\_\_\_

**Attorney:** \_\_\_\_\_ **Place of Interview:** \_\_\_\_\_

## A. OBSERVATIONAL SIGNS

◆ Cognitive Functioning	Examples
Short-term Memory Problems	Repeats questions frequently Forgets what is discussed within 15-30 min. Cannot remember events of past few days
Language/Communication Problems	Difficulty finding words frequently Vague language Trouble staying on topic Disorganized Bizarre statements or reasoning
Comprehension Problems	Difficulty repeating simple concepts Repeated questioning
Lack of Mental Flexibility	Difficulty comparing alternatives Difficulty adjusting to changes
Calculation/Financial Management Problems	Addition or subtraction that previously would have been easy for the client Bill paying difficulty
Disorientation	Trouble navigating office Gets lost coming to office Confused about day/time/year/season
◆ Emotional Functioning	Examples
Emotional Distress	Anxious Tearful/distressed Excited/pressured/manic
Emotional Lability	Moves quickly between laughter and tears Feelings inconsistent with topic

◆ Behavioral Functioning	Examples
Delusions	Feels others out “to get” him/her, spying or organized against him/her Fearful, feels unsafe
Hallucinations	Appears to hear or talk to things not there Appears to see things not there Misperceives things
Poor Grooming/Hygiene	Unusually unclean/unkept in appearance Inappropriately dressed

Other Observations/Notes of Functional Behavior
Other Observations/Notes on Potential Undue Influence

Mitigating/Qualifying Factors Affecting Observations	Ways to Address/Accommodate
Stress, Grief, Depression, Recent Events affecting stability of client	Ask about recent events, losses Allow some time Refer to a mental health professional
Medical Factors	Ask about nutrition, medications, hydration Refer to a physician
Time of Day Variability	Ask if certain times of the day are best Try mid-morning appointment
Hearing and Vision Loss	Assess ability to read/repeat simple information Adjust seating, lighting Use visual and hearing aids Refer for hearing and vision evaluation
Educational/Cultural/Ethnic Barriers	Be aware of race and ethnicity, education, long-held values and traditions



**B. RELEVANT LEGAL ELEMENTS** - The legal elements of capacity vary somewhat among states and should be modified as needed for your particular state.

<b>General Legal Elements of Capacity for Common Tasks</b>	<b>Notes on Client's Understanding/ Appreciation/Functioning Under Elements</b>
<p><i>Testamentary Capacity</i> - Ability to appreciate the following elements in relation to each other:</p> <ol style="list-style-type: none"> <li>1. Understand the nature of the act of making a will.</li> <li>2. Has general understanding of the nature and extent of his/her property.</li> <li>3. Has general recognition of those persons who are the natural objects of his/her bounty.</li> <li>4. Has/understands a distribution scheme.</li> </ol>	
<p><i>Contractual Capacity</i> The ability to understand the nature and effect of the particular agreement and the business being transacted.</p>	
<p><i>Donative Capacity</i> An intelligent perception and understanding of the dispositions made of property and the persons and objects one desires shall be the recipients of one's bounty.</p>	
<p><i>Other Legal Tasks Being Evaluated &amp; Capacity Elements:</i></p>	

**C. TASK-SPECIFIC FACTORS IN PRELIMINARY EVALUATION OF CAPACITY**

<b>The more serious the concerns about the following factors...</b>	<b>The higher the function needed in the following abilities...</b>
Is decision consistent with client's known long-term values or commitments?	Can client articulate reasoning leading to this decision?
Is the decision objectively fair? Will anyone be hurt by the decision?	Is client's decision consistent over time? Are primary values client articulates consistent over time?
Is the decision irreversible?	Can client appreciate consequences of his/her decision?

**D. PRELIMINARY CONCLUSIONS ABOUT CLIENT CAPACITY** - After evaluating A, B, and C above:

<input type="checkbox"/> <b>Intact</b> - No or very minimal evidence of diminished capacity	<i>Action:</i> Proceed with representation and transaction
<input type="checkbox"/> <b>Mild problems</b> - Some evidence of diminished capacity	<i>Action:</i> (1) Proceed with representation/transaction, or (2) Consider medical referral if medical oversight lacking, or (3) Consider consultation with mental health professional, or (4) Consider referral for formal clinical assessment to substantiate conclusion, with client consent
<input type="checkbox"/> <b>More than mild problems</b> - Substantial evidence of diminished capacity	<i>Action:</i> (1) Proceed with representation/transaction with great caution, or (2) Medical referral if medical oversight lacking, or (3) Consultation with mental health professional, or (4) Refer for formal clinical assessment, with client consent
<input type="checkbox"/> <b>Severe problems</b> - Client lacks capacity to proceed with representation and transaction	<i>Action:</i> (1) Referral to mental health professional to confirm conclusion (2) Do not proceed with case; or withdraw, after careful consideration of how to protect client's interests (3) If an existing client, consider protective action consistent with MRPC 1.14(b)

**CASE NOTES:** Summarize key observations, application of relevant legal criteria for capacity, conclusions, and actions to be taken:

## V. Techniques Lawyers Can Use to Enhance Client Capacity

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Clients with evidence of diminished capacity may still be able to make or participate in making a legal decision. The Comment to Model Rule 1.14 notes that “a client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client’s own well-being.”<sup>39</sup> How can a lawyer maximize the capacity of an older client who may be limited by one or more of the cognitive, emotional, behavioral, or mitigating factors described in Chapter IV?

**This chapter highlights practical techniques that lawyers can use to accommodate sensory and cognitive changes that become more prevalent with age, and to engender the trust and confidence of older clients with diminished capacity.**

This chapter describes an approach of “gradual counseling” by which the attorney may help the client to understand and make choices through a process of clarification, reflection, and feedback that is respectful of client values.

A key message of this chapter is that attorneys must be sensitive to age-related changes without losing sight of the individuality of each older person.<sup>40</sup> Although functional limitations do increase with age, most older adults do not have physical, sensory, or cognitive impairments. Therefore, one must not assume impairments in older clients, but one must be prepared to address these issues when they arise. Moreover, attorneys should examine their own attitudes toward aging to ensure that “ageism” does not inadvertently influence their judgments about client capacity. Lawyers also should be alert to ethnic and cultural factors that might be a barrier to communication, subliminally affecting perceptions of client abilities and behavior.

Finally, attorneys should do everything possible to make their office and their counseling approach “elder friendly” and accessible to individuals with a range of disabilities. Under the Americans with Disabilities Act

(ADA), law offices as “public accommodations” are required to make reasonable modifications to their policies, practices, and procedures to make services available to people with disabilities.<sup>41</sup> Beyond this, many older clients whose impairments do not reach the level covered under the ADA will be aided by the kinds of techniques listed below to optimize their functioning.

### A. Engendering Client Trust and Confidence

Attorneys can take steps to build the trust of older clients, allowing them to be at their best during the interview process and bolstering their decision-making ability.

- Upon introduction, take time to “**break the ice**” and, if appropriate, make a few brief remarks about areas of common interest such as weather, sports, or mutual connections.
- **Interview the client alone** to ensure confidentiality and to build trust. However, consider the important role support persons can play. If the client is more at ease with a friend or family member in the room, **consider including the support person for a portion** of the interview or at least during an introductory phase. Be sure to talk *to the client rather than past the client* to the others.
- Stress the **confidentiality** of the relationship. Some older adults may be fearful of losing control of their affairs if they divulge information. Assure the client that information will not be shared with others, including family members, without prior consent.
- Encourage maximum **client participation** to increase a sense of investment in the process.
- Respond directly to the client’s feelings and words, making the client **feel respected and valued**, which enhances trust.
- Use **encouragement** and verbal reinforcement liberally.

- Take **more time** with older clients so they are comfortable with the setting and the decision-making process to be undertaken.
- Conduct business over **multiple sessions** to increase familiarity and opportunities for trust building.

## B. Accommodating Sensory Changes

While not all older adults have hearing and vision loss, these deficits are common for a substantial proportion of Americans over the age of 65. Sensory problems, particularly in hearing, sometimes result in older individuals pretending that they know what is under discussion, becoming socially withdrawn, and in some instances, depressed. As stated in Chapter IV, lawyers should not mistake sensory loss for mental confusion. Rather, sensory changes and the older adults' response to them are mitigating factors that should be taken into consideration when assessing signs of diminished capacity.

### *To address hearing loss*

- Minimize **background noise** (e.g., close the office door, forward incoming calls) as individuals with hearing loss have difficulty discriminating between sounds in the environment.
- **Look at the client** when speaking. Many individuals with hearing loss read lips to compensate for hearing loss.
- **Speak slowly and distinctly**. Older adults may process information more slowly than younger adults.
- **Do not** over-articulate or **shout** as this can distort speech and facial gestures.
- Use a **lower pitch** of voice because the ability to hear high frequency tones is the first and most severe impairment experienced by many older adults with compromised hearing.
- Arrange seating to be conducive to conversation. **Sit close** to the client, face-to-face, at a table rather than on the far side of a desk.
- Focus more on written communication to compensate for problems in oral communication.

tion. Provide **written summaries** and follow-up material.

- Have auditory **amplifiers** available.

### *To address vision loss*

- Increase **lighting**.
- **Reduce** the impact of **glare** from windows and lighting as older adults have increased sensitivity to glare. Have clients face away from a bright window.
- **Do not** use **glossy** print materials, as they are particularly vulnerable to glare.
- Format documents in **large print** (e.g., 14- or 16-point font) and double-spaced as presbyopia (blurred vision at normal reading distance) becomes more prevalent with age.
- Give clients **additional time** to read documents, as reading speed is often slower.
- Give the client adequate **time to refocus** his or her gaze when shifting between reading and viewing objects at a distance, as visual accommodation can be slowed.
- Be mindful of **narrowing field of vision**. A client may not be aware of your presence in the room until you are directly in front of him or her.
- Have **reading glasses** and magnifying glasses available on conference tables.
- Arrange furnishings so **pathways** are **clear** for those with visual or physical limitations.

### **To accommodate hearing/vision loss, address:**

- Background noise**
- Seating position**
- Lighting**
- Large print materials**
- Hearing and vision aids**
- Speaking style and pace**

## C. Accommodating Cognitive Impairments

For clients with some evidence of cognitive impairment who may be in the murky gray area of

“questionable capacity,” the practical steps suggested below may offer significant support:

- Begin the interview with **simple questions** requiring brief responses to assess client understanding and optimal pace, as reaction time is often slower among older adults, particularly for more complex tasks.
- Conduct business at a **slower pace** to allow the client to process and digest information, as information-processing speed declines with age.
- Allow **extra time for responses** to questions, as “word-finding” can decline with age.
- **Break information** into smaller, manageable segments.
- Discuss **one issue at a time**, as divided attention between two simultaneous tasks, as well as the ability to shift attention rapidly, shows age-related decline.
- **Provide cues** to assist recall rather than expecting spontaneous retrieval of information.
- **Repeat, paraphrase, summarize**, and check periodically for accuracy of communication and comprehension. The importance of repeated testing for comprehension has been documented in research of informed consent procedures showing that comprehension is sometimes incomplete even when individuals state that they understand. This inconsistency is more pronounced among older adults, particularly those with low vocabulary and education levels.<sup>42</sup>
- If information is not understood, incompletely understood, or misunderstood, **provide corrected feedback** and check again for comprehension.
- **Provide summary notes** and information sheets to facilitate later recall. Include key points, decisions to be made, and documents to bring to next meeting.
- Schedule appointments **for times of the day** when the client is at peak performance. Peak performance periods change with age and for many older adults **mornings** are often best.
- Provide time for **rest** and bathroom breaks.

- Schedule **multiple, shorter appointments** rather than one lengthy appointment, as older adults may tire more easily than younger adults. Multiple testing sessions can also assist in identifying the client’s performance rhythms and cycles.
- Whenever possible, conduct business in the **client’s residence**. This often makes the client more relaxed, optimizes decision-making, and provides the attorney with clues about “real-world” functioning.

#### D. Strengthening Client Engagement in the Decision-Making Process

Linda F. Smith, in her seminal article “Elderlaw: Representing the Elderly Client and Addressing the Question of Competence,” describes a technique of *gradual counseling* that is useful in compensating for age-related differences in memory and problem-solving ability, and when there are questions about capacity. It provides a method for inquiring into and understanding the client’s decision-making process, and may assist such clients in thinking through their underlying concerns, goals and values, and choosing a consistent course of action.

The attorney for the limited client should engage the client in a process of gradual decision-making, which will involve clarification, reflection, feedback, and further investigation...Gradual counseling requires the attorney to repeatedly refer to the client’s goals and values in assessing each alternative and in discussing the pros and cons of an alternative. This will involve a great deal of clarifying and reflecting of the clients’ thoughts and feelings...The attorney should proceed to explain each relevant option and elicit the client’s reactions.<sup>43</sup>

Smith outlines steps in the process of “gradual counseling” and maintains that if attorneys are vigilant in pursuing these steps with a client of questionable capacity, it may assist a limited client in reaching an informed decision.<sup>44</sup>

**Gradual counseling:**

- Identify goals**
- State problem**
- Ascertain values**
- Compare options to goals**
- Give feedback**

- Confirm or reconfirm the client’s basic **goal** or problem to be solved.
- **Get feedback** from the client to ensure he or she agrees with the lawyer’s statement of the problem. Listen for important client **values**.
- Ascertain **the most important** values the client expresses. Restate these values and confirm with the client. Recognize that the values of an older client may differ from those of the attorney.

For example, a young attorney may begin to doubt the competence of her elderly client who does not wish to contest a right to income or benefits or does not wish to take a relatively simple legal action to preserve his assets. However, if the particular client has a limited life expectancy, minimal need for assets, or an emotional focus upon internal or spiritual things, that client’s decision may be quite reasonable. Because the underlying values are so important, throughout the counseling process the attorney should continue to reflect the feelings and thoughts that the client expresses . . . to understand the client’s values as fully as possible.<sup>45</sup>

- Describe the **best option** for attaining the client’s goal. Ask for the client’s feeling about that option.
- **Explain each relevant option**, and get the client’s reaction. This will enable the attorney to see whether the client understands the information and how the client responds. It will also check for consistency of values. The attorney may need to “present fewer choices and only the most salient features for or against each alternative.” This “weeding out” may allow a client of questionable capacity to reach a reasoned judgment.
- Give the client **feedback** that might be helpful. For example, if the client appears inconsistent in goals or decisions over time, pointing this out may help the client to remember and focus. If a client chooses a course that seems harmful, the attorney could express worry and concern, and get the client’s reactions to this.
- Even when there is no clearly enunciated choice by the client, the lawyer still may be able to find capacity for the limited decision at hand from the **client’s reactions** during the course of the session.

Such a “gradual counseling” approach is respectful of the client’s autonomy. Moreover, an attorney taking these steps will be assured that he or she has made a thorough attempt to find client capacity before taking any more precipitous action. However, if despite all of these techniques and accommodations, the client’s capacity for the decision or transaction is still questionable, the attorney may need assistance from a clinician.

## VI. Referrals for Consultation or Formal Assessment

This chapter describes four key matters every lawyer needs to know: (A) the basic considerations relevant to seeking consultation or referral to a clinician for formal assessment; (B) how to select a clinician; (C) the elements or steps of any referral; and (D) how to communicate with the clinician doing the assessment.

**Consultation:** A lawyer's conversation with a clinician to discuss concerns about the client's presentation. Usually client is not identified and consultation does not require client consent.

**Referral:** A formal referral to a clinician for evaluation, which may or may not result in a written report. Requires client consent.

### A. Basic Considerations in Seeking Consultation or Referral

In transactional legal representations, two common scenarios can lead to the decision to seek professional consultation or to make a formal referral for assessment.

First, the attorney may have sufficiently strong concerns about the capacity of the client that it is important to seek clinical expertise and input on the issue before proceeding further or taking protective action as allowed in Rule 1.14(b). Second, in cases of ongoing or anticipated family or other conflict, the foresighted attorney may seek to preempt a future litigation (e.g., a will contest) by having the client undergo a capacity assessment prior to execution of the legal transaction (e.g., the will).<sup>46</sup>

Under the classification schema presented in Chapter IV for distinguishing clients with (1) intact capacity, (2) mild problems, (3) more than mild problems, and (4) severe problems, an attorney may find it helpful to contact a suitable clinician in situations where the client demonstrates *more than mild problems* with diminished capacity. For clients with only *mild problems*, further evaluation generally is not necessary, unless the attorney concludes that interested third persons may challenge the legal transactions at some point, based upon allegations of mental incapac-

#### Reasons for consultation or referral in transactional legal representation:

- Concern about client capacity.
- Concern about preempting future litigation.

ity. In these situations, the attorney may want to recommend formal evaluation of the client as a defensive measure.

Sometimes an attorney will seek a private consultation with a clinician to discuss and clarify specific capacity issues before proceeding further with representation. Disclosure of the attorney's concerns is private, at least at this stage of the process, and does not involve the client. The Comment to Rule 1.14(b) provides explicit recognition of such external consultations, indicating that it is proper for attorneys to seek guidance from an "appropriate diagnostician" in cases where clients demonstrate diminished capacity.<sup>47</sup>

In other cases, an attorney may feel compelled by capacity concerns, litigation strategy, or other case circumstances to seek an independent formal capacity evaluation by a clinician. Such a decision is significant because it necessarily involves disclosure to the client of an attorney's concerns or litigation strategy, and requires a client's consent to be evaluated. It represents a significant step by the attorney that can impact the attorney-client relationship in both positive and negative ways.

Decisions of this type, thus, will sometimes necessitate lengthy and forthright discussions with clients and family members.

This being said, such capacity evaluations and written reports are usually quite valuable because when conducted properly, they furnish objective cognitive and behavioral data and professional expertise to the attorney and the case. The opinions of a clinician can serve as evidence or be advisory in a number of important functions, outlined in the box, next page.

