

# Agenda

## Ad Hoc Committee on Probate Law and Procedure

June 15, 2007  
12:00 to 2:00 p.m.

Administrative Office of the Courts  
Scott M. Matheson Courthouse  
450 South State Street  
Judicial Council Room, Suite N31

Approval of minutes.	Judge Sheila McCleve
	Steve Mikita Mary Jane Ciccarello Maureen Henry
Definition of incapacity.	
Representation of person in need of protection.	Kerry Chlarson
Other business.	Judge Sheila McCleve

**Committee Web Page:** <http://www.utcourts.gov/committees/adhocprobate/>

### Meeting Schedule

August 17, 2007  
September 21, 2007  
October 19, 2007  
November 16, 2007  
December 21, 2007  
January 18, 2008  
February 15, 2008  
March 21, 2008  
April 18, 2008  
May 16, 2008  
June 20, 2008  
July 18, 2008  
August 15, 2008  
September 19, 2008

**MINUTES**  
**Ad Hoc Committee on Probate Law and Procedure**  
Administrative Office of the Courts  
450 South State Street  
Salt Lake City, Utah 84114-0241  
May 21, 2007 - 12:00 p.m.

**MEMBERS PRESENT**

Kent Alderman  
Kerry Chlarson  
Mary Jane Ciccarello  
Reese Hansen  
Judge George Harmond  
Maureen Henry  
Richard Howe  
Judge Sheila McCleve, Presiding  
Steve Mikita  
Julie Rigby  
Judge Gary Stott  
Kathy Thyfault

**EXCUSED**

Reese Hansen

**STAFF**

Diana Pollock  
Tim Shea

**I. WELCOME AND APPROVAL OF MINUTES**

Judge Sheila McCleve welcomed the committee members to the meeting. Judge Harmond made a motion to approve the minutes of the April 20, 2007 meeting. The motion was seconded and passed unanimously.

**II. REVIEW AND PRIORITIZE TOPICS**

Tim Shea expressed the need for the committee to prioritize the different issues. Judge McCleve stated that this could lead to more investigation of the individual issues by committee members.

Judge Harmond shared two observations. First, the committee has focused on guardianship and conservatorship almost exclusively. Judge Harmond would like to focus more on educating the Bar and judges as to the standards that need to be applied when determining whether someone is incapacitated. Second, identifying medical testimony about incapacity.

Kent Alderman noted that the question of incapacity comes up daily and his experience is that the law has one view of incapacity and the medical profession has a different view. Mr. Alderman stated that the ABA recently published a manual about cases dealing with incapacity, which could be helpful to the committee.

Mary Jane Ciccarello stated that she does not disagree with the education of the different

groups, however, Ms. Ciccarello believes there is a real need to review the statute, which could require changes. She said the Utah definition of incapacity is outdated. States are moving to a functional definition. Steve Mikita stated concern that the committee not attempt to do a full scale overhaul of the statutes but to pinpoint, in a short time, things that will improve the standards of review and the procedural requirements. Mr. Mikita stated he is in favor of finding the best definition of incapacity.

Maureen Henry agreed, stating that she recently finished a paper for a medical journal on assessing capacity in elderly patients. Ms. Henry stated she found there is no consensus on the medical standard of care. There are challenging issues on the medical side that need to be recognized.

Kerry Chlarson stated that he sees a lack of appropriate representation for putative wards, and feels that the matter should be a priority. Kent Alderman stated that the practice is for the petitioner to identify an attorney to represent the ward, which results in a conflict of interest. The Code states that the court will appoint a lawyer to represent the ward.

Tim Shea stated that there seems to be a consensus to researching appropriate amendments to the Code itself. Mr. Shea asked the committee if the core issue is the definition of incapacity and the necessary medical testimony. Steve Mikita stated that the legal definition of incapacity should be established and the medical profession should follow that definition. Mary Jane Ciccarello stated that a guardianship plan should meet the needs of the individual ward. A legal definition should be arrived at and better medical information would follow. Mr. Mikita stated the court needs to understand in what areas the putative ward is functional and dis-functional in order to appoint a limited guardian.

Tim Shea asked the committee how it wanted to pursue this topic. Steve Mikita stated that an up- to- date definition of incapacity would be helpful. Mr. Mikita would also like to review other states' definitions of incapacity. Maureen Henry stated that the committee could look to other countries for definitions. Mary Jane Ciccarello stated that Wisconsin and Maryland recently did a study of their guardianships. Perhaps this committee could review their studies. Ms. Ciccarello also suggested that the committee look at the recommendations made by Wingspan regarding guardianship. Ms. Ciccarello will obtain the Wingspan information for the committee.

Judge Stott stated that the National College of Probate Judges have a library of resources that may be helpful. Their organization helps states in making changes. Judge Stott will obtain a contact person from the College for this committee to work with. Kent Alderman stated that the AARP and the ABA are good sources of materials and he will provide copies of the reports and the practitioner's guide.

Tim Shea stated that, when the Policy and Planning Committee studied the post-appointment reporting requirements of guardians, they found a number of procedural conflicts

and questions in the Code. It was noted that Senator Hillyard is a member of the Commission on Uniform Laws, which is drafting a proposed uniform law on guardians and conservators. Mary Jane Ciccarello will talk with Senator Hillyard and find out where the Commission is on this topic.

Judge Harmond noted the need for user-friendly forms. Judge Harmond asked whether subcommittees should be formed. Steve Mikita stated that he is in favor of forming subcommittees.

Kent Alderman expressed the need for a full-time probate judge. Tim Shea stated that the model for district court judges is that they are generalists and can be assigned any type of case. A couple of possibilities for achieving expertise are using the tax court model and using court commissioners. Mr. Shea stated that this does not require legislation. Judge Stott stated that there are very few states that have specialist probate judges. Mary Jane Ciccarello stated that perhaps a court commissioner could hear both commitment and guardianship issues.

Judge McCleve suggested forming subcommittees and asked for volunteers. The committee agreed that:

- Kerry Chlarson will chair the Representation Subcommittee.
- Judge Harmond will contact the colleges regarding incapacity.
- Mary Jane Ciccarello, Maureen Henry and Steve Mikita will research the definition of incapacity and due process issues.
- Judge Harmond, Kathy Thyfault and Julie Rigby will research forms and public service.

### **III. MAKING THINGS HAPPEN**

Tim Shea listed the different ways to operationalize the committee's work.

- Amending statutes. The Judicial Council reviews proposed legislation in August.
- Amending court rules. There are two rule making bodies, the Supreme Court and the Judicial Council. There are two rule-making cycles per year, with rules becoming effective in April and November. A rule change can be expedited if there is a need.
- Education: Simply making people aware of policies and procedures is an effective tool. The judiciary has two major conferences for district court judges and one major conference and several classes for clerks. The Bar has three major

conferences and classes throughout the year.

- Set policy within the statutes and rules. The law may establish discretion that could be exercised through the Council or Board of District Court Judges. Trial Court executives and clerks of courts can establish uniform operating guidelines.
- Budget requests. A budget request might accompany or be independent of legislation.

#### **IV. MONITORING AND ENFORCING REPORTING REQUIREMENTS OF GUARDIANS AND CONSERVATORS**

Tim Shea said that the Policy and Planning Committee had issued its report to the Judicial Council recommending ways to improve monitoring and enforcing the reporting requirements of guardians and conservators. There is a major rule change out for public comment. Mr. Shea stated that Utah is not enforcing reporting requirements. Mr. Shea stated that the Policy and Planning Committee's objective was to give the judge some assurance that the guardian's report is correct. The report will be served on interested people, which is the normal process, the Policy and Planning Committee recommended that the court audit select, high risk reports. The Policy and Planning Committee recommends recruiting volunteers among lawyers and CPAs. Mr. Shea said that this concept could extend to volunteer visitors to investigate the ward's conditions. Mr. Shea asked the committee for ideas on recruiting people.

Maureen Henry suggested HIPPO, AARP, the Utah Food Bank and the Statewide Volunteer Organization. Committee members also suggested law, social work and accounting students at the universities, senior lawyers, the Estate Planning Section, and the CPA association. Mary Jane Ciccarello noted that there are no resources to train volunteers. The network will need support and training. The committee suggested identifying "triggers" that would suggest further review of a report.

#### **V. OTHER BUSINESS**

There being no further business the committee adjourned at 1:50 p.m. The next meeting is scheduled for June 15, 2007 at noon.

## **Definitions of incapacity and related terms**

### **Utah**

75-1-202(22). "Incapacitated person" means any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, except minority, to the extent of lacking sufficient understanding or capacity to make or communicate responsible decisions.

75-5-303(2) Upon the filing of a petition, the court shall set a date for hearing on the issues of incapacity; and unless the allegedly incapacitated person has counsel of the person's own choice, it shall appoint an attorney to represent the person in the proceeding the cost of which shall be paid by the person alleged to be incapacitated, unless the court determines that the petition is without merit, in which case the attorney fees and court costs shall be paid by the person filing the petition.