At the same time, a formal assessment is not without danger, for there is always the potential adverse use of such an evaluation against the lawyer's client. Though the report may be protected under physician-

**Potential uses of clinical opinion regarding client capacity:**

- Expert testimony in a subsequent deposition or courtroom hearing.**
- Clarification of the areas of diminished capacity and of retained strengths.**
- Affirmation of the client's capacity.**
- Justification of the attorney's capacity concerns to disbelieving clients and family members.**
- Expert advice on strategies to compensate for identified mental deficits.**
- Indication of the need for protective action.**
- Recommendation for follow-up testing (anticipated restoration of capacity).**

patient privilege and attorney-client privilege when the client refuses to consent to disclosure, these privileges are variable under state law and subject to a host of exceptions and interpretations. Their protection from discovery in civil litigation is not absolute.<sup>48</sup>

On this point it should be emphasized that the clinical evaluation *need not result in a formal written report*. The lawyer may instruct the clinician to do the evaluation, and then to call the lawyer with preliminary, unwritten conclusions, after which the lawyer can state whether or not the clinician should commit the clinical opinion to writing.

**B. Selecting a Clinician**

Although the Comment to Rule 1.14(b) permits the lawyer to find an “appropriate diagnostician” it does not specify who is “appropriate.” Of note, although the Model Rule refers to “diagnostician,” a better term is clinician, as the process of capacity assessment involves more than a diagnosis, especially with the move away from merely making a diagnosis to describing cognitive and functional abilities.

Ideally, the most appropriate clinician would be a medical or mental health professional who is knowl-

**Who is an appropriate clinician?**

**The most important criterion is the clinician's experience and knowledge in the assessment of older adults.**

edgeable about the problems of late life, familiar with assessment approaches and instruments relevant to capacity issues, and has considerable experience conducting capacity assessments.

Types of professionals who are most likely to have such background include those listed in the box on the following page. In major metropolitan areas lawyers are more likely to be able to identify internists, psychiatrists, and psychologists with relevant background. The reality is, however, that the number of professionals with ideal credentials is small.

Lawyers in rural or smaller communities may find it difficult to locate a psychiatrist or psychologist within reasonable driving distance. In this case, the lawyer may need to rely on local professional resources even if they are not ideal. A respected medical internist with a geriatric clientele may be appropriate.

A critical step in making a referral is to articulate clearly the area of referral expertise needed. Consider whether the client’s impairment may stem from mental retardation or developmental disability, mental illness, Alzheimer’s or other type of dementia, or other possible medical cause. The expertise for examining these different etiologies can be quite different. For example, a neurologist may have expertise in problems associated with Alzheimer’s disease (a cognitive illness) while a psychiatrist is likely to have more expertise in schizophrenia (a psychiatric illness). The more closely the expertise is matched to the underlying impairment, the more likely the diagnostician can accurately assess the client and provide needed answers.

When considering a referral, the lawyer should ascertain the qualifications of the assessor. Most medical professionals are “boarded” or have “added qualifications” in one or several specialty areas. Being boarded or having added qualifications means that the individual has obtained required training and education and passed an exam. Relevant medical boarded specialties include geriatric medicine, psychiatry, neurology, geriatric psychiatry, and forensic psychiatry.

In psychology, there is increasing specialization although the boarding process has not been as important as in medicine. A small number of psychologists are boarded by the American Board of Professional Psychology (relevant boarded areas include neuropsychology).



<b>Key Professionals for Capacity Consultation or Referral</b>	
<b>Physician</b>	<b>Any MD</b>
<b>Geriatrician</b>	<b>MD specialist in aging</b>
<b>Geriatric Psychiatrist or Gero-psychologist</b>	<b>Mental health specialists in aging</b>
<b>Forensic Psychologist or Psychiatrist</b>	<b>Mental health specialists in law</b>
<b>Neurologist</b>	<b>MD specialist in the brain function</b>
<b>Neuro-psychologist</b>	<b>Psychologist specialist in cognitive testing</b>
<b>Geriatric Assessment Team</b>	<b>Multidisciplinary teams in aging</b>

chology and forensics), although most individuals who do geriatric assessments are not boarded.

Perhaps the most critical question is to *ascertain how much experience the professional has in the assessment of capacity of older adults*, or of clients with the type of presenting problem at hand.

When approaching the client's regular physician to request an evaluation, it is also useful to ask how long the physician has known the client. Armed with this information the lawyer will not only be in a better position to make a judgment about whether the individual is an "appropriate diagnostician," but also to convey in advance to the client what to expect as part of the evaluation.

Ideally, lawyers who have a large geriatric clientele will be able to recommend clinicians with whom they have had positive prior experience. Lawyers lacking those prior connections may wish to investigate

#### **Asking about qualifications of clinicians:**

- How long have you conducted such assessments?**
- How many older adults have you assessed?**
- What assessment approach and tools do you generally use?**
- How many visits are usually required and of what duration?**
- What is the likely cost of the assessment?**

resources through the local aging network. A good starting point is the local Area Agency on Aging for the county, city, or multi-county area in which the lawyer is located. Under the Older Americans Act, Area Agencies on Aging are responsible for planning and funding a wide range of services for older persons. They typically provide extensive information and referral services and may be able to identify health professionals with expertise in capacity assessment.

**To find your local Area Agency on Aging and other resources, call the Eldercare Locator toll-free line at 1-800-677-1116, or go online to [www.eldercare.gov](http://www.eldercare.gov).**

The American Psychiatric Association and American Psychological Association each have state and local affiliates. Sometimes these affiliates have referral lists based on area of expertise. State or local medical societies may be able to provide referral to geriatric medicine specialists or to physicians who identify themselves as having experience with older adults. University medical centers also may have geriatric or long-term care divisions with multi-disciplinary geriatric assessment teams.

For lawyers who see an increasing number of older adults in legal practice, it makes sense to develop referral resources in advance. In areas where there is a dearth of those with relevant specialty background, it might be possible to partner with a local health or mental health professional who is interested in gaining experience in this area.

### **C. Elements of a Lawyer's Referral to a Clinician**

Once a lawyer has identified good local clinical resources, the lawyer must consider the elements of an effective case referral. These elements are addressed below. The task of interpreting the assessment report is addressed in Chapter VII. Appendix 2 sets out a model letter requesting a client assessment.

In making a referral, it is important for the lawyer to recognize his or her own continuing role. Ultimately, the judgment about the client's capacity for the legal transaction at hand is the lawyer's to make. While the results of a clinical assessment gen-

**Referral issues to consider:**

1. **Use of consultation preliminary to referral;**
2. **Client consent for formal assessment; and**
3. **Lawyer communication with the assessor.**

**The lawyer makes the final determination of capacity for the legal transaction.**

erally will be a determining factor, client capacity is a *legal decision* and an inherent part of the lawyer-client relationship. Thus, the lawyer can use the assessment report as valuable—ideally conclusive—evidence, but still needs to “look behind” the report and make an independent judgment taking all factors into account.

***Informal Consultation***

A lawyer may consult a clinician either preliminary to or instead of making a client referral for a formal assessment. In such a consultation, the lawyer can outline client communications and reactions, as well as the legal transaction for which capacity is required. The lawyer can seek an informal opinion on the question of capacity—and on the question of whether a formal assessment is necessary. The clinician can raise questions the lawyer might have overlooked, allay or reframe the lawyer’s concerns, and suggest strategies for enhancing client capacity.

A preliminary up-front consultation on capacity can bring a lot of “bang for the buck”—in some cases saving the lawyer and the client a great deal of time, money, and angst if it avoids an unnecessary formal assessment. Or it may provide reassurance that a formal assessment is indeed the right step, as well as an indication about what kind of assessment might be optimal.

As discussed further below, communication of capacity concerns to clients and families can some-

times be a difficult and unsettling process, which occasionally may lead abruptly to termination of the representation. Thus, an attorney needs to be well-prepared before taking such a formal step, and a private consultation may be one of the preparatory steps.

***Client Consent for Informal Consultation***

Does such a preliminary consultation require client consent? If the lawyer identifies the client in the consultation, the lawyer would breach Model Rule 1.6 mandating confidentiality by failing to seek consent. Moreover, the lawyer should aim to involve the client to the greatest extent possible in all aspects of the representation. However, the Comment to Model Rule 1.14 on clients with diminished capacity provides that “in appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician” in determining client capacity.<sup>49</sup> The comment does not address the question of consent for seeking such guidance. And on the question of disclosure of otherwise confidential information, the new Model Rule 1.14(c) provides that if the elements of Model Rule 1.14(b) are met (i.e., the lawyer reasonably believes the client has diminished capacity, is at risk of substantial harm, and unable to act adequately in his or her own interest), then the lawyer may “reveal information about the client, but only to the extent reasonably necessary to protect the client’s interest.” The obvious dilemma here is that the consultation may be needed prior to, and specifically, in order to determine whether the elements of Rule 1.14(b) are met—not after the lawyer has already come to that conclusion.

One possible interpretation of the rule and comment is that, since consultation with an appropriate clinician is a very minimal protective action, the threshold for meeting the trigger criteria in Rule 1.14(b) is correspondingly low, thereby justifying very limited disclosure of otherwise confidential information. Unfortunately, authoritative resolution of the question is lacking. The lawyer needs to use good judgment and limit information revealed to what is absolutely necessary to assist with a determination of capacity. Whenever possible, the lawyer should seek to consult the assessor informally without identifying the client. In that case, the question of consent does not arise. The consultation is simply professional advice to the lawyer.

**Possible questions in an informal consult:**

- What should I look for?**
- What else might I ask?**
- What could I do to enhance capacity?**
- What am I overlooking?**
- What does it seem like to you?**
- Is a formal assessment indicated?**

***Payment for Informal Consultation***

What about payment? If the client is identified in the consultation and has given consent, the lawyer then can bill the client for the consultation, as well as for the time spent by the lawyer in speaking with the assessor. The lawyer should establish in advance the assessor fee for such consultations. However, if the client is not identified, the consultation is really a service for the lawyer, paid for by the lawyer.

**Uses of informal consultation:**

- Clinical interpretation of problem.
- Informal clinical opinion on capacity.
- Suggestions for enhancing capacity.
- Additional questions to ask client.

**If client is not identified . . .  
no consent necessary and lawyer pays fee.**

***Client Consent for Formal Assessment***

Client consent for referral for a formal assessment involves some of the same ethical considerations as client consent for an informal consultation, outlined above. On the one hand, the lawyer must not breach the confidentiality that is the hallmark of the client-lawyer relationship, and on the other hand, the lawyer knows that an assessment of capacity is necessary to assure the validity of documents or to proceed with the task at hand. If the client seems unable to give consent, the lawyer could wait until the client is stabilized, and then explain the need for referral and seek consent, or at least the “assent” of the client.

Once the client has made contact with the clinical assessor, the assessor will need to ensure there is sufficient informed consent to conduct the evaluation.<sup>50</sup> Finally, the clinician must get the client’s consent to provide the test results to the lawyer under the requirements of the Health Insurance Portability and Accountability Act (HIPAA).<sup>51</sup> But beyond the ethical dictates, as a practical matter, there can be no referral unless the client at some level agrees to have an appointment with a clinician and to participate in the interview and the selected assessment tests.

How, then, does the lawyer broach the topic of a formal assessment with the client? Suggesting an assessment seems like an ultimate judgment by the

lawyer—an authority figure in whom the client has placed trust. The client may interpret it as “My lawyer thinks I’m crazy... can’t do things for myself ... have dementia ... am just an old woman.” Indeed, “merely raising the issue of someone’s competency [capacity] can be hurtful or damaging to them.”<sup>52</sup> Moreover, the client may be intimidated by the very idea of a psychologist asking questions or of having to take a test.

**Key points in discussing with clients possible referral for evaluation include:**

- My job as a lawyer is to do everything possible to ensure that your action (e.g., writing a will, executing this contract) cannot successfully be challenged now or at a later time.**
- This kind of action can be legally challenged in the future on the grounds of legal incapacity.**
- The likelihood of a challenge is higher when a family member (or other interested party) is cut out of a will (or contract) or given a significantly lesser benefit than that which they might have expected.**
- A key preventative step is to have an assessment of capacity as close as possible to the time the legal transaction is completed.**

The referral is indeed trickier when the lawyer is not acting only to avoid later challenge, but because of genuine concern regarding the client’s decision-making abilities, particularly in the context of undue influence. It is important to alert the client to the benefits as well as the risks of a capacity assessment. The clinician is duty bound to the same disclosure.

The best approach in such situations is a compassionate but honest and direct explanation such as:

*Mrs. Jones, I am concerned about how you are doing. I am a little worried about your memory. To be sure that everything is okay for us to make this change to your will, and to make sure no one would contest it later, I would like you to meet with a clinician to do some formal assessment of your thinking. Hopefully, the testing will show us that everything is okay. If not, hopefully the testing will show us how to help you to meet your goals. The testing could come out either way, but I*

*think it is a good idea to be sure. Is it okay if I set up an appointment for a specialist to talk with you and conduct the tests?*

### ***Payment for Formal Assessment***

Payment will also be a primary concern in making a referral for assessment by a clinician. If the assessment is related to a diagnosis of the client's condition or can be directly tied to his or her medical care, then the assessment may be billable under medical insurance or Medicare. However, when the assessment is strictly for a legal purpose and the client has given consent, the lawyer will need to disclose the likely cost of such assessment and confirm the client's payment obligation or other payment arrangement before proceeding.

### ***Communicating with the Clinician***

The care with which the lawyer crafts the referral request will bear on the usefulness of the results. Setting out the full information, the legal standard, and questions up front will be more likely to yield a well-tailored assessment report. Conversely, a poorly crafted referral without a clear statement of the purpose may get results that are simply not meaningful, not understandable, or just not on target.

The referral letter will be of greatest use if it clearly sets out the reason for the request, sufficient information about the client and the circumstances, and any legal standard of capacity involved. See an example of a referral letter in Appendix 2. As noted in the U.S. Veterans Administration's *Practice Guidelines for Psychologists*:

There is always a specific reason why the psychologist is being consulted, and it is often not clearly stated. The psychologist must also understand the circumstances under which the person is allegedly unable to function under legal standards for competency. What specific areas of skill and function are at issue? In what circumstances and places? What other resources does the patient have to assist him/her in this matter? Why is the question

being asked now? Was there a critical incident? Are there any major changes (e.g., surgery, relocation) which have had or might have a significant impact on this individual's ability to make decisions?<sup>53</sup>

It is important for the lawyer to communicate with the clinician orally, as well as in writing, to make sure the assessor understands the purpose for the referral and the elements outlined in the referral letter, as noted in the checklist on this page. The aim is to ensure a complete and well-targeted assessment that is worth the money spent. Having to fill in gaps or ambiguities afterwards is both costly and an inefficient use of everyone's time.

#### **Checklist of Lawyer Referral Letter Elements:**

- 1. Client background: name, age, gender, residence, ethnicity, and primary language if not English.**
- 2. Reason client contacted lawyer; date of contact; whether new or old client.**
- 3. Purpose of referral: assessment of capacity to do what? Nature of the legal task to be performed, broken down as much as possible into its elemental components.**
- 4. Relevant legal standard for capacity to perform the task in question.**
- 5. Medical and functional information known: medical history, treating physicians, current known disabilities; any mental health factors involved; lawyer's observations of client functioning, need for accommodations.**
- 6. Living situation; family make-up and contacts; social network.**
- 7. Environmental/social factors that the lawyer believes may affect capacity.**
- 8. Client's values and preference to the extent known; client's perception of problem.**
- 9. Whether a phone consultation is wanted prior to the written report.**

## VII. Understanding and Using the Capacity Assessment Report

As the number of capacity assessments increases significantly over the next decades due to demographic changes, lawyers will become increasingly familiar with interpreting and using clinical assessments. Along with this, clinicians are developing practice standards and guidelines for such reports. This chapter aims to guide attorneys in the basic features and uses of a capacity assessment report.

The following description of a capacity assessment is drawn from a typical psychological or neuropsychological report, although the length of the report and elements included vary from practitioner to practitioner.

The term “patient” is used in this chapter since the capacity evaluation with a clinical examiner is a clinically-oriented application despite its ultimate application in a legal setting. Examples of capacity evaluation reports are provided in Appendix 2.

### A. Understanding the Elements of the Capacity Report

#### 1. Demographic Information

The report should provide basic information concerning the age, race, gender, education, marital status,

**Note: Reports of capacity assessment naturally differ somewhat depending on the professional discipline and to some extent the style of the clinician.**

and vocational status of the patient. Such basic information provides a general context for the report’s findings and conclusions.

#### 2. Legal Background and Referral

A brief description of the legal matter or issues underlying the capacity issue should be referenced early in the report. This normally would include the referral source, the specific referral question(s) presented, and the elements of capacity at issue.

#### 3. History of Present Illness

Frequently there are issues of medical and specifically neurologic and psychiatric illness that may be associated with the alleged diminished capacity of an individual. This medical history needs to be presented early in the report. Interview information obtained from the patient and collateral sources is an important part of this section.

<b>Common Elements of a Clinical Evaluation Report</b>	
<b>Element</b>	<b>Summary</b>
<b>1. Demographic Information</b>	<b>Age, race, gender, education, etc.</b>
<b>2. Legal Background and Referral</b>	<b>Legal issue at hand, referral question</b>
<b>3. History of Present Illness</b>	<b>Medical history, current symptoms, etc.</b>
<b>4. Psychosocial History</b>	<b>Occupation, current living situation, family history of psychiatric and medical illness, etc.</b>
<b>5. Informed Consent</b>	<b>Statement of client’s consent to the evaluation</b>
<b>6. Behavioral Observations</b>	<b>Appearance, speech, mood, etc.</b>
<b>7. Tests Administered</b>	<b>List of tests given</b>
<b>8. Validity Statement</b>	<b>Opinion of extent to which test results are valid</b>
<b>9. Summary of Testing Results</b>	<b>Test scores, standard scores, performance ranges as compared to age-matched normative data</b>
<b>10. Impression</b>	<b>Diagnosis; Clinical interpretation of test results; Clinical interpretation of psycholegal capacities</b>
<b>11. Recommendations</b>	<b>If appropriate, statements of recommended clinical action (e.g., treatment to help symptoms)</b>

#### **4. Psychosocial History**

The report also concisely should reference relevant aspects of the patient's psychosocial history: family history; personal and family medical history; personal and family psychiatric history; social history; and work history.

#### **5. Informed Consent**

This section will document how the examiner described the purpose of the evaluation, and the patient's understanding of the evaluation and its risk and benefits, as well as the patient's consent to participate in the evaluation.

#### **6. Behavioral Observations**

Behaviors demonstrated by the patient during the course of the evaluation are often important pieces of capacity evidence and need to be set forth in the report. These can include the patient's appearance and presentation, speech and communication abilities, mood and range of emotional expression, insight and judgment, sense of humor, and test taking approach. Indications of neurologic or psychiatric illness should be noted, such as short-term memory loss (in interview); inability to follow task directions; confusion; perseverative behaviors or answering (i.e., excess repetition of a particular response, such as a word, phrase, or gesture); paranoid or delusional thinking; hallucinatory events; or the flat affect and morbid ideation characteristic of depression.

#### **7. Tests Administered**

A listing of the full range of tests administered should be included in the report. This would include tests that the patient discontinued or was unable to complete. There are many different psychological tests available that can be incorporated into a capacity evaluation. These are summarized in Appendix 3. However, in general, tests should cover the following general areas: (1) cognitive abilities; (2) personality and emotional functioning; and (3) relevant functional abilities. The functional category takes on particular significance in a capacity evaluation, as it will include (if available) measures of the specific capacities at issue in the legal case (e.g., medical decision-making capacity, financial capacity). However, as discussed further below, all three areas of testing are needed to

comprise a comprehensive evaluation of the patient's capacity status.

When are objective tests indicated? The use of objective or performance-based instruments will vary according to the discipline of the assessor and the impairment of the client. As a rule, psychologists are more prone to use objective tests and to use more of them than physicians. Overall, the more mild, subtle, and complex a client's presentation, the more useful objective tests are likely to be. In contrast, a client with clear and obvious incapacity, such as in late stage Alzheimer's disease, is unlikely to need or even to be able to complete most objective tests for the purposes of a capacity evaluation. Further, the more likely it is that the findings of the report will be disputed, the more important it will be to use standardized tests as these are more defensible as representing objective findings versus subjective opinion.

#### **8. Validity Statement**

An essential part of any report is a brief statement by the examiner concerning the validity of both the cognitive and emotional/personality test findings. For example, "the patient gave appropriate effort during the testing, and test results are judged to be a reliable and valid indicator of the patient's level of functioning." The validity of test results can be altered by factors such as low effort, frank attempts to exaggerate deficits, or unstable medical status. In most cases of unstable medical status the examiner should wait until the patient is medically stable, but this is not always possible when an immediate result is needed. The validity measures will assist in this formulation, but other test-taking behaviors and factors also need to be considered. Exaggerated test-taking performance and sometimes outright malingering can emerge in a capacity evaluation, although most older adults will be motivated to perform at their best when the purpose is to confirm capacity for legal transactions they have initiated, as compared to personal injury and workmen's compensation settings. The validity statement focuses on effort and motivation as it influences test performance. The impact of other variables such as education, socio-economic background, and ethnicity is considered in the interpretation in the impression section.

### 9. *Summary of Testing Results*

A summary of the test results should be presented as part of the report, either in text or tabular form. Although textual description of test data is probably most common, a tabular format can be very effective as it can efficiently present the full range of data obtained (raw scores, subscale scores, percentile ranks), organized by cognitive, personality, and functional sections.

### 10. *Diagnostic and Clinical Interpretation*

This section of the report integrates all of the evaluation information into a set of clinical and capacity findings. This is a significant undertaking, as multiple sources and levels of information (from the medical record, the clinical interviews, behavioral observations, and the multiple types of tests administered) must be considered, weighed, and then translated into diagnostic findings and, separately, into clinical interpretation. For example, the clinician may state that the test results are consistent with dementia, and the patient is capable of making simple medical decisions but lacks the capacity to make complex medical and financial decisions. It is at this juncture that the value of retaining a clinician with experience in capacity evaluations will be underscored. An effective approach is to report the diagnostic impressions, cognitive, and personality impressions first, in a separate section, as prelude to clinical interpretation of the psycholegal capacities. The diagnostic statement may appear in “five axis” format, with the first item being the primary psychiatric diagnoses, the second, the personality diagnosis (if any), the third, the medical conditions affecting axes I and II, the fourth, a description of psychosocial and environmental problems, and the fifth, a “global assessment of functioning” number from 0-100.

The next section can detail the clinician’s opinion of the client’s psycholegal capacities. This opinion reflects not merely a scoring and reporting of test results, but a process of clinical inquiry and interpretation. It is important to keep in mind that the cognitive and emotional/personality findings and diagnostic assignments will not be determinative, by themselves, of the capacity outcomes in a particular matter. The capacity outcomes depend primarily on the fit, as judged by the examiner, between the individual

patient’s current functional abilities and the demands of the capacity in question within the patient’s life context. Thus, as an example, a patient diagnosed with mild Alzheimer’s disease and mild to moderate memory impairment may still be quite capable of consenting to medical treatment, if he or she demonstrates sufficient treatment consent abilities such as appreciation, reasoning, and understanding in discussing a medical intervention with a physician.

### B. *Clinical Capacity Opinions Versus Legal Capacity Outcomes*

Capacity opinions in a report often are presented in terms of the patient being capable, marginally capable, or incapable with respect to the particular capacity in question (e.g., testamentary capacity). These capacity findings are clinical opinions, which although highly relevant to the legal capacity question at issue, are also distinct. It is at this point that the distinction between “clinical capacity” and “legal capacity” is most apparent and relevant.

**The lawyer (or sometimes the judge) makes the final determination of legal capacity.**

Capacity evaluations should not (but in some cases may) present capacity opinions as actual findings of legal capacity. Clinical findings are evidence which must then be adduced by the attorney to support, along with other evidentiary sources, his or her judgment concerning the legal capacity issue at hand, such as the ability to change a will. In guardianship, judges use capacity evaluations as one form of evidence (albeit highly relevant and probative) in arriving at their determination of the need for guardianship or conservatorship.

### C. *Using the Capacity Report*

A capacity report, like other expert sources of evidence, is subject to multiple uses.

#### *Follow-up with Examiner*

Upon receiving a capacity evaluation, an attorney should allocate time to read and digest the report as thoroughly as possible. This will permit an informed

follow-up with the examiner to identify, for example, other issues needing attention or, on occasion, factual inaccuracies needing correction. Also, the attorney may need to clarify the meaning of technical language or abbreviations used in the report.

#### ***Use of the Report As Evidence***

The attorney may treat the report as informational and advisory, or as a formal assessment that could be used as evidence in a judicial setting. If the examiner is not to be designated as an expert witness in a hearing or trial, the report will in most instances not be subject to discovery, and can remain advisory in nature, as part of the attorney's client case file.

However, the application of client-lawyer privilege and doctor-patient privilege varies among the states and may not protect the report from discovery. In some cases, the attorney has sought a capacity evaluation and report specifically for purposes of inclusion in the record to substantiate or refute the client's ability concerning a legal transaction, and, in the case of guardianship, for presentation as evidence at the hearing.

#### ***Limited Guardianship and the Least Restrictive Alternative***

In general, during a guardianship or conservatorship proceeding, the findings of a capacity report should be used to support an outcome consistent with the least restrictive alternative. Thus, where possible, the findings should be used to frame judicial orders of limited guardianship or conservatorship, reserving to the client rights and powers in all areas in which he or she still retains decisional abilities. Thus, with respect to a conservatorship order, if the capacity evaluation suggests preserved abilities regarding handling small amounts of money and a small checking account, these activities (cash transactions, limited checkbook management) should be retained by the client as part of the overall order. The report also may substantiate the client's capacity to execute a durable power of attorney or a health care directive that may preclude the need for guardianship.

#### ***Protective Actions Under Model Rule 1.14***

In some instances, the findings of the capacity evaluation may compel the attorney to take protective

action with respect to an already existing client and his or her assets. Model Rule 1.14 requires that in situations of diminished capacity, the attorney take "reasonably necessary protective action." The presence of a sound capacity evaluation and report will likely make the attorney more comfortable in taking such actions, if indicated.

The Comment to Model Rule 1.14 provides the following examples of protective action and guiding principles:

Such measures could include: consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decision-making tools such as durable powers of attorney, or consulting with support groups, professional services, adult-protective agencies, or other individuals or entities that have the ability to protect the client. In taking any protective action, the lawyer should be guided by such factors as the wishes and values of the client to the extent known, the client's best interests and the goals of intruding into the client's decision-making autonomy to the least extent feasible, maximizing client capacities, and respecting the client's family and social connections.

#### ***Clinical Interventions***

There are many situations that are not adversarial, in which the attorney, client, and family are all seeking to serve the client's interests and to maximize capacity and autonomy. One important result of a capacity assessment may be specific recommendations for clinical interventions that may be recommended by the lawyer and pursued by the client and family to improve or stabilize the client's functioning. For example, in the case of the older client who has become delusional in the context of a hearing impairment, isolation, and anxiety, clinical interventions to address all three (hearing aids, more social contact, anti-anxiety medication) may very well reduce or eliminate delusions and restore the individual's capacity. In other situations, more frequent oversight and assistance with nutrition and medication may increase the client's lucidity. Afterwards, the legal transaction may be appropriately pursued.

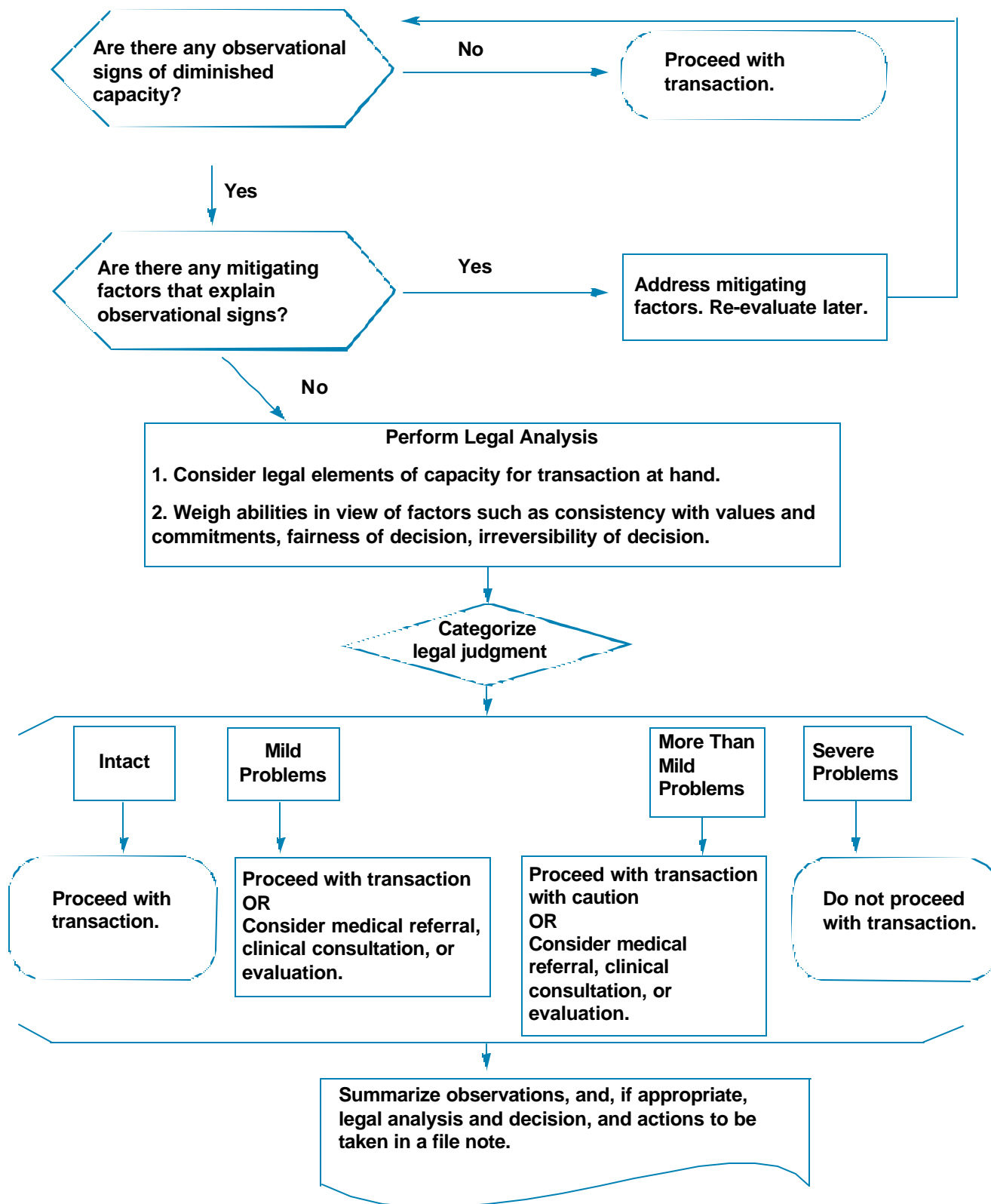


***Re-Evaluation Over Time***

Capacity status can fluctuate over time and in some instances a capacity that was initially lost (e.g., as a result of a head injury, transient acute psychosis, severe depression that later remits with treatment) will be recovered. In situations of intermittent or evolving capacity status, the value or need for a subsequent capacity evaluation should be considered.

For example, a client assessed as lacking capacity due to psychotic thinking that is secondary to severe depression may be re-evaluated for capacity after treatment for the depression. Similarly, a client assessed as lacking capacity due to confusion secondary to a urinary track infection may similarly be re-evaluated.

# Appendix 1: Capacity Assessment Algorithm for Lawyers



## Appendix 2: Case Examples

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### Introduction to Case Examples

In writing this handbook, the working group considered four possible types of case examples: (a) a case of an older adult with intact cognition and judgment, with no evidence of incapacity, who is asking for assistance with a legal transaction; (b) a case of an older adult with mild problems with capacity but where the attorney proceeds with the transaction either because the risk and complexity of the transaction are low, or after informal consultation and clarification with a clinician; (c) a case of an older adult with more than mild problems with capacity and where the lawyer seeks formal assessment; (d) a case of an older adult where the capacity problems are severe and rather obvious and the lawyer cannot proceed even to representation.

The first type of case, with intact capacity, would represent the majority of a lawyer's older adult caseload. We decided that it would likely be most helpful to include examples of cases with more than mild problems, and where the lawyer does seek formal assessment, in order to illustrate the type of case where this might occur, provide examples of good quality assessment reports, and describe how the lawyer used such reports to guide follow-up action. In contrast, we presumed that lawyers would not find it necessary to review case examples where capacity or incapacity were obvious. As such, the following two examples illustrate situations with more than mild capacity problems and where an attorney sought formal assessment. In the following case examples, the formal assessments were written by psychologists. As noted in the handbook, the style of the report received will vary depending on the discipline of the assessor. These reports are more typical of what a lawyer would receive from a psychologist rather than a physician or psychiatrist.

### **CASE EXAMPLE #1: Contract, Will, and Finances**

#### **A. Example of Attorney Model Referral Letter**

RE: Referral of Mr. Patient for Mental Health Assessment

Dear \_\_\_\_\_:

As we discussed by telephone, I am writing to make a referral of Mr. Patient for a neuropsychological assessment, with emphasis on his capacity: (1) to contract, (2) to make a will, and (3) to manage his business and financial affairs, as well as (4) his vulnerability to undue influence.

#### **Background**

I represented Mr. Patient and his now deceased wife several years ago in preparing their estate plan. Recently, Mr. Patient requested that I redraft a will for him and also prepare a buy/sell agreement for him with respect to his company Happy Valley Construction, which he owns with his brother James. Mr. Patient is 76 years old, was born and raised in Columbus, Georgia, and lives alone in his home of 34 years, although he receives home care services every day. His wife of 40 years died in 1990. He has two married daughters and one disabled single son. His daughter, Mrs. Daughter, is the only one who lives close by. She regularly helps him with shopping, paying bills, cooking, and light housekeeping. She is also named as his agent on his general durable power of attorney for financial affairs. However, she has not yet assumed the role of acting as his agent or attorney-in-fact.

As a result of my preliminary information gathering of his business and personal financial circumstances, as well as direct observations of Mr. Patient, I recommended to him that he undergo this formal evaluation. He consented to undergo the assessment, to have the results of the assessment released to me (release attached), and to pay the cost of the assessment. He should be billed directly by you. He has also consented to your contacting his daughter for additional background information.

### Triggering Issue

Mr. Patient's daughter, Mrs. Daughter, called my office to make an appointment for her father to review a contract (a buy-sell agreement) that Mr. Patient's brother asked him to sign. She also said that her father wanted to discuss rewriting his will.

I met with Mr. Patient on x/xx/xx for part of the time in private and for part of the time with his daughter present. While he appeared well-groomed and dressed appropriately and was able to describe the purpose of his visit, he showed considerable difficulty understanding the contents of the contract his brother asked him to sign. The buy-sell contract would give his brother a first option to acquire his interest in their closely-held family company (Happy Valley Construction) on very favorable terms. But it also goes a significant step further in vesting the entire company in his brother upon Mr. Patient's death and forgiving several unspecified loans made by Mr. Patient to the company. The daughter expressed concern that her uncle is taking advantage of her father's diminished health in urging him to sign such a one-sided agreement.