(3) The person alleged to be incapacitated may be examined by a physician appointed by the court who shall submit a report in writing to the court and may be interviewed by a visitor sent by the court. The visitor also may interview the person seeking appointment as guardian, visit the present place of abode of the person alleged to be incapacitated and the place it is proposed that the person will be detained or reside if the requested appointment is made, and submit a report in writing to the court.

(4) The person alleged to be incapacitated shall be present at the hearing in person and see or hear all evidence bearing upon the person's condition. If the person seeking the guardianship requests a waiver of presence of the person alleged to be incapacitated, the court shall order an investigation by a court visitor, the costs of which shall be paid by the person seeking the guardianship. The investigation by a court visitor is not required if there is clear and convincing evidence from a physician that the person alleged to be incapacitated suffers from: (a) fourth stage Alzheimer's Disease; (b) extended comatosis; or (c) profound mental retardation. The person alleged to be incapacitated is entitled to be represented by counsel, to present evidence, to cross-examine witnesses, including the court-appointed physician and the visitor, and to trial by jury. The issue may be determined at a closed hearing without a jury if the person alleged to be incapacitated or the person's counsel so requests.

75-5-304(1) The court may appoint a guardian as requested if it is satisfied that the person for whom a guardian is sought is incapacitated and that the appointment is necessary or desirable as a means of providing continuing care and supervision of the incapacitated person.

### **Uniform Probate Code (2006) from the Uniform Guardianship and Protective Proceedings Act (1997)**

5-102(4) "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.

## California

Probate Code. Section 1420.

"Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial handicap for such individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term includes mental retardation, cerebral palsy, epilepsy, and autism. This term also includes handicapping conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but does not include other handicapping conditions that are solely physical in nature.

## Maryland

Estates and Trusts

13-101.

....

(e) Disabled person.- "Disabled person" means a person other than a minor who:

(1) (i) Has been judged by a court to be unable to manage his property for reasons listed in § 13-201(c)(1) of this title; and

(ii) As a result of this inability requires a guardian of his property; or

(2) (i) Has been judged by a court to be unable to provide for his daily needs sufficiently to protect his health or safety for reasons listed in § 13-705(b) of this title; and

(ii) As a result of this inability requires a guardian of the person.

....

13-705. Appointment of guardian of disabled person.

(a) Petition and notice.- On petition and after any notice or hearing prescribed by law or the Maryland Rules, a court may appoint a guardian of the person of a disabled person.

(b) Grounds.- A guardian of the person shall be appointed if the court determines from clear and convincing evidence that a person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, including provisions for health care, food, clothing, or shelter, because of any mental disability, disease, habitual drunkenness, or addiction to drugs, and that no less restrictive form of intervention is available which is consistent with the person's welfare and safety.

## Washington

11.88.010. Authority to appoint guardians — Definitions — Venue — Nomination by principal.

(1) The superior court of each county shall have power to appoint guardians for the persons and/or estates of incapacitated persons, and guardians for the estates of nonresidents of the state who have property in the county needing care and attention.

(a) For purposes of this chapter, a person may be deemed incapacitated as to person when the superior court determines the individual has a significant risk of personal harm based upon a demonstrated inability to adequately provide for nutrition, health, housing, or physical safety.

(b) For purposes of this chapter, a person may be deemed incapacitated as to the person's estate when the superior court determines the individual is at significant risk of financial harm based upon a demonstrated inability to adequately manage property or financial affairs.

(c) A determination of incapacity is a legal not a medical decision, based upon a demonstration of management insufficiencies over time in the area of person or estate. Age, eccentricity, poverty, or medical diagnosis alone shall not be sufficient to justify a finding of incapacity.

(d) A person may also be determined incapacitated if he or she is under the age of majority as defined in RCW 26.28.010.

(e) For purposes of giving informed consent for health care pursuant to RCW 7.70.050 and 7.70.065, an "incompetent" person is any person who is (i) incompetent by reason of mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental incapacity, of either managing his or her property or caring for himself or herself, or both, or (ii) incapacitated as defined in (a), (b), or (d) of this subsection.

(f) For purposes of the terms "incompetent," "disabled," or "not legally competent," as those terms are used in the Revised Code of Washington to apply to persons incapacitated under this chapter, those terms shall be interpreted to mean "incapacitated" persons for purposes of this chapter.

## **Wisconsin**

### Chapter 54. Guardianships and Conservatorships.

#### Subchapter I. Definitions.

....

54.01(15) "Incapacity" means the inability of an individual effectively to receive and evaluate information or to make or communicate a decision with respect to the exercise of a right or power.

....

#### Subchapter II. Appointment of Guardian

....

#### 54.10(3)(a)

(a) A court may appoint a guardian of the person or a guardian of the estate, or both, for an individual based on a finding that the individual is incompetent only if the court finds by clear and convincing evidence that all of the following are true:

1. The individual is aged at least 17 years and 9 months.

2. For purposes of appointment of a guardian of the person, because of an impairment, the individual is unable effectively to receive and evaluate information or to make or communicate decisions to such an extent that the individual is unable to meet the essential requirements for his or her physical health and safety.

3. For purposes of appointment of a guardian of the estate, because of an impairment, the individual is unable effectively to receive and evaluate information or to make or communicate decisions related to management of his or her property or financial affairs, to the extent that any of the following applies:

a. The individual has property that will be dissipated in whole or in part.

b. The individual is unable to provide for his or her support.

c. The individual is unable to prevent financial exploitation.

4. The individual's need for assistance in decision making or communication is unable to be met effectively and less restrictively through appropriate and reasonably available training, education, support services, health care, assistive devices, or other means that the individual will accept.

54.10(3)(b)

(b) Unless the proposed ward is unable to communicate decisions effectively in any way, the determination under par. (a) may not be based on mere old age, eccentricity, poor judgment, or physical disability.

54.10(3)(c)

(c) In appointing a guardian under this subsection, declaring incompetence to exercise a right under s. 54.25 (2) (c), or determining what powers are appropriate for the guardian to exercise under s. 54.18, 54.20, or 54.25 (2) (d), the court shall consider all of the following:

1. The report of the guardian ad litem, as required in s. 54.40 (4).

2. The medical or psychological report provided under s. 54.36 (1) and any additional medical, psychological, or other evaluation ordered by the court under s. 54.40 (4) (e) or offered by a party and received by the court.

3. Whether the proposed ward has engaged in any advance planning for financial and health care decision making that would avoid guardianship, including by executing a durable power of attorney under ch. 243, a power of attorney for health care, as defined in s. 155.01 (10), a trust, or a jointly held account.

4. Whether other reliable resources are available to provide for the individual's personal needs or property management, and whether appointment of a guardian is the least restrictive means to provide for the individual's need for a substitute decision maker.

5. The preferences, desires, and values of the individual with regard to personal needs or property management.

6. The nature and extent of the individual's care and treatment needs and property and financial affairs.

7. Whether the individual's situation places him or her at risk of abuse, exploitation, neglect, or violation of rights.

8. Whether the individual can adequately understand and appreciate the nature and consequences of his or her impairment.

9. The individual's management of the activities of daily living.

10. The individual's understanding and appreciation of the nature and consequences of any inability he or she may have with regard to personal needs or property management.

11. The extent of the demands placed on the individual by his or her personal needs and by the nature and extent of his or her property and financial affairs.

12. Any physical illness of the individual and the prognosis of the individual.

13. Any mental disability, alcoholism, or other drug dependence of the individual and the prognosis of the mental disability, alcoholism, or other drug dependence.

14. Any medication with which the individual is being treated and the medication's effect on the individual's behavior, cognition, and judgment.

15. Whether the effect on the individual's evaluative capacity is likely to be temporary or long term, and whether the effect may be ameliorated by appropriate treatment.

16. Other relevant evidence.

54.10(3)(d)

(d) Before appointing a guardian under this subsection, declaring incompetence to exercise a right under s. 54.25 (2) (c), or determining what powers are appropriate for the guardian to exercise under s. 54.18, 54.20, or 54.25 (2) (d), the court shall determine if additional medical, psychological, social, vocational, or educational evaluation is necessary for the court to make an informed decision respecting the individual's competency to exercise legal rights and may obtain assistance in the manner provided in s. 55.06 (8) [s. 55.11 (1)] whether or not protective placement is made.

54.10(3)(e)

(e) In appointing a guardian under this subsection, the court shall authorize the guardian to exercise only those powers under ss. 54.18, 54.20, and 54.25 (2) (d) that are necessary to provide for the individual's personal needs and property management and to exercise the powers in a manner that is appropriate to the individual and that constitutes the least restrictive form of intervention.

....