As to his will, he urgently wants to redo it, now that his wife has died (although her death is now several years passed). I had prepared his current will when his wife was still alive. Under his current will, his disabled son would receive half the estate in trust, while the two daughters would each get one-quarter of the estate. He states that he now wants everything to go equally to his three children, but he appears to be confused about the nature and extent of property in his estate and about the terms of his present will.

His daughter also reports high levels of forgetfulness, confusion, and poor judgments, especially around financial transactions. She is concerned that he is unable to handle neither his business nor personal financial affairs, and she currently does most of his personal bill paying for him.

### Relevant Legal Standards

*Contractual capacity.* In this state, the test of whether party has sufficient mental capacity to execute a valid contract is whether he is possessed of sufficient mind and reason for a full and clear understanding of the nature and consequences of making the contract. A more complicated contract calls for a higher level of capacity than a simple one. While a buy-sell agreement is not unusually complex, the proposed agreement in this case goes well beyond the usual buy-sell terms, and would in effect be a will substitute for a major part of his estate, as well as forgiving several loans (the number or amount of which I have not yet verified).

*Testamentary capacity.* In this state, the capacity to make a will is defined as requiring: (1) an understanding that a will is a disposition of property to take effect after death, (2) a general understanding of the property subject to the will, (3) a knowledge of the persons related to him by ties of blood and of affection who would be the usual beneficiaries of a will, and (4) an ability to conceive and express by words, written or spoken, or by signs, or by both, any intelligible scheme of disposition. It is possible for one to have testamentary capacity but not contractual capacity.

*Legal incapacity to manage one's property.* This is the standard used to determine the need for a court-appointed guardian in this state: a court may appoint a guardian for a person who is: (1) incapacitated by reason of mental illness, mental retardation, mental disability, physical illness or disability, chronic use of drugs or alcohol, detention by a foreign power, disappearance, or other cause; and (2) as a result of such condition, incapable of managing his or her estate, and (3) the appointment is necessary either because the property will be wasted or dissipated unless proper management is provided or because the property is needed for the support, care, or well-being of such person or those entitled to be supported by such person.

*Undue influence.* "Undue influence" is influence that amounts either to deception or to force and coercion which destroys free agency. It is recognized that lesser amount of influence may be necessary to dominate a mind that is impaired by age or disease. However, honest persuasion or argument does not constitute undue influence in the absence of fraud or duress when the individual in question has the mental capacity to choose between his original intention and the wishes of the other person

**Medical/Social/Functional Information**

Mr. Patient reports that he is on medication for diabetes and heart problems. His daughter reports that he had bypass surgery in 1989 or 1990 and that he had surgery on his lungs in 2000. His personal physician is Dr. Medical, at (address and phone). My contacts with Mr. Patient go back 15 years, and he was always quite knowledgeable in business affairs, very caring of his family, and active. My own observations are that he is now clearly quite frail and variable in his level of understanding, alertness, and confusion. Only his daughter appears to have regular contact with him. She is very concerned about his welfare and very distrustful of her uncle. The uncle essentially runs the business alone now, but maintains contact with Mr. Patient. Mr. Patient appears to have great trust in his brother.

In summary, I request an evaluation for the purposes described above. Please include the following in your assessment report if possible:

- Mental health diagnosis
- Tests conducted
- Analysis of test results
- Applicability to situation at hand
- Specific assessment of the ability of Mr. Patient to:
  - execute a contract (the buy-sell agreement described above)
  - make a will
  - manage his business and financial affairs
- Assessment of his vulnerability to undue influence
- Suggestions for improving his capacity or accommodating his deficiencies, if any.

I understand that the evaluation and report can be completed by x/xx/xx. If that time frame changes, please let me know. Please send your report to me at my Columbus office address. I appreciate your help with the case and look forward to working with you in the future.

Sincerely,

## B. Example of Psychological Assessment Report

**Name:** Mr. Patient  
**Sex:** Male  
**Race:** Caucasian  
**Age:** 76  
**DOB:** x/xx/29  
**MRN:** xxxxxxxx

**Education:** 6  
**Occupation:** Real estate/construction business owner  
**Marital Status:** Widowed  
**Handedness:** Right  
**Date Seen:** x/xx/xx  
**Date of Report:** x/xx/xx

**I. BACKGROUND INFORMATION** Mr. Patient was referred as an outpatient to the Neuropsychology Clinic by his attorney, Mr. Legal, Esq., for evaluation of the patient's cognitive and emotional status, and capacities to contract (execute a buy/sell agreement), manage his overall business and financial affairs, and make a will.

**History of Present Illness:** Mr. Patient reportedly has a 3- to 5-year history of memory problems, which reportedly developed insidiously and have gotten progressively worse over time. He reportedly has not been previously evaluated for these problems.

In interview, Mr. Patient stated that he does not have any problems with his memory. He also generally denied any other cognitive or functional problems. He stated that he does not have any help at home, but that his daughter comes by sometimes to help him pay bills or to bring him groceries. He denied problems with his driving. Regarding mood or personality changes, he reported that he is "doing fine" and denied any symptoms of depression or anxiety. Upon inquiry by the examiner, he expressed only a vague knowledge of a buy-sell agreement regarding his business that has reportedly been prepared by his brother.

Mr. Patient's daughter, Ms. Daughter, described a much more serious situation. Ms. Daughter said that her father has had memory problems for at least 5 years, and that his memory has become noticeably worse over the past 3 years. She said that she first noticed something was different when she left her accounting job in the family business in 1998 over some disagreements with her uncle James, who co-owns the business with her father. She said that her father did not seem to be taking up for her, which was uncharacteristic of him. She said that she later realized that her father was forgetting about these disagreements and his role in resolving them. Ms. Daughter reported that he currently asks the same question repeatedly, forgets conversations, and constantly misplaces items. She said that he has more trouble remembering people's names. She said that he has comprehension problems, but pretends to understand people when they talk to him. She reported that when they go to restaurants, he gets lost on his way back from the restroom. She reported that he has not driven since July 2000 when he had lung surgery. She said that just prior to that, he complained to her about getting lost while driving in a familiar area.

Regarding functional changes, Ms. Daughter reported that her father has no meaningful activities around the home. He has had full-time caregivers since July 2000. She noted that he still cannot remember their names. She reported that prior to these home health care arrangements, her father was not bathing and was wearing the same clothes every day. She reported that she has handled all of her father's bill paying since October 2000. She said that she also tries to supervise his business transactions. Ms. Daughter reported that her father co-owns an excavation business Happy Valley Construction, with his brother James. The business is located in Columbus, Georgia.

Mr. Patient reportedly has a separate business where he also buys, develops, and sells real estate. Ms. Daughter stated that her father has agreed on several occasions to consult her before signing any business documents, but then forgets to do this.

Ms. Daughter reported several poor business decisions her father has made recently. She said that in the past year he sold a piece of real estate for \$10,000 that was worth \$100,000. She also reported that he has made almost \$500,000 in loans to the family business over the past 2 years, and that these loans have not been repaid. She reported that her father initially loaned \$200,000 to Happy Valley in 1998, \$90,000 of which went to his nephew, who also works for the company. She stated that there does not appear to be a note for the loan to his nephew. She reported that the remaining \$300,000 was loaned out in October 2000.

Ms. Daughter also expressed concern about a proposed buy-sell agreement that was presented to her father by his brother while she was out of town. This agreement reportedly presents terms that are very favorable to the brother. It apparently states that if her father dies, the company will go to her uncle James and the money owed by the

company to her father will be forgiven. She noted that in this buy/sell agreement, some property that belongs to her father is listed instead as company property. Upon learning of this agreement, Ms. Daughter encouraged her father to contact his attorney Mr. Legal to discuss this.

Finally, Ms. Daughter expressed concern about whether her father may have recently signed a new will. Although he has no recollection of signing a new will, she indicated that he had stated that his brother had recently mentioned the “need” for a new will.

Regarding mood or personality changes, Ms. Daughter reported that her father is more laid back and even indifferent. She said that he used to be very focused on and concerned about his business affairs, but now seems often indifferent to them. She denied symptoms of anxiety or depression, but noted that he naps a lot during the day. She also stated that he always wants to eat because he forgets that he has already eaten.

Social/Academic/Occupational History: Mr. Patient reportedly was born and raised in Columbus, Georgia. He reported that he had 4 brothers and sisters. The patient’s father was a farmer and iron smith. The patient was reportedly married for 40 years when his wife died in 1990. He reported that he has two daughters and one son with a disability. He currently lives alone.

Mr. Patient reportedly completed 6 years of education. He reportedly buys and sells real estate and co-owns an excavation business called Happy Valley Construction Company, Inc. Mr. Patient reportedly started the excavation business and then brought his brothers into the business at a later time.

Prior Medical History: Mr. Patient’s medical history reportedly is significant for diabetes and history of blood clots. Surgical history reportedly includes four-way coronary artery bypass graft (1989) and partial lung resection (2000). The patient reportedly does not drink alcohol and does not smoke. There is reportedly no history of alcohol or other substance abuse.

Family medical history is reportedly positive for myocardial infarction in his brother, stomach cancer in his sister, skin cancer in his sister, and possible AD in his mother.

Psychiatric History: Mr. Patient reportedly has no history of mental health treatment. As noted above, he reportedly has had no prior evaluations for his memory problems.

Medications: Coumadin, Exelon, Prevacid, Tenormin, ginkgo biloba, Ambien, Detrol, Claritin.

**II. BEHAVIORAL OBSERVATIONS** Mr. Patient presented as a well-groomed, nicely dressed 76 year-old Caucasian man. He was accompanied to the evaluation by his daughter, Ms. Daughter.

In interview, the patient’s speech was fluent and reasonably goal-directed but lacked spontaneity. Responses were terse and impoverished. Comprehension appeared generally intact. Affect was mildly constricted, and mood was pleasant but irritable. Insight was judged to be very poor. There was no indication or report of formal hallucinations or delusions, or of a thought or perceptual disorder. There was no indication or report of suicidal ideation, plan, or intent.

During testing, Mr. Patient was alert and pleasant but would quickly become irritable and uncooperative with testing. He exhibited mild performance anxiety. He displayed task frustration by abandoning or avoiding tasks. He showed no response to encouragement from the psychometric technician. He displayed inability to complete some tasks due to comprehension problems. He made a few perseverative and intrusion errors. He required constant redirection to task. He showed a complete lack of test-taking strategies.

At one point, he refused to continue testing and started to leave, but was persuaded by his daughter to continue. Because of his reluctance to participate, and the examiner’s concern that he would prematurely terminate the testing, only an abbreviated test battery could be administered. Nevertheless, sufficient information was obtained to respond fully to the referral questions. Overall, the patient appeared to put forth variable but acceptable effort during the testing. Much of his reluctance to participate related to tasks that he appeared unable to perform. Overall, the current test results are an accurate representation of Mr. Patient’s current levels of cognitive and emotional functioning, and of his current financial abilities.

### III. TESTS ADMINISTERED

California Verbal Learning Test - II (CVLT-II)  
 Clinical Interview  
 Cognitive Competency  
 Executive Clock Drawing Task (CLOX)  
 Financial Capacity Instrument (FCI)<sup>54</sup>  
 Geriatric Depression Scale (GDS)

Mattis Dementia Rating Scale (DRS)  
Token Test  
Trails A and B  
WAB Auditory Comprehension  
Wide Range Achievement Test-3 (reading subtest)

#### **IV. SUMMARY OF RESULTS**

Please see attachment.

#### **V. IMPRESSIONS AND SUMMARY**

##### **Neuropsychological Findings:**

##### **1. Probable dementia, currently moderate (DRS=89/144, CDR= 2.0).**

The neuropsychological test results were consistent with probable moderate dementia. Evidence for this impression included severe impairment on a dementia screening instrument and impairments in high-load verbal learning, recall, and recognition memory (severe to profound), simple short-term verbal recall (severe), orientation to time (severe), orientation to place (severe), simple auditory comprehension (severe), reading abilities (moderate), visuospatial construction of a clock drawing (mild), simple visuomotor tracking (mild), propositional auditory comprehension (moderate), and spontaneous construction of a clock drawing (severe). The patient was unable to complete a measure of visuomotor tracking/set flexibility. In addition, the patient's daughter reported that he has had progressive memory and other cognitive problems for as long as five years.

Functional testing and interview data were also consistent with moderate dementia. Mr. Patient was severely impaired on a cognitive measure of everyday problem solving abilities. On a functional measure of financial capacity, the patient showed intact performance only on simple tasks of naming coins/currency, coin/currency relationships, and single and multi-item grocery purchases. He demonstrated significant impairment on tests of counting coins/currency, understanding financial concepts, making change for a vending machine, tipping, conceptual understanding of a checkbook/register, pragmatic use of a checkbook/register, conceptual understanding of a bank statement, use of a bank statement, detection of telephone fraud, conceptual understanding of bills, identifying and prioritizing bills, and knowledge of his personal financial assets and activities. In addition, the patient's daughter indicated that he has home health care aides around the clock. She reported that prior to these arrangements, the patient was not bathing and wore the same clothes every day. She said that he currently has no meaningful activities around the home.

As discussed above, due to the patient's reluctance to participate fully in the testing, only an abbreviated test battery was administered. Some cognitive domains were not assessed (e.g., expressive language, general intellectual abilities), and other domains were not assessed as comprehensively as they normally would be.

##### **2. Possible Alzheimer's disease.**

Mr. Patient's neurocognitive profile was consistent with possible AD. High-load verbal learning, recall, and recognition memory were moderately to severely impaired and he was unable to benefit from semantic or recognition cueing. He showed 0% recall after a short delay, which is consistent with the rapid decay of information over delay seen in AD. In addition, he had 0% short-term recall of verbal items from the memory subtest of the DRS. Mr. Patient demonstrated characteristic impairments on measures of executive function (simple visuomotor tracking, propositional auditory comprehension, and spontaneous construction of a clock drawing) and inability to complete a measure of visuomotor tracking/set flexibility.

Clinical course was consistent with AD. Mr. Patient's cognitive difficulties reportedly have been slowly progressive over the past 5 years. He also has a family history of possible AD.

In the examiner's judgment, it is highly probable that Mr. Patient has AD. However, he needs a neurological work-up for dementia before the clinical diagnosis can be established conclusively.

##### **Capacity Findings:**

**1. Probable current incapacity to enter into contracts.** This incapacity would include loan agreements, real estate contracts, and corporate buy/sell agreements.

The history, interview information, and test data indicated that Mr. Patient is probably incapable currently of entering into contracts such as the proposed buy-sell agreement. Ms. Daughter reported that her father has recently



sold some real estate at a fraction of what it is worth. She said that he has also made several large loans to his business recently, but seems generally unaware of these loans and the fact that they are not being repaid. He had very little specific knowledge regarding the proposed buy-sell agreement and seemed confused about its purpose.

Contractual capacity is a higher order legal competency which draws upon a variety of cognitive abilities, including memory, conceptual knowledge, reading ability, mental flexibility/executive function, and judgment. As discussed above, Mr. Patient is suffering from a moderate progressive dementia, probably of the Alzheimer's type, and he currently demonstrates significant deficits in all cognitive domains tested, including attention, memory, comprehension, and executive function. Screening for reading abilities revealed that Mr. Patient currently reads at the 2nd grade level (2%ile for age), which reflects a decline from estimated premorbid levels.

In the examiner's opinion, Mr. Patient no longer possesses the abilities to read and comprehend contractual documents, to recall essential information and details about contractual matters, to have the mental flexibility and judgment to negotiate effectively, or to make such business decisions in his best interest. In summary, he is no longer capable of entering into contracts, and it is likely that he has lacked this capacity for several years.

## **2. Probable current incapacity to make a new will.**

Interview and test data indicated that Mr. Patient is probably incapable currently of making a new will. Mr. Patient was unable to provide an adequate description of a will, stating only "It's where you put stuff in different people's names." He was also unable to set forth the nature and extent of his property to be listed within a will, describing his assets initially only as "farmland." When specifically prompted about items of property including his business, home, bank accounts, and stocks, he stated that he wanted these things to go to his children. When asked about debts owed to him, he stated that no one owed him any money. When reminded that he had loaned money to his business, and that repayment of these loans could be made to his estate after his death, he acknowledged that these debts were still outstanding. However, he could not recall the exact amount of the loans. Mr. Patient's lack of knowledge of assets/property to be passed in his will was also reflected in his poor performance on Domain 8 of the FCI, which tests general knowledge of personal assets and estate arrangements.

Mr. Patient did know the objects of his bounty and did indicate a general plan of distribution, stating that he would want his property to pass to his children equally. However, on testing Mr. Patient indicated that he had not yet made a will, whereas his daughter reported that he has a current will.

It is the examiner's judgment that Mr. Patient currently lacks testamentary capacity.

## **3. Probable current incapacity to manage business-related and everyday financial affairs.**

History, interview, and test data indicated that Mr. Patient is also currently incapable of managing his overall financial affairs and making business-related decisions. In interview, Mr. Patient demonstrated inaccurate knowledge of his financial and business affairs. For example, the patient indicated that he goes into work at his excavation business every day, even occasionally running construction equipment, whereas the patient's daughter reported that he is retired and that his brother operates and manages the business on his own. She reported that her father continues to manage his own finances, but makes poor business decisions (e.g., recently sold some property for 10% of what it was worth). She reported that her father has agreed several times not to sign anything without letting her review it first, but then forgets to consult her.

Functional testing of financial abilities revealed overall severe impairment in financial capacity. On testing, Mr. Patient demonstrated intact performance on tasks of naming coins/currency, coin/currency relationships, and single and multi-item cash purchases. However, he was impaired on tests of counting coins/currency, understanding financial concepts, making change for a vending machine, tipping, conceptual understanding of a checkbook, use of a checkbook, conceptual understanding of a bank statement, use of a bank statement, detection of telephone fraud, conceptual understanding of bills, identifying and prioritizing bills, and knowledge of personal financial activities. Taken together, these findings indicate that he is no longer capable of managing any aspect of his business and financial affairs.