#### 54.36 Examination of proposed ward.

##### 54.36(1)

(1) Whenever it is proposed to appoint a guardian on the ground that a proposed ward allegedly has incompetency or is a spendthrift, a physician or psychologist, or both, shall examine the proposed ward and furnish a written report stating the physician's or psychologist's professional opinion regarding the presence and likely duration of any medical or other condition causing the proposed ward to have incapacity or to be a spendthrift. The privilege under s. 905.04 does not apply to the statement. The petitioner shall provide a copy of the report to the proposed ward or his or her counsel, the guardian ad litem, and the petitioner's attorney, if any. Prior to the examination on which the report is based, the guardian ad litem, physician, or psychologist shall inform the proposed ward that statements made by the proposed ward may be used as a basis for a finding of incompetency or a finding that he or she is a spendthrift, that he or she has a right to refuse to participate in the examination, absent a court order, or speak to the physician or psychologist and that the physician or psychologist is required to report to the court even if the proposed ward does not speak to the physician or psychologist. The issuance of such a warning to the proposed ward prior to each examination establishes a presumption that the proposed ward understands that he or she need not speak to the physician or psychologist. Nothing in this section prohibits the use of a report by a physician or psychologist that is based on an examination of the proposed ward by the physician or psychologist before filing the petition for appointment of a guardian, but the court will consider the recency of the report in determining whether the report sufficiently describes the proposed ward's current state and in determining the weight to be given to the report.

I am forwarding the portions of the Utah Advance Health Care Directive Act that address capacity issues.

There is much in the Wisconsin code that I like.

Some of the traits that would improve Utah's law would include:

1. Defining capacity in functional terms, allowing a particular function to be placed in the hands of a guardian only if the individual lacks the capacity to perform that function.
2. Define capacity with sufficient specificity to assure that physicians or court visitors can apply a specific legal standard.
3. Impose a guardianship/conservatorship only if pre-incapacity planning through POAs for health care and finances/trusts, etc., fails.
4. Assure that physicians or other qualified professionals (LCSWs, Psychologists, NPs) who conduct assessments for the courts are educated in the legal standards (research shows that this dramatically improves a physician's ability to assess capacity).
5. Consider whether the capacity definitions should be in regulations, rather than law, so that the definition can change as emerging research informs our understanding in this area.

I am sorry to be unable to contribute to Friday's meeting.

Thanks.

Maureen

75-2a-103 (Effective 01/01/08)

...

(3) "Capacity to appoint an agent" means that the individual understands the consequences of appointing a particular person as agent.

(10) "Health care decision making capacity" means an individual's ability to make an informed decision about receiving or refusing health care, including:

(a) the ability to understand the nature, extent, or probable consequences of the health care;

(b) the ability to make a rational evaluation of the burdens, risks, benefits, and alternatives to the proposed health care; and

(c) the ability to communicate a decision.

75-2a-104 (Effective 01/01/08). Capacity to make health care decisions --  
Presumption -- Overcoming presumption.

(1) An individual is presumed to have:

(a) health care decision making capacity; and

(b) capacity to make or revoke a health care directive.

(2) To overcome the presumption of capacity, a physician who has personally examined the individual and assessed the individual's health care decision making capacity must:

(a) find that the individual lacks health care decision making capacity;

(b) record the finding in the individual's medical chart including an indication of whether the individual is likely to regain health care decision making capacity; and

(c) make a reasonable effort to communicate the determination to:

- (i) the individual;
- (ii) other health care providers or health care facilities that the physician would routinely inform of such a finding; and
- (iii) if the individual has a surrogate, any known surrogate.

(3) (a) If a physician finds that an individual lacks health care decision making capacity in accordance with Subsection (2), the individual may at any time, challenge the finding by:

- (i) submitting to a health care provider a written notice stating that the individual disagrees with the physician's finding; or
- (ii) orally informing the health care provider that the individual disagrees with the physician's finding.

(b) A health care provider who is informed of a challenge pursuant to Subsection 3)(a) shall promptly inform an individual, if any, who is serving as surrogate of the individual's challenge.

(c) A surrogate informed of a challenge to a finding under this section, or the individual if no surrogate is acting on the individual's behalf, shall inform the following of the individual's challenge:

- (i) any other health care providers involved in the individual's care; and
- (ii) the health care facility, if any, in which the individual is receiving care.

(d) An individual's challenge to a finding under this section is binding on a health care provider and a health care facility unless otherwise ordered by a court.

(e) If an individual does not challenge a finding, the health care provider and health care facility may rely on a surrogate to make health care decisions for the individual.

(4) A health care provider or health care facility providing care to the individual that relies on a surrogate to make decisions on behalf of an individual has an ongoing obligation to consider whether the individual continues to lack health care decision making capacity.

(5) If at any time a health care provider finds, based on an examination and assessment, that the individual has regained health care decision making capacity, the health care provider shall record the results of the assessment in the individual's medical record, and the individual can direct his health care.

From: <mjcicar@xmission.com>  
To: Tim Shea <tims@email.utcourts.gov>  
Date: 6/10/07 11:51PM  
Subject: Re: June 15 meeting (0.96/3.50)

Dear Tim, Maureen, Steve, and Kent,

Thanks to Tim and Maureen for their suggestions so far. I have been meaning to get our subgroup together before the June 15 meeting, but I simply did not have the time. I would like to schedule a time we five can meet as soon as possible starting the week of June 25.

As I mentioned at our last full committee meeting, I will not attend the June 15 meeting as I will be out of town between June 11 and 25, in part for fun, but in part to help take care of my mother-in-law who is having serious health problems. I will contact you all the week of June 25 to see when we can get together.

I am writing from home and I am not able to send attachments from here. In fact, when I tried earlier to send you links, I lost my whole first draft of this message!

I would like to suggest that our group come up with a plan of action and present it to the full group at the July meeting. I think we need to examine the following (and this is in a very abbreviated version):

1. The current definition of incapacity in the Utah Probate Code and whether or not this should be changed.

2. What guidance does the court now have for determining incapacity? The standard of proof is clear and convincing, but this means little in terms of what medical evidence needs to be presented.

3. Are the current due process protections sufficient? Some aspects of this area are being examined by another group (the one looking at the issue of providing legal counsel to the proposed ward), but these rights are necessarily connected to the issue of determining incapacity and must be included in a general review of incapacity.

4. If there is a determination of incapacity, then how does the court go about ordering a limited guardianship?

These are just four initial issues I think our subgroup can examine under the rubric of incapacity. However, I think it would be extremely premature to present to the full committee any suggestion for a definition of incapacity at the June 15 meeting.

I am giving you here my suggestions for materials we should review as we proceed. I do not know if the whole committee would want to spend the time with these materials, but I think we should. They include a seminal article on the legal definitions of incapacity by Charlie Sabatino. I mailed a copy of this article to Tim today and I hope that he can make copies available to you at the June 15 meeting.

I also think we should look at the website for the National Probate Court and its excellent resource guide. This is found at:

<http://www.ncsconline.org/wc/CourTopics/ResourceGuide.asp?topic=Probct>.

Once there, you will be able to link to the ABA publication on "Judicial Determination of Capacity of Older Adults in Guardianship Proceedings". This is an excellent resource for us. This can also be downloaded directly from the ABA Commission on Law and Aging site at [www.abanet.org/aging](http://www.abanet.org/aging).

Again, once at the Probate Court Resource Guide site, if you look under Ethics, you will find several references to the Stetson Law Review, Vol. 31, No. 3 (Spring 2002). There are many excellent articles in this issue. But, most importantly, this issue includes the Wingspan Recommendations and I really think we need to review them carefully. I am sorry that I wasn't able to get you a copy of the recommendations, but I hope that you can look up the law review and see them. They can be found on pages 595-609.

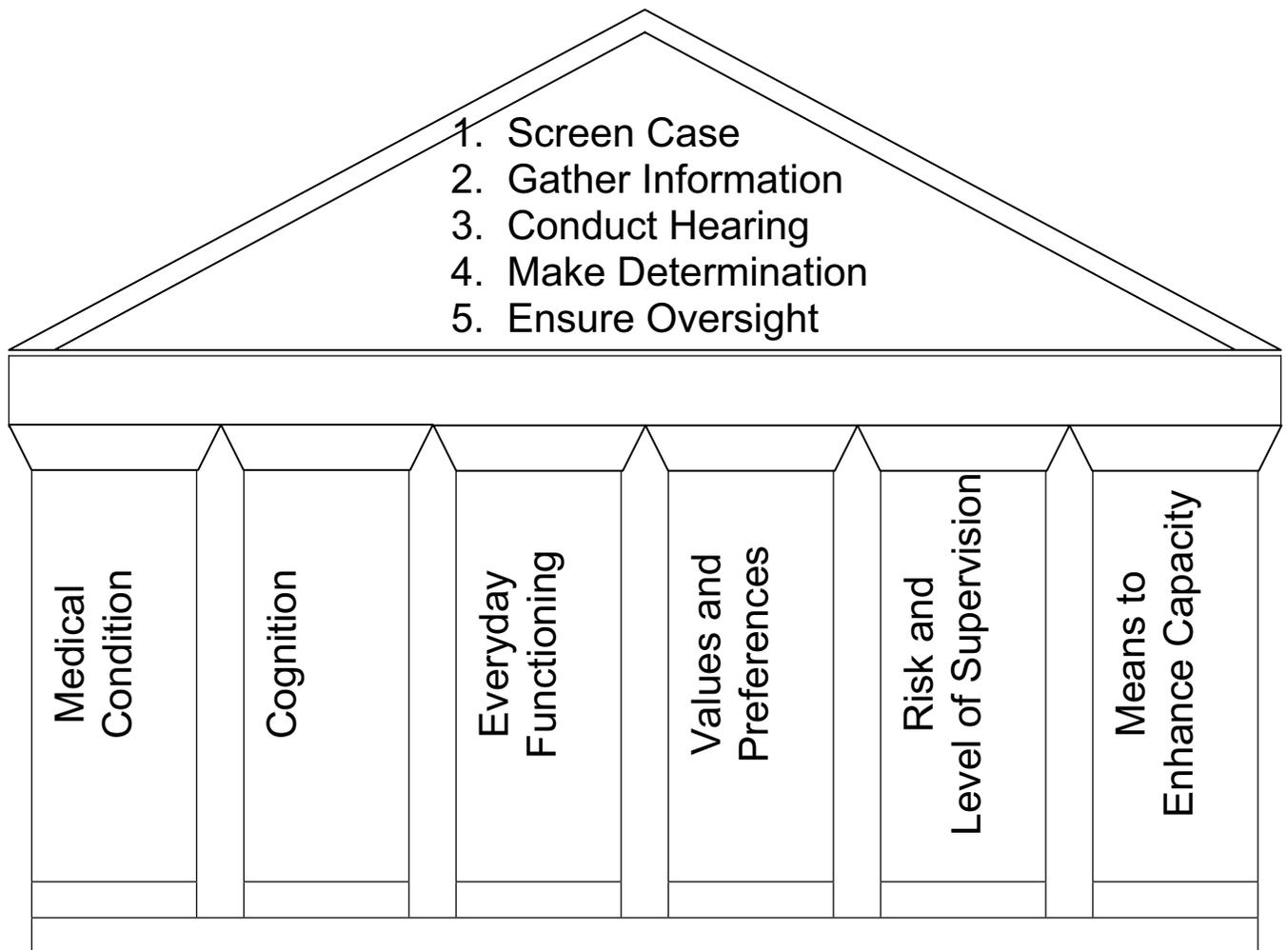
I also think we should carefully examine what Wisconsin has done. Their guardianship reform efforts can be found at:

<http://www.cwag.org/legal/guardian%2Dsupport>. From there you can scroll around and find specific statutory changes.

I hope all goes well at the June 15 meeting and I look forward to getting together with you all soon.

Mary Jane

# Judicial Determination of Capacity of Older Adults in Guardianship Proceedings



American Bar Association  
Commission on Law and Aging

American Psychological Association

National College of Probate Judges

## Judicial Determination of Capacity of Older Adults in Guardianship Proceedings

### Disclaimer

The views expressed in this document have not been approved by the governing or policy-setting bodies of the American Bar Association, the American Psychological Association, or the National College of Probate Judges, and should not be construed as representing policy of these organizations. Materials in this book were developed based on the consensus of a working group.

**This document is not intended to establish a standard of practice against which juridical or clinical practice is to be evaluated. Rather, it provides a framework that judges may find useful and effective in capacity determination.**

Although the principles presented herein are intended to be generally relevant across all legal jurisdictions, law and practice differ across state jurisdictions and sometimes even across county lines. **Thus, this book is intended to supplement (and cannot substitute for) a judge's working knowledge of the capacity and guardianship statutes and case law specific to his/her jurisdiction.** This book focuses on issues in capacity determination, not all of adult guardianship.

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Judges are not like baseball umpires, calling strikes and balls or merely labeling someone competent or incompetent. Rather, the better analogy is that of a craftsman who carves staffs from tree branches. Although the end result—a wood staff—is similar, the process of creation is distinct to each staff. Just as the good wood-carver knows that within each tree branch there is a unique staff that can be ‘released’ by the acts of the carver, so too a good judge understands that, within the facts surrounding each guardianship petition, there is an outcome that will best serve the needs of the incapacitated person, if only the judge and the litigants can find it.<sup>1</sup>

## Acknowledgements

This book is the result of a collaborative effort of members of the American Bar Association (ABA) Commission on Law and Aging, the American Psychological Association (APA), and the National College of Probate Judges (NCPJ).

This book was guided by a judicial advisory panel convened for this project: Hon. Steve M. King, of Texas, Hon. Gary Cassavechia, of New Hampshire, and Hon. John N. Kirkendall, of Michigan. The handbook was also reviewed by additional members of the Executive Committee of the National College of Probate Judges: Hon. Grace G. Connolly, Hon. Ramond C. Eubanks, Hon. William J. Bate, Hon. Luke Cooley, Hon. Joseph A. Egan Jr., Hon. Irvin G. Condon, Hon. John W. Voorhees, Hon. Jack R. Puffenberger, and Ms. Mary Joy Quinn. The handbook received additional review by members of the NCPJ, including Hon. Nikki Towry DeShazo, Hon. John R. Maher, and Hon. Lawrence A. Belskis. Additional reviewers included Erica Berman, Ann Soden, and Jack Schwartz. Forms and guides in this book were informed and inspired by the work of others, including Hons. King, Kirkendall, and Cassavechia, the Carolina Legal Assistance, Joan O’Sullivan, and the Massachusetts Guardianship Task Force.

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## Introduction

### Background

- Guardianships for older adults are **increasing**.
- Guardianship law and practice is undergoing **dramatic revision**.
- Definitions of capacity have **evolved** to reflect modern understandings of brain dysfunction, functional abilities, and the law: 
  - ▶ Capacity is task specific, not global.
  - ▶ Capacity can fluctuate.
  - ▶ Capacity is situational.
  - ▶ Capacity is contextual.
- Determining capacity in older adults with complex impairments can be **difficult**.
- Limited guardianships based on partial loss of capacity can be **challenging** to craft.

### Goals of This Book

- To provide **practical tools** for capacity determination.
- To address the needs of a **wide audience** of judges.
- To **improve communication** between judges and healthcare professionals.
- To provide resources useful in identifying **less restrictive alternatives** and fashioning **limited guardianship**, while recognizing that plenary guardianship often may be appropriate.
- To call attention to **temporary and reversible causes of impairment**. 
- To assist courts in **enhancing the capacity** of older adults. 

### Use of This Book

- Forms and resources referenced herein are **available online** to download for ready use and modification at <http://www.abanet.org/aging>; <http://www.apa.org/pi/aging>; and <http://www.ncpj.org>. In the hard copy version, the symbol “” indicates that additional information can be found in the online version of the book; if reading the online version, the symbol provides a link to the resource.
- Forms and resources **may be reproduced** for use in guardianship proceedings (for other uses, refer to copyright page).
- Although the forms are generally relevant, each form will need to be modified to suit local practices. Judges are encouraged to **freely adapt** forms to jurisdictional needs and laws.
- This book is generally **consistent with the *Uniform Guardianship and Protective Proceedings Act*<sup>2</sup> or UGPPA**. 

## The Role of Judges in Capacity Determinations

### Judges Balance Multiple Goals

- Decide capacity in a manner that balances well-being and rights.
- Promote self-determination.
- Identify less restrictive alternatives to guardianship. 
- Provide guidance to guardians. 
- Make determinations of restoration.
- Craft limited guardianship when appropriate. 

### What Is Limited Guardianship?

- A limited guardianship is a relationship in which the guardian “is assigned only those duties and powers that the individual is incapable of exercising.”<sup>3</sup>
- The concept of limited guardianship is promoted in the UGPPA<sup>4</sup> and the *National Probate Court Standards*, which directs probate judges to “detail the duties and powers of the guardian, including limitations to the duties and powers, and the rights retained by the individual.”<sup>5</sup>
- In some cases, such as coma or advanced dementia, individuals are totally impaired by their medical condition. In other cases, a fine tuned assessment may help to identify specific areas—**even if relatively small in scope**—in which the individual may retain rights.
- Examples of limitations to guardianship include rights retained by an individual to: 
  - Determine living arrangements.
  - Spend small amounts of money.
  - Make and communicate choices about roommates.
  - Initiate and follow a schedule of daily and leisure activities.
  - Establish and maintain personal relationships with friends and relatives.
  - Determine degree of participation in religious activities.