## **4. Probable vulnerability to undue influence.**

In addition to his capacity impairment, it is very likely that Mr. Patient is currently vulnerable to undue influence in his business and other activities. Early on in their disease course, as their short-term memory and comprehension abilities erode, patients with AD become increasingly vulnerable to the influence of others. It is likely that Mr. Patient's reported recent poor business decisions may reflect such a vulnerability. For example, during testing Mr. Patient failed to detect a telephone credit card scam situation and agreed to provide his credit card number over the phone to an unknown caller.

## **VI. RECOMMENDATIONS**

1. We recommend that Mr. Patient be referred to the UAB Memory Disorders Clinic for a full neurological and dementia evaluation.
2. Continued pharmacotherapy with cholinesterase inhibitors appears to be appropriate.
3. Mr. Patient and his family should consider legally securing his business, financial, and personal affairs as soon as possible. Mr. Patient could potentially benefit from formal guardianship and conservatorship.
4. Mr. Patient's cognitive and emotional status should continue to be closely monitored. This evaluation would provide a useful baseline if follow-up testing were indicated.

*The results of this evaluation are confidential.*

### **C. Note on Post-Assessment Action by the Attorney**

Based on this assessment, Mr. Patient's attorney concluded that she should not proceed in doing Mr. Patient's will, nor with execution of the buy-sell agreement. The attorney informed Mr. Patient of the assessment results and provided a copy to Mr. Patient and, with his permission, to his daughter. (However, if Mr. Patient had not given permission, the attorney would have to determine whether disclosure might be a necessary action to protect the legal interests of his client under Model Rule 1.14.)

The attorney advised Mr. Patient and his daughter that it is time for his daughter to handle his financial affairs as his legal agent. The attorney provided the daughter with a background brochure explaining the responsibilities and tips for carrying out the responsibilities of a fiduciary under a durable power of attorney. Finally, the attorney reinforced the assessor's recommendation for referral to the UAB Memory Disorders Clinic.

## Attachment—Test Scores

Domain	Test	Raw Score	Scaled/Index	%ile
<b>Dementia Severity</b>	DRS Total*	89		
<b>Attention</b>	DRS Attention*	29		
<b>Receptive Language</b>	WAB Auditory Comp.*	57		<1
<b>Memory</b>	DRS Memory*	9		
	CVLT-II Recall Trials 1-5*	16	25	
	Short Delay Free Recall*	0	-3	
	Short Delay Cued Recall*	0	-3.5	
	Long Delay Free Recall*	0	-2.5	
	Long Delay Cued Recall*	0	-3.5	
	Perseverations*	0	-1	
	Cued Recall Intrusions*	0	-1	
	Discriminability*	0.3	-3	
	False Positives*	10	1.5	
<b>Visuospatial</b>	DRS Construction*	6		
	CLOX 2*	11		
<b>Abstraction/Judgment</b>	DRS Conceptualization*	24		
	Cognitive Competency*	10		
<b>Executive Function</b>	DRS Initialization/Perseveration*	21		
	Trails A seconds (errors)*	161 (5)		4
	Trails B seconds (errors)*	2000		
	CLOX 1*	8		
	Tokens*	8		
<b>Mood/Personality</b>	Geriatric Depression Scale*	0		
<b>Achievement</b>	WRAT-3 Reading	27	SS:4, Grade:2	2
<b>Additional Tests</b>	FCI Domain 1 Total	43	-0.73	23
	FCI Domain 2 Total	10/23		
	FCI Domain 3 Total	17	-2.53	<1
	FCI Domain 4 Total	19	-30.20	<1
	FCI Domain 5 Total	2	-5.84	<1
	FCI Domain 6 Task 6C	0	-9.54	<1
	FCI Domain 7 Total	11/19		
	FCI Domain 8 Total	12	-3.04	<1

## CASE EXAMPLE #2: Guardianship

### A. Example of Attorney Model Referral Letter

RE: Referral of Mr. Doe for Mental Health Assessment

Dear \_\_\_\_\_:

As we discussed by telephone, I am writing to make a referral of Mr. Doe for a mental health assessment, with primary emphasis on financial management abilities and, to a lesser extent, health care decision-making capacity. I am representing Mr. Conservator, who is the court-appointed conservator for Mr. Doe. Mr. Doe has consented to the assessment and either he or Mr. Conservator will contact you to arrange an appointment. Mr. Doe also has consented to release of the assessment results to Mr. Conservator, as well as to me as counsel for Mr. Conservator (see attached release). Mr. Doe has consented to your contacting his son for additional information. Mr. Conservator has agreed to payment for the proposed assessment from the funds of Mr. Doe, but will need a statement of the procedure's cost in advance. Below is background information that may be of help in conducting the assessment and preparing the report.

Background: According to Mr. Conservator, Mr. Doe is a Korean War veteran, age 72, a widower with four adult children. He has multiple chronic medical conditions as detailed in his records (attached), as well as a history of alcohol problems, various mental problems, and possibly some degree of dementia. Mr. Conservator reports that Mr. Doe shows some degree of confusion, yet still seems to have some understanding of his financial situation. Mr. Conservator was appointed by the County Probate Court to serve as conservator in 1995. In that capacity, he manages all of the income of Mr. Doe (military benefits, Social Security, small pension). Mr. Doe has no substantial assets and lives with his son. Mr. Conservator provides Mr. Doe with a stipend of \$600 per month for food, gas, and other spending. Mr. Conservator reports that he was selected as conservator due to evidence of quarrels among Mr. Doe's children. Mr. Doe has expressed confidence in his son. However, the son has medical and neurological problems of his own due to an auto accident.

Triggering Issue: Recently, Mr. Doe has had specific needs for larger amounts of cash, and has expressed frustration to Mr. Conservator that he lacks control of his income and must make requests in order to use it. Mr. Doe states that he has the capacity to manage his own funds, but that if he cannot do so, he would like his son to be the conservator. Mr. Conservator as court-appointed fiduciary understands that he is under a duty to seek the least restrictive alternative and maximize the autonomy of the conservatee. He needs professional advice on evaluating the specific abilities of Mr. Doe to manage money and avoid undue influence before taking any action before the court.

In addition, Mr. Conservator noted that Mr. Doe has discussed the importance of making his own health care decisions, and Mr. Conservator inquired about the possibility of having Mr. Doe execute an advance directive. Please include in the assessment an evaluation of Mr. Doe's capacity to make health care decisions and to appoint a health care agent.

Relevant State Law Provisions: In this state, a court may appoint a conservator if an individual is "incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to manage property or financial affairs or provide for his or her support or for the support of his legal dependents without the assistance of a conservator. A finding that the individual displays poor judgment, alone, shall not be considered sufficient evidence that the individual needs a conservator." [citation] A conservator has broad financial powers, unless limited by the court (in an order appointing a "limited conservator"), including the power to make gifts, convey property, engage in estate planning or create a trust, but must make decisions based on the values and preferences, as well as the best interests of the protected individual.

In this state, capacity to make health care decisions is based on the ability of an individual to "understand the significant benefits, risks, and alternatives to proposed health care" [citation]. Capacity to appoint a health care agent is

based on a person’s ability to “understand the nature and effect” of such an appointment [citation]. The level of capacity needed to appoint an agent is generally lower than that needed to make complex health care decisions or to give instructions about such decisions in advance.

Specific Assessment Request: Mr. Conservator requests that the following information be included in your assessment report:

- Mental health diagnosis
- Tests conducted
- Analysis of test results
- Applicability of results to situation at hand
- Specific assessment of the ability of Mr. Doe to –
  - Understand basic financial concepts
  - Understand the sources and amounts of his income
  - Make financial judgments
  - Pay bills
  - Make monetary calculations, including making change on a transaction
  - Contract for goods or services
  - Avoid exploitation or undue influence
- Assessment of Mr. Doe’s capacity to execute an advance directive for health care.

Please send your report and invoice to Mr. Conservator at [address], with a copy of the report to me at this office, and a copy to Mr. Doe at [address]. I appreciate your help with this case and look forward to working with you in the future.

## **B. Example of Psychological Report**

### **REASON FOR REQUEST:**

Mr. Doe was referred from Mr. ———, representing Mr. Doe’s conservator, for neuropsychological and functional testing. Mr. Doe is expressing dissatisfaction in his current conservator (known to Mr. Doe as his “guardian” and referenced as guardian in this report) and a question as to whether he still needs to have a guardian. Given his current cognitive status, there is also a question regarding his capacity to complete an advance directive and capacity to make treatment decisions.

### **INFORMED CONSENT:**

Prior to the interview and testing, the nature and purpose of this evaluation was explained. The patient was told that the findings would be provided in a written report to the referring attorney as requested by his guardian; that testing would evaluate his thinking, memory, and problem-solving related to his need for a guardian; that the results of the testing could support his desire not to have a guardian (benefit from his perspective), or the testing could indicate that he does need a guardian (risk from his perspective). Mr. Doe appeared to understand the nature, purpose, risks and benefits of the evaluation. Mr. Doe stated that he understood the testing was to re-evaluate his cognition, and to compare to previous test performance, with a focus on financial decision-making and, to a lesser extent, medical decision-making. He consented to the interview and testing.

### **PRESENTING PROBLEM AND HISTORY:**

Mr. Doe is a 72-year-old male. He worked as a truck driver, tile worker, and mason. He currently lives with a son who is disabled from a car accident (reportedly with memory problems and gait problems). He has another son and two daughters.

Mr. Doe is a Korean war veteran (served 1950-1954) who receives a 100% service-connected disability for “psychosis,” and 10% for superficial scars and ear infection.

Psychiatric history includes alcohol abuse (6-8 beers per night plus valium), sober 15 years. History of schizophrenia is unclear; more recent diagnoses for Mr. Doe are dementia due to multiple etiologies (alcohol abuse, head injury) and mood disorder secondary to general medical condition, with psychotic features. He has had four psychiatric hospitalizations beginning in 1956.

Medical history is taken from medical records provided by Mr. ——. Medical history includes recurrent cancer (lung, throat). Mr. Doe is still smoking and is followed privately for medical problems. He is also noted to be s/p gun shot wound to head (no information but apparently superficial), history of GI problems, and history of seizures.

Mr. Doe was appointed a guardian for finances while living in Louisiana, for money management problems related reportedly to alcohol abuse. He was appointed a guardian for finances (conservator) in this state after he moved back here in 1995. He has expressed recent frustration that he is only paid \$600 per month (from which he buys food, gas, and for spending money for himself and his son). He desires more control over his finances. For example, he was upset that his lawyer requested receipts prior to releasing money for his daughter’s wedding. He expresses a desire for control over his money and states his son at home could help with paying bills. He would like to have \$2,000 to take a vacation trip through ME and NH. He cannot identify any benefits to himself with having a guardian.

MEDICATIONS include Codeine 30mg, Acetaminophen 300mg T1 every 6 hours prn, Phenobarbital 30mg t1 qhd, Oxybutynin 5mg t1 bid, Phenytoin 100mg t1 tid, Citalopram 40mg t 1/2 qd, Paroxetine 20mg t1 qd, Olanzapine 7.5mg t1 qhs, Thioridazine 100mg t1 bid, Trazodone 50mg t2 qhs.

NEUROPSYCHOLOGICAL TESTING has been done in the past in 1996 and 1998, as well as 1970 and 1972. Recent testing found significant deficits in memory and planning/organization, moderate deficits in verbal skills, relative strengths (low average performance) for visual skills. Early testing found low average IQ.

CT SCAN OF HEAD completed 7/30/99 found no lesions, but moderate dilation of lateral ventricles raising a suspicion for early normal pressure hydrocephalus.

#### **COLLATERAL INTERVIEW:**

With the guardian’s and the patient’s consent, the patient’s son, with whom he lives, was contacted. His son said that he has lived with his father since his father’s return in 1995. He said that his father (the patient) has had problems “thinking straight” for most of his life. He noted that he feels these problems have gotten worse in the past two years. He said that he helps his father to take care of the house and to make meals. The son acknowledged that his father has been a poor manager of money in the past, particularly when drinking. He said that earlier in his life, when his father drank more actively, the family had to struggle to pay for meals and bills. He said that he is reluctant to help his father manage his money as money has been a source of conflict between them in the past. He also acknowledges that he (the son) is having some difficulties organizing his affairs since his car accident; and confirmed some ongoing differences with his siblings, including differences in matters concerning his father.

#### **DATA:**

Medical Record Review  
Clinical interview + Financial & Health care interview  
Wechsler Adult Intelligence Scale III (WAIS)—subtests  
Wechsler Memory Scale III (WMS)—subtests

Controlled Oral Word Association Test “FAS”  
 Boston Naming Test (BNT)  
 Geriatric Depression Scale (GDS)  
 Independent Living Scales—Money Management and Health and Safety scales

**MENTAL STATUS:**

Mr. Doe missed his first scheduled appointment, having confused it with another canceled appointment, but, with a reminder call, arrived 20 minutes early for his next appointment. He was neatly groomed, thin, elderly male. He presented as mildly anxious, eager to please, and concerned about his test performance. There was no evidence of active depression or psychosis, but he complained of fears and concerns about mental breakdown and suicidality (although he was not actively suicidal at the time of the interview). He was oriented to person, place, and near time (thought it was 8/30 rather than 8/31).

**TESTING:**

ATTENTION as measured by digits forward was in the average range for his age (5 digits forward), while CONCENTRATION as measured by digits backward was in the low average range for his age (3 digits backward). He also evidenced problems with sustained attention during testing, having trouble focusing on instructions and problems for an extended period of time.

VERBAL AND VISUAL MEMORY were severely impaired, consistent with previous test performance. Immediate recall of stories was in the borderline-defective range (a decline from 96, 98 testing) and 30-minute delayed recall of stories was in the borderline-defective range (about the same as before) with 32% of the material remembered at delay from the initial presentation. Immediate recall of designs was in the borderline range, while delayed recall of designs was in the borderline-defective range (both about the same as before) with 6% of the material remembered at delay from the initial presentation.

VERBAL SKILLS on the WAIS-III were in the borderline to borderline-defective range. Word knowledge (Vocabulary) was borderline-defective (a decline from previous testing). Abstract reasoning (Similarities) was in the borderline-defective range (about the same as before) and Everyday reasoning (Comprehension) was in the borderline range (a decline from before). Confrontation naming (BNT) was in the defective range with anomia evidenced during testing.

VISUAL SPATIAL SKILLS on the WAIS III were in the low average to defective range. Attention to visual detail (Picture Completion) was in the defective range. Visual-problem solving (Matrix Reasoning) was in the low average range.

EXECUTIVE FUNCTION on the FAS was in the low average to borderline range. Also, test performance was consistently impulsive (didn't wait to hear instructions before answering), gave up easily—for this reason on many of the tests he was given additional instruction and many opportunities to expand on his first answer or to think about it more/again to maximize his performance. Also, he was slightly disinhibited.

DEPRESSION screening with the GDS indicated mild depression (14/30), but in fact most of the responses seemed related to his intrusive thoughts and concerns about his thinking, rather than depression.

FINANCIAL DECISION-MAKING on the ILS was in the low/dependent range. He knew some basic financial concepts (Social Security, home insurance, health insurance) but could not say when income tax was due. His procedur-

al skills were quite limited. He counted out some basic change, but could not calculate change due from a \$5 bill or co-payment due on a bill. Also, he was unable to write checks to pay bills. His financial judgment was marginal. He has some sensitivity to reasons it was important to pay bills and ways to avoid getting cheated out of his money, but could not give well elaborated reasons on this. In interview he was unable to estimate the sources of his income, the size of his savings account. He noted he likes to give gifts but tries to avoid giving gifts to friends.

HEALTH CARE MANAGEMENT on the ILS was in the low/dependent range, although a bit better than his financial management skills. He was able to give accurate responses for a number of emergency medical and safety situations although some of his explanations about his current health situation were vague—he had trouble describing his current state of health, the importance of bathing (although noted he showers every day), a plan for managing his medications. In interview he had some definite ideas about managing his health care. He very much wants to make his own decisions regarding his health care. If he was unable to make decisions he'd like his son (who lives with him) to do so. He feels knowing his children and granddaughter is what “makes life worth living” for him and that he values continued living highly, i.e., states he would like to continue to live even with disabilities in walking, talking, and thinking. These views are informed in part by his religious beliefs.

### **SUMMARY AND CONCLUSIONS:**

Mr. Doe is a 72-year-old male with a current diagnosis of dementia due to multiple etiologies and mood disorder secondary to general medical condition. He has a guardian for finances and is expressing displeasure at the controls (wants more money per month, wants to be able to have larger sums for trips and presents). There is also a question of medical decision-making and capacity to name a health care proxy.

### **Results of Cognitive Testing:**

Neuropsychological testing finds intact simple attention, relative strengths in visual problem solving and verbal fluency. Otherwise, there are severe deficits in concentration and working memory, delayed memory, verbal problem solving. He was very pleasant and cooperative during testing, but was consistently impulsive in his test responses. Results and history are consistent with the following diagnoses.

- I. Clinical Disorders and Other Conditions that may be a focus of clinical attention:
  - Dementia due to multiple etiologies
  - Mood disorder related to General Medical Condition
  - Alcohol Dependence in sustained full remission
- II. Personality Disorders and Mental Retardation:
  - None
- III. General Medical Conditions:
  - History of cancer; history of gun shot wound to head; question of NPH
- IV. Psychosocial and Environmental Problems: Problems related to guardian, family conflict
- V. Global Assessment of Functioning: 38 (current)

### **Results of Functional Testing/Capacity Findings:**

1. Understanding of basic financial concepts:  
Mr. Doe has very limited knowledge of his own finances or important financial concepts.
2. Understanding of sources and amount of income:  
Mr. Doe was not able to state the sources and amount of his current income.
3. Making financial judgments:  
Results of both the cognitive and functional testing indicate that his ability to make financial judgments is poor.



4. Paying bills:

During testing, Mr. Doe was unable to understand a bill statement or appropriately write checks in response to the statement.

5. Making monetary calculations, including making change on a transaction:

Mr. Doe has good social skills and is able to count some change, however, he was unable to determine the amount owed to him as a result of a financial transaction.

6. Contracting for goods or services:

Results of both the cognitive and functional testing indicate that Mr. Doe lacks the ability to contract for goods or services.

7. Avoiding exploitation or undue influence:

Due to Mr. Doe's problems with reasoning and executive functioning, he is at high risk for exploitation and undue influence. Whether his son could fill the role of conservator is uncertain without more formal assessment of the son—but it appears that there is a history of family conflict about finances and this would not be the optimal situation even if the son was more able to manage money himself. For now I would recommend working with Mr. Doe to keep the conservator in place.

8. Making medical decisions and appointing a health care proxy:

In terms of medical decision-making, testing and interview suggests he holds strong values and beliefs about his health and care decisions, and can understand basic aspects of his health and health care. This combined with results of neuropsychological testing suggests that he would be capable of completing an advance directive although may need extra attention and careful explanation in educating about the process and options. He can likely make simple medical decisions but as the decision in question is more difficult, this may tax his ability to remember basic information about the risks and benefits of treatments, and thus he may for those decisions utilize the input of a health care proxy or concerned family member.

**Clinical Interventions Recommended:**

Mr. Doe's clinical status may be improved with the following interventions.

1. Medication review by a primary care doctor, geriatrician, or neurologist to consider whether it is possible that any of his current medications may be contributing to decreased ability to process information and concentrate.
2. Referral to neurology to follow up on possible Normal Pressure Hydrocephalus (NPH) given CT findings and evidence of probable decline in cognition.
3. If significant medication changes are made to reduce their potential impact on cognition, and/or if Mr. Doe is diagnosed with and treated for NPH, it would be important to re-assess his cognition to determine if his functioning has improved.
4. Given Mr. Doe's strong desire for more autonomy, it might be worth working with Mr. Doe to improve avenues for his autonomy, and increased financial freedom in context of conservatorship. For example, can he be given a sum of money for a trip or a present as a trial (with request to return receipts later).

Thank you for this referral.

### **C. Note on Post-Assessment Action by Attorney**

Based on this assessment, the attorney advised that the conservatorship should remain in place at the present time, but that Mr. Conservator should make efforts to expand Mr. Doe's financial decision-making authority. The attorney recommended that Mr. Doe be allowed a specified amount of funds in addition to his regular allowance, with the understanding that Mr. Doe would report back to the conservator on expenditures and provide receipts. The attorney also supported the recommendation in the assessment report for a medication review and a referral to a neurologist concerning NPH diagnosis and treatment. If changes in medication and/or NPH treatment result in cognitive improvements, and if Mr. Doe appears able to manage the extra funds provided him, some modification of the scope of the conservatorship might be discussed in the future. The attorney also advised that Mr. Conservator appears to be the most appropriate fiduciary, even though Mr. Doe may want his son to fill this role, due to uncertainty about the son's financial management capabilities and the son's conflicts with his siblings. However, with Mr. Doe's permission, Mr. Conservator should increase his contacts with the son and with Mr. Doe's other children.

The attorney advised the conservator that Mr. Doe appears to have the capacity to appoint a health care agent, and to indicate basic health care preferences in an advance directive. Further investigation might be necessary to determine whether the son could serve as the agent. Mr. Doe should seek counsel for the preparation of an advance directive. The attorney noted that the local legal services program has a lawyer who specializes in aging issues including advance directives, and that Mr. Doe appears to qualify for such assistance. The attorney gave Mr. Conservator a brochure about health care decision-making for discussion with Mr. Doe.

## Appendix 3: Brief Guide to Psychological and Neuropsychological Instruments

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For the purposes of this fact sheet, psychological tests are described in four categories: (1) tests used to evaluate and document symptoms of cognitive impairment; (2) tests used to rate the type and severity of emotional or personality disorder; (3) tests used to detect unusual response styles, or the validity of test taking; and (4) tests used to evaluate specific functional capacities or abilities. A brief guide to cognitive screening instruments is provided at the end of this appendix.

This listing is not meant as an exhaustive or definitive list, but provides an overview of some of the more commonly assessed domains and tests. The number of tests can be somewhat overwhelming; added to this is that evaluators may refer to tests by shortened names or abbreviations. For more information on specific tests, please refer to the reference books noted at the end of this chapter.

### A. Tests for Evaluating Cognitive Impairment

A comprehensive psychological or neuropsychological evaluation would typically assess the domains of appearance and motor activity, mood, level of consciousness, attention, memory, language, visual-spatial or constructional ability, reasoning, fund of information, and calculations. Some of these areas are assessed through observation of the client's presentation and communication during a clinical interview. Other areas can be assessed through standardized, norm-referenced tests.

#### 1. *Appearance, Orientation, and Motor Activity*

*Definition:* Although typically assessed through observation, not testing, an important part of a comprehensive evaluation is examination of appearance, grooming, weight, motor activity (active, agitated, slowed), and orientation to person, place, time, and current events.

#### 2. *Level of consciousness*

*Definition:* Although also typically assessed through observation, not testing, the evaluator will also observe the degree of alertness and general mental confusion, rating as alert, lethargic, or stupor. Additional assessment with basic measure of attention may be necessary.

#### 3. *Attention*

*Definition:* Attention concerns the basic ability to attend to a stimulus; also the ability to sustain attention over time, as well as freedom from distractibility.

*Tests:*

- Digit Span Forward/Digit Span Backward from the Wechsler Adult Intelligence Scale–III (WAIS-III) or the Wechsler Memory Scale–III (WMS-III)
- Working Memory (from the WMS-III)
- Paced Auditory Serial Attention Test (PASAT)
- Visual Search and Attention Test (VSAT)
- Visual Attention (from the Dementia Rating Scale (DRS))
- Trails A of the Trail Making Test

#### 4. *Memory and Learning*

*Definition:* Memory assessment involves evaluation of the system by which individuals register, store, retain, and retrieve information in verbal and visual domains.

*Tests*

- Memory Assessment Batteries (from the WMS-III or the Memory Assessment Scales (MAS))

- Auditory Verbal Learning Test
- Recall and Recognition (from the DRS)
- Fuld Object Memory Evaluation
- California Verbal Learning Test (CVLT)
- Hopkins Verbal Learning Test (HVLTL)

### 5. *Language*

*Definition:* Language includes a number of abilities such as spontaneous speech, the fluency of speech, repetition of speech, naming or word finding, reading, writing, comprehension. The presence of aphasia (difficulty receiving or expressing speech) and thought disordered speech is also noted.

*Tests:*

- Boston Naming Test (BNT)
- Controlled Oral Word Association Test (commonly called the “FAS”)
- Boston Diagnostic Aphasia Examination (BDAE)
- Token Test

### 6. *Executive Function*

*Definition:* The assessment of executive functions concern planning, judgment, purposeful and effective action, concept formation, and volition. This area is often an extremely important aspect of capacity.

*Tests:*

- Similarities (from the WAIS-III)
- Trails B of the Trail Making Test (TMT)
- Wisconsin Card Sorting Test
- Stroop Color Word Test
- Delis-Kaplan Executive Function System (DKEFS)
- Malloy
- Mazes

### 7. *Visual-Spatial and Visuo-Constructional Reasoning and Abilities*

*Definition:* Visual spatial assessment involves evaluation of visual-spatial perception, problem solving, reasoning, and construction or motor performance involving visual-spatial skills.

*Tests:*

- Performance subtests from WAIS-III, such as Block Design, Object Assembly, Matrix Reasoning
- Hooper Visual Organization Test
- Visual Form Discrimination Test
- Clock Drawing
- Rey-Osterrieth Complex Figure
- Line Bisection

### 8. *Verbal Reasoning and Abilities*

*Definition:* The assessment of verbal reasoning involves evaluation of logical thinking, practical judgments, and comprehension of relationships. Related abilities are fund of knowledge, which is the extent of information known and retained, and calculation concerning arithmetic skills.

*Tests:*

- Verbal subtests from the WAIS-III, such as Similarities, Comprehension, Information, Arithmetic
- Proverbs

## 9. *Motor Functions*

*Definition:* Tests of motor function provide basic ability about praxis or motor skills in each hand, which are important for distinguishing observed deficits on tasks involving motor performance from primary (motor) or secondary (central nervous system) deficits.

*Tests:*

- Finger Tapping
- Grooved Pegboard

## B. Tests for Emotional and Personality Functioning

Tests of emotional and personality functioning can provide a more objective means to assess the range and severity of emotional or personal dysfunction.

### 1. *Mood and Symptoms of Depression, Anxiety, and Psychoses*

*Definition:* These scales assess the individual's degree of depressed or anxious mood, and associated symptoms such as insomnia, fatigue, low energy, low appetite, loss of interest or pleasure, irritability, feelings of helplessness, worthlessness, hopelessness, or suicidal ideation. Some scales will also assess the degree of hallucinations, delusions, suspicious or hostile thought processes.

*Tests:*

- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia
- Dementia Mood Assessment Scale (DMAS)
- Beck Depression Inventory (BDI)
- Beck Anxiety Inventory (BAI)
- Brief Symptom Inventory (BSI)

### 2. *Personality*

*Definition:* Personality inventories are occasionally used in capacity assessment to explore unusual ways of interacting with others and looking at reality that may be impacting sound decision-making. Projective personality tests are relatively less structured and allow the patient open-ended responses. Objective tests in contrast typically provide a question and ask the patient to choose one answer (e.g., “yes” or “no”).

*Tests:*

- Rorschach
- Minnesota Multiphasic Personality Inventory–2 (MMPI)
- Profile of Mood States (POMS)

## C. Tests of Effort, Motivation, or Response Style

These measures, also referred to as validity tests, are structured in such a way to detect inconsistent or unlikely response patterns indicative of attempts to exaggerate cognitive problems. They serve as one type of evidence permitting the clinician to judge the validity of the overall cognitive testing. Generally they detect test-taking response patterns that deviate from chance responding or from norms for established cognitively impaired clinical populations like AD. If the tests are positive, they suggest an intentional (or in some cases subconscious) test-taking approach to exaggerate deficits. It remains a clinical judgment as to how to interpret the clinical meaning of the test-taking bias/exaggeration. In some cases, they may reflect malingering for monetary secondary gain, whereas in others they may indicate a factitious disorder or sometimes a somatoform disorder. Tests of validity may be used when the examiner is concerned that the individual has a reason to gain from “faking bad” on the test, such as in disability claims. Older adults who are receiving capacity evaluation are most likely to be giving maximal effort to perform at their highest level, in which case formal tests of validity are probably not indicated.

## 1. *Validity*

*Definition:* Validity tests are structured in such a way to detect inconsistent or unlikely response patterns indicative of attempts to exaggerate cognitive dysfunction.

*Tests:*

- Test of Memory Malingering (TOMM)
- 21 Item Test
- 15 Item Test
- CVLT-II Forced Choice

## D. Tests for Evaluating Specific Capacities or Abilities

When capacity or competency is specifically in question, a comprehensive evaluation would include direct assessment of the area in question. We include here instruments designed for clinical (not research) use. As these tests are more recently developed, we include a more detailed description of the instruments. Specific information on reliability and validity relevant to the Daubert standard of scientific admissibility can be found in the test manuals and is also summarized in several chapters.<sup>55</sup>

### 1. *Adult Functional Adaptive Behavior Scale (AFABS)*

*Primary Reference:* P.S. Pierce, *Adult Functional Adaptive Behavior Scale: Manual of Directions* (1989).

*Area Assessed:* Functional Abilities for Independent Living

*Description:* The Adult Functional Adaptive Behavior Scale (AFABS) was developed to assist in the assessment of ADL and IADL functions in the elderly to evaluate their capacity for personal responsibility and the matching of a client to a placement setting. The AFABS consists of 14 items. Six items rate ADLs: eating, ambulation, toileting, dressing, grooming, and managing (keeping clean) personal area. Two items tap IADLs: managing money and managing health needs. Six items tap cognitive and social functioning: socialization, environmental orientation (ranging from able to locate room up through able to travel independently in the community), reality orientation (aware of person, place, time, and current events), receptive speech communication, expressive communication, and memory. Items are rated on four levels: 0.0 representing a lack of the capacity, 0.5 representing some capacity with assistance, 1.0 representing some capacity without assistance, and 1.5 representing independent functioning in that area. Individual scores are summed to receive a total score in adaptive functioning. The AFABS assesses adaptive functioning through interviewing an informant well-acquainted with the functioning of the individual in question. The informant data is combined with the examiner's observation of and interaction with the client to arrive at final ratings. The AFABS is designed for relatively easy and brief administration (approximately 15 minutes). The author recommends it be administered only by professionals experienced in psychological and functional assessment, specifically a psychologist, occupational therapist, or psychometrician, although research with the AFABS has also utilized psychiatric nurses and social workers trained in its administration.

### 2. *Aid to Capacity Evaluation (ACE)*

*Primary Reference:* Edward Etchells et al., *Assessment of Patients Capacity to Consent to Treatment*, 14 J. Gen. Internal Med. 27-34 (1990).

*Area Assessed:* Medical Decision-Making

*Description:* The ACE is a semi-structured assessment interview that addresses seven facets of capacity for an actual medical decision (not a standardized vignette): the ability to understand (1) the medical problem, (2) the treatment, (3) the alternatives to treatment, and (4) the option of refusing treatment (5); the ability to perceive consequences of (6a) accepting treatment and (6b) refusing treatment; and (7) the ability to make a decision not substantially based on hallucinations, delusions, or depression. These reflect legal standards in Ontario, Canada but also correspond to U.S. legal standards.

### 3. *Capacity Assessment Tool (CAT)*

*Primary Reference:* M.T. Carney et al., *The Development and Piloting of a Capacity Assessment Tool*, 12 J. Clinical Ethics 17-23 (2001).

*Area Assessed:* Medical Decision-Making

*Description:* The CAT proposes to evaluate capacity based on six abilities: communication, understanding choices, comprehension of risks and benefits, insight, decision/choice process, and judgment. It uses a structured interview format to assess capacity to choose between two options in an actual treatment situation; as such, it does not use a hypothetical vignette.

### 4. *Capacity to Consent to Treatment Interview (CCTI)*

*Primary Reference:* Daniel C. Marson et al., *Assessing the Competency of Patients with Alzheimer's Disease Under Different Legal Standards*, 52 Arch. Neurol. 949-954 (1995).

*Area Assessed:* Medical Decision-Making

*Description:* The CCTI is based on two clinical vignettes; a neoplasm condition and a cardiac condition. Information about each condition and related treatment alternatives is presented at a fifth to sixth grade reading level with low syntactic complexity. Vignettes are presented orally and in writing; participants are then presented questions to assess their decisional abilities in terms of understanding, appreciation, reasoning, and expression of choice.

### 5. *Competency Interview Schedule (CIS)*

*Primary Reference:* G. Bean et al., *The Assessment of Competence to Make a Treatment Decision: An Empirical Approach*, 41 Can. J. Psych. 85-92 (1996).

*Area Assessed:* Medical Decision-Making

*Description:* The CIS is a 15-item interview designed to assess consent capacity for electro-convulsive therapy (ECT). Patients referred for ECT receive information about their diagnosis and treatment alternatives by the treating clinician, and the CIS then assesses decisional abilities based on responses to the 15 items

### 6. *Decision Assessment Measure*

*Primary Reference:* J.G. Wong et al., *The Capacity of People with a "Mental Disability" to Make a Health Care Decision*, 30 Psych. Med. 295-306 (2000).

*Area Assessed:* Medical Decision-Making

*Description:* Wong et al., working in England, developed a measure that references incapacity criteria in England and Wales (understanding, reasoning, and communicating a choice), based on methodology by Thomas Grisso et al. (*The MacArthur Treatment Competence Study: II. Measures of Abilities Related to Competence to Consent to Treatment*, 19(2) L. & Human Behavior 127-148 (1995)). Their instrument also assesses the ability to retain material because it is one of the legal standards for capacity in England and Wales (though not in the United States). A standardized vignette regarding blood drawing is used to assess paraphrased recall, recognition, and non-verbal demonstration of understanding (pointing to the correct information on a sheet with both correct information and distracter/incorrect information).

### 7. *Decision-Making Instrument for Guardianship (DIG)*

*Primary Reference:* S.J. Anderer, *Developing An Instrument to Evaluate the Capacity of Elderly Persons to Make Personal Care and Financial Decisions* (1997) (Unpubl. doctoral dissertation, Allegheny Univ. of Health Sciences).

*Area Assessed:* Self Care, Home Care, Financial, (Guardianship)

*Description:* The Decision-Making Instrument for Guardianship (DIG) was developed to evaluate the abilities of individuals to make decisions in everyday situations often the subject of guardianship proceedings. The instrument consists of eight vignettes describing situations involving problems in eight areas: hygiene, nutrition, health

care, residence, property acquisition, routine money management in property acquisition, major expenses in property acquisition, and property disposition. Examinees are read a brief vignette describing these situations in the second person. Detailed scoring criteria are used to assign points for aspects of problem solving including defining the problem, generating alternatives, consequential thinking, and complex/comparative thinking. The DIG is carefully standardized. Standard instructions, vignettes, questions, and prompts are provided in the manual. In addition, detailed scoring criteria are provided. Sheets with simplified lists of salient points of each vignette, provided in large type, help to standardize vignette administration and emphasize the assessment of problem solving and not reading comprehension or memory. Vignettes are kept simple, easy to understand, and are brief.