### Benefits of Limited Guardianship

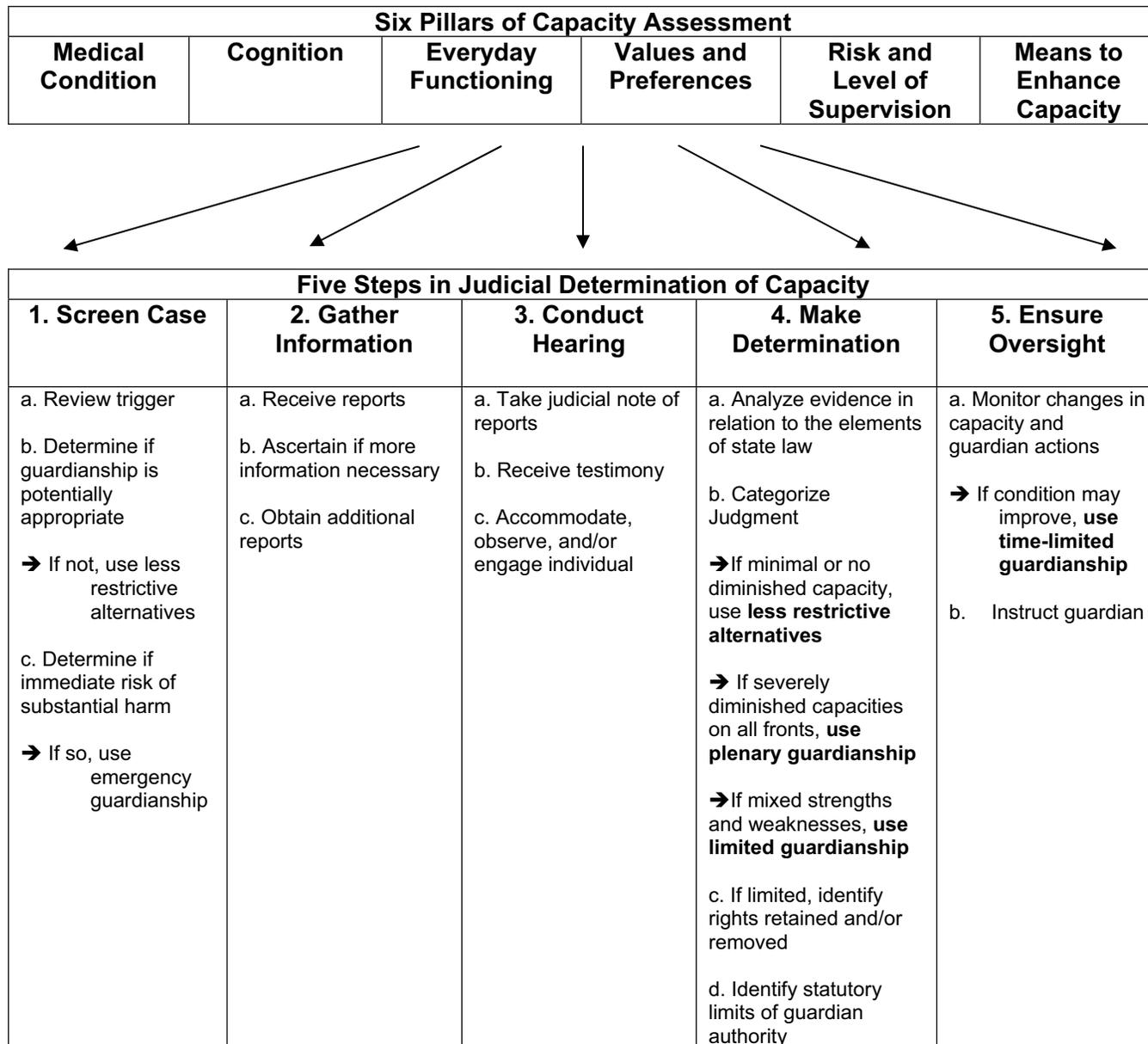
- Maximizes the autonomy of the person with diminished capacity.<sup>6</sup>
- Is directly responsive to the concept of the least restrictive alternative.
- Supports an individual’s mental health.<sup>7</sup>
- Encourages the guardian to take into account the wishes of the individual, moving the relationship more toward collaboration and compromise.

### Risks of Limited Guardianship

- In some cases, the elder is at risk for or has been subject to abuse, and the use of limited guardianship could keep the elder at some degree of continuing risk. In these cases, plenary guardianship may be the appropriate protective mechanism.

## Overview of Capacity Assessment

**A** comprehensive assessment of capacity for guardianship proceedings requires collecting information on six factors. In this book, these factors will be referred to as the “Six Pillars of Capacity Assessment.” Information about these factors may be obtained from healthcare professionals, court investigators, guardians ad litem, family members, adult protective service workers, and other involved parties. This book describes the six pillars of capacity assessment and how they inform each judicial action step in adult guardianship proceedings. Links to related model forms and resources are provided throughout the book.



## Six Pillars of Capacity

### 1. Medical Condition Producing Functional Disability

- Historically, many state statutes 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 judicial determinations.
- Today, judges require information on the specific disorder causing diminished capacity. With aging, a wide range of neurological and psychiatric conditions may impact capacity. [!\[\]\(d6c4cc9a92381c8dd8bec5ce712ee2af\_img.jpg\)](#)
- Some conditions are temporary and reversible. [!\[\]\(2e0a361732049875be4e0ad156d4f239\_img.jpg\)](#)

### 2. Cognitive Functioning Component

- “Cognitive functioning” is a component of statutory standards for capacity in many states.
- The 1997 UGPPA defines an incapacitated person as an individual who ... 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>8</sup>
- Cognitive functioning includes alertness or arousal, as well as memory, reasoning, language, visual-spatial ability, and insight. Neurological as well as psychiatric or mood disorders may impact information processing. [!\[\]\(feb3ba362cbead28144bd29701a8048b\_img.jpg\)](#)

### 3. Everyday Functioning Component

- Until recent years, the everyday functioning tests found in state law were fairly vague and subjective, such as “incapable of taking care of himself”;<sup>9</sup> “unable to provide for personal needs and/or property management”;<sup>10</sup> or “incapable of taking proper care of the person’s self or property or fails to provide for the person’s family.”<sup>11</sup>
- Vague standards invite judgments of incapacity based upon the court’s opinion of the reasonableness of one’s behavior—essentially, a subjective test.
- Many states now set a higher and more objective bar for weighing functional behavior by focusing only on one’s ability to provide for one’s “essential needs,” such as “inability to meet personal needs for medical care, nutrition, clothing, shelter, or safety.”<sup>12</sup>
- Healthcare professionals divide everyday functioning into the “activities of daily living” or “ADLs” (grooming, toileting, eating, transferring, dressing) and the “instrumental activities of daily living” or “IADLs”—abilities to manage finances, health, and functioning in the home and community. [!\[\]\(b5bfbe237dcc6fc7340d789169daa234\_img.jpg\)](#)

## 4. Consistency of Choices with Values, Preferences, and Patterns

- Capacity reflects the consistency of choices with the individual’s life patterns, expressed values, and preferences. Choices that are linked with lifetime values are rational for an individual even if outside the norm.
- Knowledge of values is not only important in determining capacity, but also in the guardianship plan. The UGPPA provides that a guardian must “consider the expressed desires and personal values of the [individual] to the extent known to the guardian.”<sup>13</sup>
- Core values may affect the individual’s preference for who is named guardian, as well as preferences concerning medical decisions, financial decisions, and living arrangements. 

## 5. Risk of Harm and Level of Supervision Needed

- Most state statutes require that the guardianship is necessary to provide for the essential needs of the individual (i.e., there are no other feasible options), or that the imposition of a guardianship is the least restrictive alternative for addressing the proven substantial risk of harm.<sup>14</sup>
- The social and environmental supports may decrease the risk. Lack of supports may increase risk. In this manner, the degree of risk is not merely a consideration of the condition and its effects, but the consideration of these within the environmental supports and demands.
- The level of supervision determined by the judge must match the risk of harm to the individual and the corresponding level of supervision required to mitigate that risk.
- In some cases, the risk is low and the need can be addressed through a less restrictive alternative or limitation to guardianship. In other cases, less restrictive alternatives have failed or are inappropriate, and a plenary guardianship is necessary to protect the well being of the elder.

## 6. Means to Enhance Capacity

- The judge must be vigilant for means to enhance capacity through practical accommodations and medical, psychosocial, or educational interventions. 
- The mere existence of a physical disability should not be a ground for guardianship, since most physical disabilities can be accommodated with appropriate medical, functional, and technological assistance directed by the individual.
- Information about enhancing capacity informs many judicial actions:
  - **Hearing.** How to maximize capacity at the hearing. 
  - **Review Period.** What is the appropriate period for judicial review, especially if **restoration** of capacity through treatments is possible.
  - **Plans.** What treatments, services, habilitation should be detailed in the guardianship plan. 

## Step One: Screen the Case

### 1a. Review Trigger

- *What is bringing this case to court now?*
- Identify the immediate issue or occurrences that brought the case to court at this time—for example, a question of institutional placement, sale of property, medical treatment, or financial exploitation.
- Ensure that the triggering issue concerns protection of the individual, and is not for the convenience or benefit of a third party, such as a family, heir, hospital, or nursing home. Judges may address the concerns of other parties, but “the interests of the incapacitated person should take precedence.”<sup>15</sup>

### 1b. Determine if Guardianship Is Potentially Appropriate

- *Have all procedural requirements been met?*
  - Is venue proper?
  - Are notice and service proper?
  - Has counsel been appointed if required or if needed?
  - Has individual been informed of hearing rights?
- *Is guardianship necessary and helpful in this case?*

Put a mechanism in place to screen out cases that are inappropriate for guardianship. Some courts have designated staff to work with petitioners, ensuring that cases that come before the court for judicial intervention are necessary and that petitioning the court for guardianship is, in reality, a last resort. Seek to determine that:

  - ▶ There are no **less restrictive alternatives**. Perhaps the individual has executed durable health care and financial powers of attorney, and there is no allegation of abuse of those powers. Perhaps the only issue is authority for medical treatment and the state has a default surrogate law allowing family members to make health care decisions. Perhaps a more supervised housing setting or intensive in-home services would abrogate the need for a guardian. [📄](#)
  - ▶ A guardian **would solve the issue**. There are some situations where putting a guardian in place would not address the problem at hand. “Guardianship is not appropriate in some circumstances. A probate guardian cannot make a person reveal where assets, such as vehicles are hidden, cannot [in some instances] force mental health treatment, cannot provide personal services if the person is never at home, is threatening, locks caregivers out of the home, or is homeless by choice.”<sup>16</sup>

## 1c. Determine if Immediate Risk of Substantial Harm

- *Is this a case of “emergency” guardianship?*
- A guardianship case may come before the judge as a petition for emergency guardianship. For example, there is need for an urgent medical procedure and no one to provide informed consent, or there is a family dispute and someone is seeking to “kidnap” the individual to an unknown location. Most states, as well as the UGPPA<sup>17</sup> and the *National Probate Court Standards*<sup>18</sup> have provisions for emergency guardianship.
- In some states, and in the *UGPPA*, the appointment of an emergency guardian is *not a finding of diminished capacity*, or evidence that a permanent guardian is needed.
- Because time is of the essence, procedural requirements for emergency guardianships are less than for permanent guardianship. Thus, it is important to exercise **caution**.
- Be sure the case presents a **true emergency** according to state law. That is, the individual’s health, safety, or welfare will be substantially harmed over the time it takes for compliance with regular guardianship procedures.
- Be sure the emergency guardianship does not become an **automatic doorway** to permanent guardianship that bypasses procedural safeguards.

## Step Two: Gather Information

### 2a. Receive Reports

- Information about the case may be brought by many parties.
- A **Court Investigator Report** (a guardian ad litem or other court investigator or visitor—the use of these terms varies by jurisdiction) may be required or requested.

As the eyes and ears of the court, the investigator can identify the triggering issue, less restrictive alternatives, risk of harm, whether there is a need for clinical evaluation, whether the individual requires counsel, the family situation, who might provide important testimony, and suggestions for limitations to guardianship and/or elements of a guardian plan, as well as evaluate the six pillars of capacity.

  - See [page 20](#) for a model court investigator report.
- A **Clinical Evaluation Report** may be required or requested.

A comprehensive evaluation will cover all six pillars of capacity, namely: the medical condition, cognitive functioning, everyday functioning, values and preferences, risk and level of supervision needed (including social support), and means to enhance capacity at the hearing and later.

  - See [page 23](#) for a model order for clinical evaluation.
- Families and other lay persons may submit affidavits providing important information.

### 2b. Ascertain if More Information Is Necessary

- After reviewing the information, further assessment or investigation may be necessary for the following reasons:
  - ▶ **State statutory requirements.** State statutes set out the necessary elements of a clinical evaluation, which generally reflect the elements in the state definition of “incapacitated person.”<sup>19</sup> For specific statutory requirements of clinical evaluations, see <http://www.abanet.org/aging/guardianship.html>.
  - ▶ **Red flags signaling need for more in-depth information.** If the individual has temporary or reversible causes of cognitive impairment or other mitigating factors that have not been addressed, a more sophisticated and in-depth evaluation is warranted. 
  - ▶ **Clinical statement appears one-sided.** A clinical evaluation secured by the petitioner is for the purpose of supporting the petition and may lack attention to the individual’s areas of strength, a prognosis for improvement, or important situational factors. An independent assessment can flesh out skeletal or purely one-sided information.

## 2c. Obtain Additional Reports

- If a review of the information reveals that information is not available on all six pillars of capacity assessment or has other shortcomings, then more information must be obtained from the clinician, court investigator, family, or other informants. a model order for independent evaluation.
- A judge may need to order an independent and more comprehensive evaluation by a clinical professional. See [page 23](#) for a model order for independent evaluation.

## Step Three: Conduct Hearing

### 3a. Take Judicial Note of Reports

The judge by his or her own motion may recognize the report of the guardian ad litem, or physician's report or other clinical statement, and admit them into evidence.

### 3b. Receive Testimony

The judge may receive testimony from witnesses, such as relatives, friends, neighbors, care providers, geriatric care managers, or others, called by the petitioner or the individual who is the subject of the petition. The individual, him or herself, may or may not speak. In some jurisdictions and in some cases, the guardian ad litem or court investigator makes a statement.

### 3c. Accommodate, Observe, and/or Engage the Individual

- The individual has a **right** to be present at the hearing.
- About half of the state laws and the UGPPA **require** that the individual be present unless good cause is shown.
- **The individual's presence is encouraged as it:**
  - Allows his or her involvement in the proceedings. Often, people may want their "day in court" and feel more satisfaction from the hearing if they are present and involved, whether a guardian is appointed or not.
  - Allows the judge an opportunity to observe, personally, the individual.
  - May shed a different light on the case.
- **The individual may not be present if:**
  - A medical condition prevents it (e.g., person is in a coma).
  - The individual does not wish to come.
- To determine if the individual can attend, obtain clinical or court investigative reports concerning the individual's presence at the hearing. Assessments of whether attendance at the hearing would be harmful or not realistically possible may be included in the petition, clinical evaluation form, or court investigator report.
- **The following questions may guide this process:**
  - Does the individual want to be present?
  - Would it be harmful in any way?
  - Would the individual understand at least some of the proceeding?
  - Would the individual be able to communicate in court?
  - What accommodations are needed (e.g., hearing amplifier, move location of hearing) to maximize participation?

The individual and his or her attorney will determine whether the person becomes a witness. However, in an uncontested case, the judge may gain insight and/or may make the person feel involved by engaging him or her with a few questions.

## Step Four: Make Determination

### 4a. Analyze Evidence in Relation to Elements of State Law

#### **1. The Medical Condition**

*What is the medical cause of the individual's alleged incapacities and will it improve, stay the same, or get worse?* Based on up-to-date clinical reports, determine the cause of the diminished capacity. Depression and delirium are often mistaken for dementia and need to be ruled out.

#### **2. Cognitive Functioning**

*In what areas is the individual's decision-making and thinking impaired and to what extent?* Consider whether the individual is lucid or confused, alert or comatose, or can understand information, communicate, or can remember information over time. Consider areas of strength and weakness and the severity of impairment.

#### **3. Everyday Functioning**

*What can the individual do and not do in terms of everyday activities? Does the individual have the insight and willingness to use assistance or adaptations in problem areas? Can the person:*

##### **Care of Self**

- Maintain adequate hygiene, including bathing, dressing, toileting, dental
- Prepare meals and eat for adequate nutrition
- Identify abuse or neglect and protect self from harm

##### **Financial**

- Protect and spend small amounts of cash
- Manage and use checks
- Give gifts and donations
- Make or modify a will
- Buy or sell real property
- Deposit, withdraw, dispose, or invest monetary assets
- Establish and use credit
- Pay, settle, prosecute or contest any claim
- Enter into a contract, financial commitment, or lease arrangement
- Continue or participate in the operation of a business
- Resist exploitation, coercion, undue influence

##### **Medical**

- Make and communicate a healthcare decision or medical treatment
- Choose health facility
- Choose and direct caregivers
- Make an advance directive
- Manage medications
- Contact help if ill or in a medical emergency

##### **Home and Community Life**

- Maintain minimally safe and clean shelter
- Be left alone without danger
- Drive or use public transportation

- Make and communicate choices about roommates
- Initiate and follow a schedule of daily and leisure activities
- Travel
- Establish and maintain personal relationships with friends, relatives, co-workers
- Determine his or her degree of participation in religious activities
- Use telephone
- Use mail
- Avoid environmental dangers, such as the stove and poisons, and obtain appropriate emergency help

#### **Civil or Legal**

- Retain legal counsel
- Vote
- Make decisions about legal documents
- Other rights under state law

#### **4. Consistency of Choices with Values, Patterns, and Preferences**

*Are the person's choices consistent with long-held patterns or values and preferences?* Each of the above factors must be weighed in view of the individual's history of choices and expressed values and preferences. Do not mistake eccentricity for diminished capacity. Actions that may appear to stem from cognitive problems may in fact be rational if based on lifetime beliefs or values. Long-held choices must be respected, yet weighed in view of new medical information that could increase risk, such as a diagnosis of dementia.