#### **8. Direct Assessment of Functional Status (DAFS)**

*Primary Reference:* David A. Loewenstein et al., *A New Scale for the Assessment of Functional Status in Alzheimer's Disease and Related Disorders*, 44 *J. Gerontology: Psych. Sci.* 114-121 (1989).

*Area Assessed:* Functional Abilities for Independent Living

*Description:* The Direct Assessment of Functional Status (DAFS) was designed to assess functional abilities in individuals with dementing illnesses. The scale assesses seven areas: time orientation (16 points), communication abilities (including telephone and mail; 17 points), transportation (requiring reading of road signs; 13 points), financial skills (including identifying and counting currency, writing a check and balancing a checkbook; 21 points), shopping skills (involving grocery shopping; 16 points), eating skills (10 points), dressing and grooming skills (13 points). The composite functional score has a maximum of 93 points, exclusive of the driving subscale, which is considered optional. The DAFS requires that the patient attempt to actually perform each item (e.g., is given a telephone and asked to dial the operator). The entire assessment is estimated to require 30-35 minutes to complete. Any psychometrically trained administrator can administer the scale. The DAFS has been used for staging functional impairment in dementia, from one to three, in a group of 205 individuals with probable Alzheimer's disease.

#### **9. Financial Capacity Instrument (FCI)**

*Primary Reference:* Daniel C. Marson et al., *Assessment of Financial Capacity in Patients with Alzheimer's Disease: A Prototype Instrument*, 57 *Arch. Neurol.* 877-884 (2000).

*Area Assessed:* Financial

*Description:* The Financial Capacity Instrument (FCI) was designed to assess everyday financial activities and abilities. The instrument assesses six domains of financial activity: basic monetary skills, financial conceptual knowledge, cash transactions, checkbook management, bank statement management, and financial judgment. The FCI is reported to require between 30-50 minutes to administer, depending on the cognitive level of the examinee. The FCI uses an explicit protocol for administration and scoring.

#### **10. Hopemont Capacity Assessment Interview (HCAI)**

*Primary Reference:* Barry Edelstein et al., *Assessment of Capacity to Make Financial and Medical Decisions* (1993) (Paper presented at Toronto meeting of the American Psychological Association, August 1993).

*Area Assessed:* Financial, Medical Decision-Making

*Description:* The Hopemont Capacity Assessment Interview (HCAI) is a semi-structured interview in two sections. The first section is for assessing capacity to make medical decisions. The second section is for assessing capacity to make financial decisions and will be discussed here. In the interview the examinee is first presented with concepts of choice, cost, and benefits and these concepts are reviewed with the examinee through questions and answers. The examinee is then presented medical or financial scenarios. For each scenario the individual is asked basic questions about what he or she has heard, and then asked to explain costs and benefits, to make a



choice, and to explain the reasoning behind that choice. The HCAI uses a semi-structured format. General instructions are provided. Specific standardized introductions, scenarios, and follow-up questions are on the rating form.

### **11. Independent Living Scales (ILS)**

*Primary Reference:* Patricia A. Loeb, *Independent Living Scales* (1996).

*Areas Assessed:* Care of Home, Health Care, Financial (Guardianship)

*Description:* The Independent Living Scales (ILS) is an individually administered instrument developed to assess abilities of the elderly associated with caring for oneself and/or for one's property. The early version of the ILS was called the Community Competence Scale (CCS). The CCS was constructed specifically to be consistent with legal definitions, objectives, and uses, in order to enhance its value for expert testimony about capacities of the elderly in legal guardianship cases. The ILS consists of 70 items in five subscales: Memory/Orientation, Managing Money, Managing Home and Transportation, Health and Safety, and Social Adjustment. The five subscales may be summed to obtain an overall score, which is meant to reflect the individual's capacity to function independently overall. Two factors may be derived from items across the five subscales: Problem Solving and Performance/Information. The ILS has extensive information on norms, reliability, and validity.

### **12. MacArthur Competence Assessment Tool - Treatment (MACCAT-T)**

*Primary Reference:* Thomas Grisso & Paul S. Applebaum, *Assessing Competence to Consent to Treatment* (1998).

*Area Assessed:* Medical Decision-Making

*Description:* The MacCAT-T utilizes a semi-structured interview to guide the clinician through an assessment of the capacity to make an actual treatment decision. It does not use a standardized vignette. Patients receive information about their condition, including the name of the disorder, its features and course, then are asked to "Please describe to me your understanding of what I just said." Incorrect or omitted information is cued with a prompt (e.g., "What is the condition called?"), and if still incorrect or omitted, presented again. A similar disclosure occurs for the treatments, including the risks and benefits of each treatment alternative. Next, patients are asked if they have any reason to doubt the information and to describe that. They are then asked to express a choice and to answer several questions that explicate their reasoning process, including comparative and consequential reasoning and logical consistency.

### **13. Multidimensional Functional Assessment Questionnaire (MFAQ)**

*Primary Reference:* Center for the Study of Aging and Human Development, *Multidimensional Functional Assessment: The OARS Methodology* (1978).

*Area Assessed:* Functional Abilities for Independent Living

*Description:* The Multidimensional Functional Assessment Questionnaire (MFAQ) was developed to provide a reliable and valid method for characterizing elderly individuals and for describing elderly populations. The MFAQ supersedes the nearly identical Community Survey Questionnaire (CSQ, a predecessor which also was developed by the Duke Center). Both instruments frequently have been called the "OARS," in reference to the program that developed the instrument throughout the 1970s. The MFAQ or the CSQ was already in use by well over 50 service centers, researchers, or practitioners nationally when the MFAQ was published (1978). Part A provides information in five areas of functioning, including activities of daily living. The Activities of Daily Living (ADL) dimension assesses 14 functions including both instrumental and physical ADLs. *Instrumental ADLs are:* use telephone, use transportation, shopping, prepare meals, do housework, take medicine, handle money. *Physical ADLs are:* eat, dress oneself, care for own appearance, walk, get in/out of bed, bath, getting to bathroom, continence. Part B of the MFAQ assesses the individual's utilization of services, that is, whether and to what extent the examinee has received assistance from various community programs, agencies, relatives, or friends, especially within the latest six months. Questioning also includes the examinee's perceived need for the various services.

#### **14. Philadelphia Geriatric Center Multilevel Assessment Inventory (MAI)**

*Primary Reference:* M. Powell Lawton & Miriam Moss, *Philadelphia Geriatric Center Multilevel Assessment Instrument: Manual for Full-length MAI* (undated).

*Area Assessed:* Functional Abilities for Independent Living

*Description:* The Philadelphia Geriatric Center Multilevel Assessment Inventory (MAI) was designed to assess characteristics of the elderly relevant for determining their needs for services and placement in residential settings. The MAI is a structured interview procedure that obtains descriptive information about an elderly respondent related to seven domains. Each of the domains (except one) is sampled by interview questions in two or more subclasses, which the authors call sub-indexes. The full-length MAI consists of 165 items; the middle length MAI has 38 items, and the short-form has 24 items. The domains assessed are physical health, cognitive, activities of daily living, time use, personal adjustment, social interaction, and perceived environment. The MAI manual provides considerable structure for the process of the interview, sequence and content of questions, and scoring. It describes criteria for 1 to 5 rating of each of the domains, but these criteria are not tied specifically to item scores. The manual discusses general considerations for interviewing elderly individuals and dealing with special problems of test administration with this population (e.g., dealing with limited hearing or vision).

### **E. Cognitive Screening Tests**

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

**1. Blessed Information-Memory-Concentration Test (BIMC):** The BIMC is a 33-point scale with subtests of orientation, personal information, current events, recall, and concentration. There is a short version with six items. It has adequate test-retest reliability and correlation with other measures of cognitive impairment.

**2. Mental Status Questionnaire (MSQ):** The MSQ is a 10-item, 10-point scale assessing orientation to place, time, person, and current events. It has low to modest sensitivity for detecting neurological illness.

**3. Mini Mental State Examination (MMSE):** The MMSE is a 30-point screening instrument that assesses orientation, immediate registration of three words, attention and calculation, short-term recall of three words, language, and visual construction. The MMSE is widely used and has adequate reliability and validity. Positive findings require more in-depth evaluation. Limitations of the MMSE, discussed in Chapter IV, include the potential for false positives or false negatives, and the association of MMSE scores with age, education, and ethnicity. Longer versions and telephone versions of the MMSE are available.

**4. The Seven Minute Screen (7MS):** This screening instrument consists of four subtests: recall, verbal fluency, orientation, and clock drawing. It has adequate test-retest reliability and inter-rater reliability.

**5. Short Portable Mental Status Questionnaire (SPMSQ):** The SPMSQ is scored as a sum of errors on subtests of orientation, location, personal information, current events, and counting backwards. Race and age corrections to scores are available.

### **F. Key Test Reference Books**

Thomas Grisso et al., *Evaluating Competencies: Forensic Assessments and Instruments* (2d ed. 2002).

Asenath LaRue, *Aging and Neuropsychological Assessment* (1992).

Muriel D. Lezak, *Neuropsychological Assessment* (3d ed. 1995).

Peter A. Lichtenberg et al., *Handbook of Assessment in Clinical Gerontology* (1999).

Otfried Spreen & Esther Strauss, *A Compendium of Neuropsychological Tests: Administration, Norms, and Commentary* (2d ed. 1998).

## Appendix 4: Dementia Overview<sup>1</sup>

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### What is dementia?

Dementia is a syndrome characterized by decline in memory in association with either decline in other cognitive abilities, e.g., judgment and abstract thinking, or personality change. The resulting impairment must be severe enough to interfere with work or usual social activities or relationships.<sup>2</sup> The requirement for decline distinguishes dementia from life-long mental retardation, although a person with mental retardation can develop dementia if his or her cognitive abilities decline from a previous level. The requirement also means that a person with high previous intelligence can have dementia if his or her cognitive abilities decline to average levels, and this decline interferes with work or usual social activities or relationships.

Outdated terms: terms that were used in the past, such as *senility*, *chronic brain syndrome*, and *hardening of the arteries*, are rarely used now because they are imprecise and inaccurate.

### What causes dementia?

Dementia can be caused by more than 70 diseases and conditions. The most common cause is Alzheimer's disease, which is present in 60 percent to 75 percent of dementia cases in the United States. The second most common cause is vascular or multi-infarct disease, which is present in 10 percent to 20 percent of cases. Alzheimer's disease and multi-infarct disease often co-exist in a condition referred to as *mixed dementia*. Other diseases and conditions that can cause dementia include Lewy body disease, fronto-temporal disease (including Pick's disease), Creutzfeldt-Jacob disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), and AIDS.<sup>3</sup>

Reversible dementia. In a small minority of people with dementia, the condition may be partially or completely reversible with treatment of underlying causes, such as chronic infections, thyroid disease, and normal-pressure hydrocephalus.<sup>2,4</sup> Unfortunately, these situations are rare.

### How common is dementia?

The total number of people with dementia in the United States is not known. That is because most people with dementia do not have a diagnosis, and no study with a nationally representative sample and procedures for diagnosing dementia has been completed.

Estimates of the number of people with Alzheimer's disease come from studies of smaller community samples. Results of two widely cited studies indicate that 2 percent of people age 65 to 74 have Alzheimer's disease, with the proportion increasing to 8 percent to 19 percent of people age 75 to 84, and 29 percent to 42 percent of people age 85 and over.<sup>5,6</sup> Combining these proportions and U.S. Census data indicates that 2.6 million to 4.5 million people age 65 and over (7 percent to 13 percent of all people age 65 and over) had Alzheimer's disease in 2000. Since prevalence rises rapidly with age, the total number of people with Alzheimer's disease will increase greatly as the age groups 75 to 84 and 85+ grow in coming decades. Alzheimer's disease occurs in a small proportion (probably less than one percent) of people under age 65. That proportion may increase in the future as the disease is recognized earlier.

Assuming that Alzheimer's disease is present in 60 percent to 75 percent of all cases of dementia in the U.S. and that it affected 2.6 to 4.5 million people age 65 and over in 2000, one could estimate that 3.4 to 7.5 million people age 65 and over had dementia in 2000. Preliminary data from the Health and Retirement Survey indicate that there may be 400,000 people under age 65 with dementia, for a total of 3.9 to 8 million people with dementia in all age groups in 2000.

### What are the symptoms of dementia?

As noted above, dementia is characterized by decline in memory associated with decline in other cognitive abilities or personality change. Many descriptions of the symptoms of dementia focus primarily on symptoms of Alzheimer's disease. Symptoms of other dementing diseases and conditions are often described

1. Prepared by Katie Maslow, M.S.W., of the Alzheimer's Association, Washington, D.C.
2. American Psych. Ass'n, *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (4th ed. 1994).
3. Paul T. Costa et al., *Recognition and Initial Assessment of Alzheimer's Disease and Related Dementias*, 19 Clinical Practice Guideline (1996).
4. Charles Cefalu and George T. Grossberg, *Diagnosis and Management of Dementia*, 2 Am. Fam. Physician Monograph (2001).
5. Ron Brookmeyer et al., *Projections of Alzheimer's Disease in the United States and Public Health Impact of Delaying Disease Onset*, 88 Am. J. Pub. Health 1337-1342 (1998).
6. Liesi E. Hebert et al., *Alzheimer's Disease in the U.S. Population: Prevalence Estimates Using the 2000 Census*, 60 Arch. Neurol. 1119-1122 (2003).

only as they differ from the symptoms of Alzheimer's disease.

Alzheimer's disease generally begins gradually. Its causes are not known, but much has been learned in recent years about the risk factors, biology, and course of the disease (see *Unraveling the Mystery*<sup>7</sup>). The earliest symptoms of Alzheimer's disease are usually memory problems, especially problems with learning and recall of new information. Other early symptoms include difficulty with language (e.g., word-finding) and disturbances in visuospatial skills that can result in getting lost in a familiar setting. Deficits in executive functions (e.g., planning, organization, and judgment) are also common. These cognitive changes limit the person's ability to work and carry out activities that are needed for independent living, e.g., driving, shopping, cooking, and managing finances. The person may or may not be aware of, and be disturbed by, these changes.<sup>3,8,9</sup>

Alzheimer's disease is progressive. Over time, the person's cognitive deficits worsen, and other kinds of symptoms appear. Many people with Alzheimer's disease are depressed. Some become withdrawn, apathetic, and/or irritable. Agitation is common, and some people with Alzheimer's disease develop psychiatric and behavioral symptoms, e.g., delusions, aggression, wandering, and inappropriate sexual behaviors. Most people with the disease require 24-hour supervision at least in the middle stage of their illness. Eventually, they become unable to bathe, dress, toilet, and feed themselves. Gait and swallowing difficulties are also common in the late stage of the disease.<sup>3,7</sup> Death usually occurs sooner than would be predicted on the basis of population data.<sup>10</sup>

Vascular or multi-infarct dementia differs from Alzheimer's dementia in that it generally begins more abruptly and exhibits a step-wise progression of symptoms. This is because the condition is usually caused by a stroke, multiple small strokes, or changes in blood supply to the brain that result in specific brain lesions. A person's cognitive and other symptoms depend on the type, location, and extent of these lesions; thus, symptoms vary greatly from one person to another.<sup>3,11</sup>

Lewy body disease differs from Alzheimer's disease in that it usually progresses more rapidly. Visual hallucinations, fluctuating cognitive abilities, changing attention and alertness, and motor signs of parkinsonism are also more common.<sup>8,12</sup>

Fronto-temporal disease (including Pick's disease) differs from Alzheimer's disease in that learning ability and visuospatial skills are often less affected, and noncognitive symptoms are more common. Patients frequently exhibit profound apathy, distractibility, and impulsivity.<sup>3,8</sup>

### **Can stages of dementia be identified?**

Various staging systems have been developed for dementia. These systems are useful because they provide a conceptual framework that often helps families, care providers, and others understand where their relative or client is in the course of his or her illness, and therefore, think about and plan for the person's current and future care. Some relatively simple staging systems identify only 3 stages (mild, moderate, and severe) and define the stages in very general terms. Other staging systems are more complex and precise. An example of the latter type is the Global Deterioration Scale, a 7-stage system based on the severity of a person's cognitive and self-care deficits and psychiatric and behavioral symptoms.<sup>13</sup> Despite the usefulness of this and other staging systems, it is important to remember that the progression of dementing diseases and conditions and the timing of particular symptoms vary greatly from one person to another. Thus few patients progress through the stages exactly as they are defined in any system.

### **How can cognitive changes that are common in normal aging be distinguished from dementia?**

It is often very difficult to distinguish memory problems and other cognitive changes that are common in normal aging from the early symptoms of dementia, in part because cognitive changes in normal aging are not well understood.<sup>2,3,14</sup> In its dementia guideline, the American Medical Association points out that a person with dementia will eventually become unable to maintain independent functioning, whereas independent function-

7. Nat'l Inst. Health, U.S. Dep't of Health and Hum. Servs, *Alzheimer's Disease: Unraveling the Mystery* (NIH Pub. No. 02-3782) (2002).

8. Jeffrey L. Cummings & Greg Cole, *Alzheimer's Disease*, 287 JAMA 2335-2338 (2000).

9. Claudia H. Kawas, *Early Alzheimer's Disease*, 349 New Eng. J. Med. 1056-1063 (2003).

10. Eric B. Larson et al., *Survival After Initial Diagnosis of Alzheimer's Disease*, 140 Annals of Internal Med. 501-509 (2004).

11. David L. Nyenhuis & Philip B. Gorelick, *Vascular Dementia: A Contemporary Review of Epidemiology, Diagnosis, Prevention, and Treatment*, 46 J. Am. Geriatrics Soc'y 1437-1448 (1998).

12. Estrella Gomez-Tortosa et al., *Dementia with Lewy Bodies*, 46 J. Am. Geriatrics Soc'y 1449-1458 (1998).

13. Barry Reisburg et al., *The Global Deterioration Scale for Assessment of Primary Degenerative Dementia*, 139 Am. J. Psyc. 1136 (1982).

14. Ronlad C. Peterson et al., *Current Concepts in Mild Cognitive Impairment* 58 Arch. Neurol. 1985-1992 (2001).

ing is preserved in normal aging. To distinguish dementia and normal aging without waiting to see whether the person's functioning worsens, the guideline suggests several comparisons: for example, in dementia, the person's family is likely to be more concerned about his or her forgetfulness, whereas in normal aging, the person may be more concerned; similarly, in dementia, there is likely to be notable decline in memory for recent events and ability to converse, whereas in normal aging, the person remembers important events and maintains the ability to converse.<sup>15</sup> These and other comparisons are helpful but not definitive in distinguishing the two conditions.

Mild Cognitive Impairment is a condition that is receiving increasing attention as researchers attempt to understand the causes of Alzheimer's disease and find ways to prevent and treat it. For research purposes, it is efficient to study people who are at high risk for the disease, and many elderly people are now enrolled as subjects in observational studies and clinical trials where they are diagnosed as having mild cognitive impairment. An unknown number of elderly people are also being diagnosed with mild cognitive impairment outside of research settings. Many researchers and clinicians believe that all people with mild cognitive impairment will eventually transition to Alzheimer's disease.<sup>16</sup> Reported rates of transition range from 6 percent to 25 percent per year in individuals age 66 to 81 at the start of the study.<sup>17</sup> Some clinicians and advocates question the wisdom of diagnosing mild cognitive impairment in people who are quite old at time of diagnosis, may be upset by the diagnosis, may not transition for four or more years, and may be denied insurance and/or admission to certain residential care facilities if the diagnosis is known.

### **Why is it important to diagnose dementia and the underlying cause of the dementia?**

Some physicians are reluctant to diagnose dementia or its underlying cause because they think the conditions are hopeless and are hesitant to call attention to them

unless asked by the family.<sup>18</sup> Over the past decade, dementia and its causes are being diagnosed more often, primarily because of the availability of medications for Alzheimer's disease and greater general awareness of Alzheimer's and dementia. Still many people with dementia have not been diagnosed.<sup>19</sup> Physicians may be aware of a patient's cognitive deficits even if they have not conducted a formal evaluation, but even when a formal diagnosis is made, the patient and family may not be told, and the diagnosis may not be entered into his or her medical record.<sup>20</sup>

Diagnosis of dementia is important because it allows the person, and perhaps more so his or her family, to understand what is happening to the person and increases the likelihood that they will access available information and supportive services. It also increases the likelihood that physicians will initiate treatments and be alert to limitations in the person's ability to report symptoms accurately, manage medications safely, and understand and comply with other recommendations. Early diagnosis is important because it gives the person and family time to make financial, legal, and medical decisions while the person is capable.

### **How can dementia be diagnosed?**

Dementia and Alzheimer's disease can be diagnosed with high accuracy (90 percent or higher) when standardized diagnostic criteria are used.<sup>21</sup> Diagnosis of vascular or multi-infarct disease, Lewy body disease, and fronto-temporal disease is often more difficult because many people with these conditions have atypical or nonspecific symptoms.<sup>20</sup> The first steps in diagnosis are a focused history and physical, mental status testing, and discussions with the family, if any. Laboratory tests are often used, primarily to rule out reversible or partially reversible causes of dementia. There is disagreement about the value of neuroimaging procedures, but virtually all experts agree that these procedures are useful for younger patients and patients with unusual symptoms.

15. American Med. Ass'n, *Diagnosis, Management, and Treatment of Dementia: A Practical Guide for Primary Care Physicians* (1999).

16. John C. Morris et al., *Mild Cognitive Impairment Represents Early-Stage Alzheimer's Disease*, 58 *Arch. Neurol.* 397-405 (2001).

17. Ronald C. Peterson et al., *Practice Parameter: Early Detection of Dementia: Mild Cognitive Impairment (An Evidence-Based Review)*, 56 *Neurol.* 1133-1142 (2001).

18. Linda Boise et al., *Diagnosing Dementia: Perspectives of Primary Care Physicians*, 39(4) *Gerontologist* 457-464 (1999).

19. Linda Boise et al., *Dementia Assessment in Primary Care: Results from a Study in Three Managed Care Systems*, 59A *J. Gerontology: Med. Sciences* 621-626 (2004).

20. James Chodosh et al., *Physician Recognition of Cognitive Impairment; Evaluating the Need for Improvement*, 52 *J. Am. Geriatrics Soc'y* 1051-1059 (2004).

21. David S. Knopman et al., *Practice Parameter: Diagnosis of Dementia (An Evidence-Based Review): Report of the Quality Standards Subcommittee of the American Academy of Neurology*, 56 *Neurol.* 1143-1153 (2001).

Delirium and depression can present with symptoms similar to dementia. Recognition and differential diagnosis of these three conditions is important. Delirium is an acute condition that can and should be treated quickly. Depression is also treatable in older people. In addition, however, people with dementia are at increased risk of developing delirium, and many people with dementia also have depression; thus, the three conditions often coexist. Effective treatment of coexisting delirium and/or depression may improve cognitive functioning in a person with dementia, although research suggests that treatment for depression often does not have as much effect as expected on the person's cognitive functioning.

### Treatment of dementia

Many medical associations and other groups have developed guidelines and consensus statements about treatment of dementia.<sup>22</sup> These documents differ in length, primary focus, and intended audience, but their recommendations are similar. While acknowledging that the effects of available medications for Alzheimer's disease are often modest, the documents generally recommend an initial trial of the medications. Aggressive treatment of cardiovascular conditions is recommended since these conditions can cause vascular dementia and hasten onset of symptom development in people with Alzheimer's disease. The guidelines and consensus statements recommend careful evaluation of mood and behavioral symptoms and efforts to manage these symptoms nonpharmacologically, if possible. They also recommend treatment of depression, attention to safety issues (e.g., driving, wandering, and firearms), referrals to community services, and involvement and support of family caregivers.<sup>3,7,8,14,23,24,25</sup>

### Coexisting medical conditions in people with dementia

Many people with dementia also have other serious medical conditions. Medicare fee-for-service claims for 1999 show, for example, that 30 percent of beneficiaries with dementia also had coronary heart disease, 28 percent also had congestive heart failure, 21 percent also had diabetes, and 16 percent also had thyroid disease.<sup>26</sup> These medical conditions and the medications and other procedures that are used to treat the conditions can worsen cognitive and other symptoms in a person with dementia. At the same time, dementia clearly complicates the treatment of the other conditions. Families and other informal and paid caregivers of people with dementia and co-existing medical conditions are often coping with extremely difficult care situations.

### Where do people with dementia live?

No precise information is available about where people with dementia live, but available data suggest that at any one time, about 20 percent of all people with dementia are in nursing homes; about 10 percent are in assisted living or other residential care facilities; and the remaining 70 percent are at home alone or with a family member or other informal caregiver.

People with dementia who live alone: Studies indicate that about 20 percent of people with dementia live alone.<sup>27,28</sup> About half of these people have a relative or friend who functions as a caregiver, but the other half have no one. Some of these individuals have mild dementia, but many have moderate to severe dementia. They may come to the attention of attorneys when a landlord, neighbor, or law enforcement official realizes they are unable to care for themselves and may create safety problems for others. Lack of an available surrogate decisionmaker may make them difficult clients.

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22. Katie Maslow et al., *Guidelines and Care Management Issues for People with Alzheimer's Disease and Other Dementias*, 10 *Disease Mgmt. Health Outcomes* 693-706 (2002).
  23. George T. Grossberg & Abhilash K. Desai, *Management of Alzheimer's Disease*, 58A *J. Gerontology Med. Sciences* 331-353 (2003).
  24. Gary W. Small et al., *Diagnosis and Treatment of Alzheimer's Disease and Related Disorders: Consensus Statement of the American Association for Geriatric Psychiatry, the Alzheimer's Association, and the American Geriatric Society*, 278 *JAMA* 1363-1371 (1997).
  25. Rachelle S. Doody et al., *Practice Parameter: Management of Dementia (An Evidence-Based Review): Report of the Quality Standards Subcommittee of the American Academy of Neurology*, 56 *Neurol.* 1154-1166 (2001).
  26. Julie P.W. Bynum et al., *The Relationship Between a Dementia Diagnosis, Chronic Illness, Medicare Expenditures, and Hospital Use*, 52 *J. Am. Geriatrics Soc'y* 187-194 (2004).
  27. Krista L. Prescop et al., *Elders with Dementia Living in the Community With and Without Caregivers: An Epidemiological Study*, 11 *Int'l Psychogeriatrics* 235-250 (1999).
  28. Pamela Arnsberger Webber et al., *Living Alone with Alzheimer's Disease: Effects on Health and Social Service Utilization Patterns*, 34 *Gerontologist* 8-14 (1994).

## End Notes

1. University Health Sys. Consortium & U.S. Dep't of Veterans Affairs, *Dementia Identification and Assessment: Guidelines for Primary Care Practitioners* (1997); David S. Geldmacher & Peter J. Whitehouse, *Evaluation of Dementia*, 335 New Eng. J. Med. 330 (1996); Peter V. Rabins et al., *Practical Dementia Care* (1999).
2. *Id.*
3. *Id.* See also Nat'l Inst. on Aging, Nat'l Inst. of Health, U.S. Dep't of Health & Human Servs., *Progress Report on Alzheimer's Disease* (NIH Pub. No. 99-4664) (1999).
4. See Arthur C. Walsh et al., *Mental Capacity* (2d ed. 1994) for a discussion of the case law concerning the lawyer's malpractice liability for knowingly allowing an incapacitated person to execute legal documents.
5. The factors contained in this Comment to Rule 1.14 actually derive from a recommendation at the National Conference on Ethical Issues in Representing Older Clients, 62 Fordham L. Rev. (1994), and, in particular, from an article prepared for the conference by Peter Margulies entitled *Access, Connection, and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity*, 62 Fordham L. Rev. 1073 (1994).
6. John Parry, *Decision-Making Rights Over Persons and Property*, in *The Mentally Disabled and the Law* (Samuel J. Brakel et al. eds., 3d ed. 1985).
7. Larry Frolik, *Plenary Guardianship: An Analysis, a Critique and a Proposal for Reform*, 23(2) Ariz. L. Rev. 599-660 (1981); Peter Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 Mo. L. Rev. 215-236 (1975).
8. Walsh et al., *supra* note 4, at §2.02; see also, John Parry & F. Phillips Gilliam, *Handbook on Mental Disability Law* (2002).
9. Walsh et al., *supra* note 4 at §2.02; Parry & Gilliam, *supra* note 8, at 147. See also Louis A. Mezzullo & Mark Woolpert, *Advising the Elderly Client* (2004).
10. Parry & Gilliam, *supra* note 8, at 147-148.
11. *Id.*
12. Walsh et al., *supra* note 4, at §2.09; Mezzullo & Woolpert *supra* note 9, at §32:11.
13. Walsh et al., *supra* note 4, at §2.10; Mezzullo & Woolpert *supra* note 9, at §32:12.
14. Mezzullo & Woolpert, *supra* note 9, at §32:14.
15. John J. Regan et al., *Tax, Estate & Financial Planning for the Elderly* (2003).
16. Uniform Health-Care Decisions Act § 1(3) (1993), <http://www.law.upenn.edu/bll/ulc/fnact99/1990s/uhcda93.pdf>.
17. Alan Meisel, *The Right to Die* (2d ed. 1999); Barry R. Furrow et al., *Health Law* § 6-9 (1995).
18. Benjamin N. Cardozo School of Law, *ADA Mediation Guidelines* (2000). Also see Erica Wood, *Dispute Resolution and Dementia: Seeking Solutions*, 35 Georgia Law Review 2, 785 (2001); and <http://www.mediate.com/adamediation/>.
19. States use differing terms for state intervention in the financial affairs or personal affairs of incapacitated persons. The term "guardianship" is used here to refer to the judicial process for appointing a decision-maker over the personal and/or financial affairs of an incapacitated person, regardless of the particular term or terms used in any specific jurisdiction.
20. Charles P. Sabatino & Susanna L. Basinger, *Competency: Reforming Our Legal Fictions*, 6 J. of Mental Health & Aging 119 (2000).
21. American Bar Ass'n Comm'n on the Mentally Disabled & Comm'n on Legal Problems of the Elderly, *Guardianship: An Agenda for Reform* (1989); Stephen Anderer, *Determining Competency in Guardianship Proceedings* (1990).
22. Sally Hurme & Erica Wood, *Now and Then: Factoids on Adult Guardianship Statutory Reform* (2001) (unpublished paper available through the Am. Bar Ass'n Comm'n on Law and Aging).
23. See, e.g., Idaho Code § 15-5-101(a)(1) (1999); Minn. Stat. Ann. § 525.54, subd. 2 (West 1998); N.H. Rev. Stat. Ann. § 464-A:2(XI) (1999).
24. Uniform Guardianship and Protective Proceedings Act § 102(5) (1997), <http://www.law.upenn.edu/bll/ulc/fnact99/1990s/ugppa97.htm>.
25. Sabatino & Basinger, *supra* note 20.
26. For elements of each state's definition, see chart on *Initiation of Guardianship Proceedings*, Sally Hurme & Erica Wood, American Bar Association Commission on Law and Aging, <http://www.abanet.org/aging/guardian2.pdf>.
27. Sabatino & Basinger, *supra* note 20.
28. Thomas Grisso, *Evaluating Competencies* (2d ed. 2003).
29. American Psych. Ass'n, *Diagnostic and Statistical Manual of Mental Disorders—IV* (4th ed. 1994).
30. Thomas Grisso & Paul S. Appelbaum, *MacArthur Competency Assessment Tool for Treatment (MacCAT-T)* (1998).
31. Daniel C. Marson & Laurie Zebley, *The Other Side of the Retirement Years: Cognitive Decline, Dementia and Loss of Financial Capacity*, J. Retirement Planning 30-38 (2001); Sherry L. Willis & K. Warner Schaie, *Everyday Cognition: Taxonomic and Methodological Considerations*, in *Mechanisms of Everyday Cognition* (J.M. Puckett & H. W. Reese eds., 1993).
32. Patricia Aderent, *The Elderly, Incompetency, and Guardianship* (1979) (unpublished Masters thesis, St. Louis University, St. Louis, Mo.).
33. Irving Hellman, *Elder Abuse Consultations: Financial Capacity Evaluations for Cases of Fiduciary Abuse and Undue Influence*, 18 Psych. in Long-Term Care 5-8 (2004).
34. 62 Fordham L. Rev. 5 (March 1994).
35. *Id.* at 1073.
36. *Id.* at 1087.
37. *Id.* at 1089.
38. Scott Y. H. Kim et al., *Current State of Research on Decision-Making Competency of Cognitively Impaired Elderly Persons*, 10 Am. J. of Geriatric Psych. 151-165 (2002).
39. American Bar Ass'n Ctr. for Professional Responsibility, *Client-Lawyer Relationship: Rule 1.14 Client with Diminished Capacity*, in *Model Rules of Professional Conduct*, [http://www.abanet.org/cpr/mrpc/rule\\_1\\_14.html](http://www.abanet.org/cpr/mrpc/rule_1_14.html).
40. American Bar Ass'n Comm'n on Legal Problems of the Elderly (currently Comm'n on Law and Aging) & Legal Counsel for the Elderly, Inc. of AARP, *Effective Counseling of Older Clients: The Attorney-Client Relationship* (1995).
41. 42 U.S.C. §§ 12181-12189 (2004).
42. H. A. Taub & Marilyn T. Baker, *The Effect of Repeated Testing Upon Comprehension of Informed Consent Materials by Elderly Volunteers*, 9(3) Experimental Aging Research 135-138 (1983).
43. Linda F. Smith, *Representing the Elderly Client and Addressing the Question of Competence*, 14 J. of Contemporary L. 61 at 90 & 92 (1988).
44. *Id.* at 92-96.
45. *Id.* at 91 & 93.
46. Daniel C. Marson et al., *Testamentary Capacity and Undue Influence in the Elderly: A Jurisprudent Therapy Perspective*, 28 L. & Psych. Rev. 71-96 (2004).
47. American Bar Ass'n Ctr. for Professional Responsibility, *supra* note 39, at Comment [6].
48. See Bumele V. Powell & Ronald C. Link, *The Sense of a Client: Confidentiality Issues in Representing the Elderly*, 62 Fordham L. Rev. 1197, 1234-1238 (1994); T. P. Ludington, *Reports of Treating Physician Delivered to Litigant's Own Attorney As Subject of Pretrial or Other Disclosure, Production, or Inspection*, 82 A.L.R.2d 1162 (1962).

## End Notes

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49. American Bar Ass'n Ctr. for Professional Responsibility, *supra* note 39, at Comment [6].
50. National Ctr. for Cost Containment, U.S. Dep't of Veterans Affairs, *Clinical Assessment for Competency Determination: A Practice Guideline for Psychologists* (1997).
51. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 stat. 1936.
52. Michel Silberfeld & Arthur Fish, *When the Mind Fails: A Guide to Dealing with Incompetency* (1994).
53. National Ctr. for Cost Containment, U.S. Dep't of Veterans Affairs, *supra* note 50, at 7-9.
54. The Financial Capacity Instrument (FCI) is a capacity test developed by Marson and colleagues that directly assesses a patient's financial management skills across 18 abilities (task level), 9 activities (domain level), and overall (global level). Other capacity measures that include financial test items include the Independent Living Scales (ILS), the Direct Assessment of Functional Skills (DAFS), and the Structured Assessment of Independent Living Skills (SAILS). A description of these tests and their references in the literature may be found in Appendix 3.
55. Barry Reisberg, *Senile Dementia*, in II *The Encyclopedia of Aging* 907-915 (G. Maddox et al., eds. 2001).