Key areas to consider include matters such as:

- Does the individual want a guardian?
- Does the individual prefer that decisions be made alone or with others?
- Whom does the individual prefer to be guardian/make decisions?
- What makes life good or meaningful for an individual?
- What have been the individual's most valued relationships and activities?
- What over-arching concerns drive decisions—e.g., concern for the well-being of family, concern for preserving finances, concern for maintaining privacy, etc.?
- Are there important religious beliefs or cultural traditions?
- What are the individual's strong likes, dislikes, hopes, and fears?
- Where does the individual want to live?

#### **5. Risk of Harm and Level of Supervision Needed**

*What is the level of supervision needed? How severe is the risk of harm to the individual?* Determine what degree of supervision will address the individual's needs and mitigate the risk of harm.

#### **6. Means to Enhance Functioning**

*What treatments might enhance the individual's functioning?* Consider if treatments for the underlying condition might improve functioning. Notice whether the individual might be able to use technological aids to maintain independence. Key interventions are:

- Education, training, or rehabilitation
- Mental health treatment
- Occupational, physical, or other therapy
- Home or social services
- Medical treatment, operation, or procedure
- Assistive devices or accommodation

## 4b. Categorize Judgment and Make Findings

- There is no simple formula that will help judges make the determination. The following broad classification could serve as an initial schema:
  - If **minimal or no** incapacities, petition not granted, use less restrictive alternative.
  - If **severely diminished** capacities in all areas, or if less restrictive interventions have failed, use plenary guardianship.
  - If **mixed strengths and weaknesses**, use limited guardianship.
- When appropriate (or if required by law), a concise written record of the key findings and rationale for the judge’s decision will serve as:
  - the basis for any appeal;
  - the basis for limiting the guardianship order; and
  - the basis for an effective plan to serve the individual’s needs.

## 4c. If Limited Order, Identify Rights Retained and/or Removed

- The cases in which there are “mixed areas” of strengths and weaknesses present the greatest challenge—and the greatest opportunity—for the “judge as craftsman” to tailor a limited order to the specific needs and abilities of the individual.

## 4d. Identify Statutory Limits of Guardian’s Authority

- State guardianship statutes, honed by state case law, will set the start-point on which to base the scope of the court order. Statutes vary in the extent of rights and duties automatically transferred to the guardian.
- In many states, most or all rights are transferred to the guardian unless retained with the incapacitated person by court order.
- In other states, all rights are retained unless specifically transferred to the guardian by court order.
- Some statutes carve out basic rights that are retained by the individual unless the court orders otherwise—such as the right to vote or the right to make a will.

## Step Five: Ensure Court Oversight

### 5a. Monitor Changes in Capacity and Guardian Actions

- Court monitoring of guardianships has many critical functions, one of which is monitoring changes to the individual's level of capacity.
- **Short-term Review of Capacity**  
If the individual's level of capacity may improve soon with treatment (e.g., for subdural hematoma after a fall), the guardianship should be referred for review within a short time period.
- **Annual Review of Capacity**  
Unlike with probate of decedents' estates, in guardianship there is a living being whose needs may change over time, may last for many years, and may include excruciatingly complex decisions about medical treatment, placement, and trade-offs between autonomy and beneficence. An initial assessment on which the court made an original order may no longer be valid and a re-assessment may be required. A limited order or guardianship plan may require revision. Annual reports should note changes in capacity.
- See [page 37](#) for a model annual report.

### 5b. Instruct Guardian

- The guardian can be provided immediate instructions by the court, which may include the frequency of reporting and the requirement to submit a guardianship plan.
- A guardianship plan, required in some jurisdictions, is a forward-looking document in which the guardian describes to the court the proposed steps to be taken for care of the individual. A guardianship plan provides an avenue to promote individual autonomy and rights, as well as to strengthen accountability. Guardianship plans are useful because they<sup>20</sup>:
  - ▶ Establish a baseline against which subsequent reports can be measured.
  - ▶ Reflect care-planning for nursing home residents under federal regulations.<sup>21</sup>
  - ▶ Allow for minor changes without consulting the court, but would require court approval for any substantial adjustments.
- Guardianship plans should involve the incapacitated person to the extent possible to outline the services and strategies that will be used to implement the order, including, most importantly, how those rights retained in limited orders will be ensured. Even where legal consent is not possible, the assent of the person should be sought.
- Guardianship plans can detail treatments and services and the values that should guide future decisions as have been discovered in the clinical and court investigative reports.
- See [page 35](#) for a model guardianship plan.

## **APPENDIX 1: MODEL ORDERS AND FORMS**

These materials are available online at <http://www.abanet.org/aging>;  
<http://www.apa.org/pi/aging>; and <http://www.ncpj.org>.

**These forms match the general framework  
presented in this book.**

**Revise these forms according to your  
jurisdictional needs and laws.**

## Model Form for Confidential Judicial Notes

State of	In the XXX Court of Justice XXX Division
County of	File No.
In the Matter of:	
<b>Procedural</b>	
<b>Procedural Requirements.</b>	
Is venue proper?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are notice and service proper?	<input type="checkbox"/> yes <input type="checkbox"/> no
Has counsel been appointed if required or if needed?	<input type="checkbox"/> yes <input type="checkbox"/> no
Has individual been informed of hearing rights?	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Appropriateness of Guardianship.</b>	
Will guardianship solve this problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have all less restrictive alternative been exhausted?	<input type="checkbox"/> yes <input type="checkbox"/> no
<i>If emergency guardianship requested</i>	
Is there immediate risk of substantial harm?	<input type="checkbox"/> yes <input type="checkbox"/> no
Would individual be harmed if regular guardianship procedures used?	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Clinical Reports.</b>	
Does it meet state requirements?	<input type="checkbox"/> yes <input type="checkbox"/> no
Is it balanced (vs. one sided)?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are reversible causes of impairment / mitigating factors considered?	<input type="checkbox"/> yes <input type="checkbox"/> no

## **Determination**

### **The Medical Condition**

What is the medical condition affecting functioning?

How long has it been going on and other historical facts?

How severe is the condition?

Will it improve with time or treatment?

What are the reversible or mitigating factors?

### **Cognitive Functioning**

In what areas are the individual's decision-making and thinking impaired and to what extent?

### **Everyday Functioning**

Financial Strengths:

Weaknesses:

Health Care Strengths:

Weaknesses:

Personal Safety and Hygiene Strengths:

Weaknesses:

Home and Community Strengths:

Weaknesses:

Other Civil Matters Strengths:

Weaknesses:

### **Consistency of Choices with Values, Patterns, and Preferences**

Does the individual want a guardian? If so, whom?

How does the person prefer decisions are made (alone or with others)?

Where does the person want to live? Why?

What makes life meaningful or good?

What factors are of greatest concern to this person in making decisions?

Are there any religious or cultural beliefs to be considered?

### **Risk of Harm and Level of Supervision Needed**

What are the risks to the individual?

What social factors protect or increase risk?

How significant is this risk? How likely is the risk?

What level of supervision is needed to ensure safety while preserving autonomy?

### **Means to Enhance Functioning**

What treatments or accommodations might enhance the individual's functioning?

### **Categorization of finding**

[ ] **Minimal or no diminished** capacity → **less restrictive alternatives, dismiss petition.**

[ ] **Severely diminished** capacities on all fronts → **plenary guardianship.**

[ ] **Mixed** strengths and weaknesses → **limited guardianship.**

Limits, special:

Limits, statutory requirements:

## **Oversight**

### **Period of Review**

Condition may improve

Time-limited guardianship → guardianship will expire in \_\_\_ days.

or

Short-term review → guardian to  file inventory/appraisal  
 report on medical status  
in \_\_\_ days.

or

Annual review → guardian to file report in 12 months.

### **Guardian Report**

**Bond/Sureties:**

**Inventory/Appraisal:**

**Financial Accounting:**

### **Guardianship Plan – Elements of Care Planning:**

Treatments to be considered:

- Education, training, or rehabilitation
- Mental health treatment
- Occupational, physical, or other therapy
- Home or social services
- Medical treatment, operation, or procedure
- Assistive devices or accommodation

Notes on plan:

Medical needs:

Personal needs:

Financial needs:

Values to be considered:

## Model Court Investigator Report

State of	In the XXX Court of Justice XXX Division
County of	File No.
In the Matter of:	

### **1. Screen Case**

#### **1a. Review Trigger**

What brings the case to court now?

#### **1b. Appropriateness of Guardianship**

Have all procedural requirements been met?  yes  no

Will guardianship solve this problem?  yes  no  
If not, why not?

Have less restrictive alternatives been explored?  yes  no  
If not, suggest less restrictive alternatives to try:

#### **1c. Appropriateness of Emergency Procedures (if Emergency Guardianship Requested)**

Is there immediate risk of substantial harm? (medical emergency, abuse)  yes  no  
Describe:

Would individual be harmed if regular guardianship procedures were used?  yes  no  
How?

### **2. Gather Information**

#### **2a. Receive Reports**

Who has submitted affidavits or reports?

- Individual (alleged incapacitated person)  Family  
 Healthcare Professionals  Adult Protective Service  
 Other: \_\_\_\_\_

#### **2b. If a Healthcare Professional Has Submitted a Report**

Does it meet state requirements?  yes  no

Is it balanced (vs. one sided)?  yes  no

Is information sufficient for capacity?

- Medical conditions  Severity  Prognosis  Reversible causes of dementia  
 Cognitive and emotional functioning  Everyday functioning  
 Values and preferences  Risk of harm  
 Treatments, accommodations, or devices that may improve capacity

#### **2c. If Additional Information Is Needed, Obtain Additional Information**

- Written reports by the individual, family, healthcare professionals  
 Interviews with individual, family, healthcare professionals

**Notice**

Who served notice?

Where was notice served?

Describe how the individual's rights were communicated and the method (written, verbal) and language used:

What was the individual's understanding of the concept of guardianship?

good       fair       poor       unable to determine

What was the individual's attitude towards guardianship?

consenting     opposed     unable to determine

**Interview**

Date and place of interview:

Physical health:                     excellent     good         fair         poor

Comments:

Mental health:                     excellent     good         fair         poor

Comments:

Cognitive functioning:             excellent     good         fair         poor

Comments:

Emotional functioning:             depressed     anxious     manic       psychotic

Comments:

Everyday abilities (ability to care for self, make financial and medical decisions, live independently):

**Recommendations for the Hearing**

Is the individual able to attend the hearing?

If yes, what accommodations should be made for the individual?

What needs are there regarding representation of the individual by counsel?

Who should testify at the hearing?

**Recommendations for the Guardianship Order**

Is guardianship needed?

Can this order be limited in any way? If yes, how?

**Recommendations for the Guardianship Plan**

What education, training, treatment, procedure, devices, or living situation might help the individual?

## **Supplemental Attachment for Court Investigator Report Capacity Checklist**

**Use this checklist to determine if there is sufficient information regarding the individual's capacity.**

### **1. Medical Condition**

What are the physical diagnoses? How severe are they? Might they improve? When?  
What are the mental diagnoses? How severe are they? Might they improve? When?  
When did the problem start, how long has it been going on, are there any recent medical or social events, what treatments and services have been tried?:  
What are the medications, including dosage? Could medications make capacity worse?  
Have all temporary or reversible causes of cognitive impairment been evaluated and treated?  
Are there any mitigating factors (e.g., hearing loss, vision loss, bereavement) that may cause the person to appear incapacitated and could improve with time or treatment?

### **2. Cognitive Functioning**

What is the individual's level of alertness/arousal, orientation, memory and cognitive abilities, psychiatric and emotional state?

### **3. Everyday Functioning**

What can the individual do in terms of taking care of self? Making financial decisions? Making medical decisions? Taking care of the home environment and functioning independently in the community?  
What is the level of functioning related to any other specific legal matters in this case (e.g., sale of home, move to nursing home)?

### **4. Values**

Does the person want a guardian? If yes, who does the person want to be guardian?  
Where does the person want to live? What is important in a home environment?  
What makes life good or meaningful for an individual? What have been the individual's most valued relationships and activities?  
Does the individual prefer that decisions be made alone or with others? If others are involved, with whom does the individual prefer to make decisions?  
What over-arching concerns drive decisions—e.g., concern for the well-being of family, concern for preserving finances, worries about pain, concern for maintaining privacy, etc.?  
Are there important religious beliefs or cultural traditions? What are the individual's strong likes, dislikes, hopes, and fears?  
Are there any specific preferences regarding decisions for personal care, financial, medical, or living situation?

### **5. Risk of Harm and Level of Supervision Needed**

Is there immediate risk of substantial harm? Is there an ongoing level of risk of harm to the individual or others? How/why? Has the individual been victim to abuse, neglect, or exploitation? What level of supervision and what level of guardianship is needed to protect the individual?

### **6. Means to Enhance Capacity**

Can the individual attend the hearing?  
Are any accommodations necessary for the hearing, such as change of location, adjusting approach for hearing, visual, cognitive loss? Holding the hearing at bench or in chambers?  
In the future, would any education, training, treatment, assistive device, or housing arrangement benefit the individual?

## Model Order for Clinical Evaluation

State of	In the XXX Court of Justice XXX Division
County of	File No.
In the Matter of:	

1. Provide a clinical evaluation of (*name*) for the purposes of guardianship.
2. The purpose of this evaluation is to enable to the court to determine whether the individual identified above is incapacitated according to (*state*) definition, and requires a guardian. (*Add any other issues that are also facing the court, e.g., issues requiring special powers.*)
3. This individual is being evaluated for guardianship due to (*give any background information that is essential to understanding the case*).
4. Additional historical information that may be helpful to you in understanding the case is (*cite examples of problem behavior, social, medical, or legal background factors*).
5. For the purpose of guardianship in this state, the following definition of incapacity applies: (*cite statutory standard for an incapacitated person*).
6. Whenever possible, this court seeks to limit any guardianship orders, providing the guardian with authority only in the areas in which the individual needs decisional or functional assistance.
7. In your report, please address the following elements:
  - (i). Describe mental or physical conditions impacting everyday functioning, including: diagnosis, severity of illness, prognosis, history, medications. Describe any medical or psychosocial factors that may be the cause of temporary and reversible impairment, such as depression, malnutrition, dehydration, transfer trauma, polypharmacy, alcohol use, or other factors that require immediate attention.
  - (ii). Describe the level of alertness/arousal, cognitive functioning, and psychiatric or emotional symptoms.
  - (iii). Describe the individual's strengths and weaknesses in the following areas:
    - Care of self
    - Financial
    - Health care
    - Home and community life
    - Civil matters

- (iv) Indicate extent to which current choices are consistent with the individual's long-held commitments and values. Is there any information about the individual's values or preferences that should be considered in the guardianship determination and plan? Do educational potential, adaptive behavior, or social skills enhance current or future functioning?
  - (v) Given the above diagnosis and functional strengths/weaknesses, what is the immediate and ongoing risk of harm to the individual? What social and environmental demands/supports increase or decrease risk? What level of supervision is needed to prevent serious harm?
  - (vi) What treatments and services might help the person? What is the most appropriate housing situation? Can any needs can be met with any less restrictive alternatives to guardianship?
  - (vii). Can the individual attend the hearing? If so, what accommodations should be considered to maximize the individual's participation?
8. Record the results of your evaluation on the enclosed form.
  9. Indicate your professional licensure and professional expertise.
  10. Note that a court-ordered clinical evaluation for guardianship is a statement signed under the penalties of perjury.

## Model Clinical Evaluation Report

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

See  for instructions.

**Note, text boxes appear in online form and will expand to size of text.**

### 1. PHYSICAL AND MENTAL CONDITIONS

#### A. List Physical Diagnoses:

Overall Physical Health:  Excellent  Good  Fair  Poor

#### B. List Mental (DSM) Diagnoses:

Overall Mental Health:  Excellent  Good  Fair  Poor

Overall Mental Health will:  Improve  Be stable  Decline  Uncertain

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

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

#### C. List all Medications:

Name	Dosage/Schedule

These medications may impair mental functioning:  Yes  No  Uncertain

#### D. Reversible Causes.

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

Explain:

#### E. Mitigating Factors.

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

Yes  No  Uncertain

Explain:

**2. COGNITIVE AND EMOTIONAL FUNCTIONING** Describe below or  in Attachment the individual's strengths and weaknesses.

**A. Alertness/Level of Consciousness**

Overall Impairment:  None  Mild  Moderate  Severe  Non Responsive  
Describe:

\_\_\_\_\_

**B. Memory and Cognitive Functioning**

Overall Impairment:  None  Mild  Moderate  Severe  
Describe below or  in Attachment

\_\_\_\_\_

**C. Emotional and Psychiatric Functioning**

Overall Impairment:  None  Mild  Moderate  Severe  
Describe below or  in Attachment

\_\_\_\_\_

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

**3. EVERYDAY FUNCTIONING.** Describe below or  in Attachment the individual's strengths and weaknesses.

**A. Activities of Daily Living (ADL'S)**

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

Level of Function:  Independent  Needs Support  Needs Assistance  Total Care  
Describe:

\_\_\_\_\_

**B. Instrumental Activities of Daily Living (IADL'S)**

**Financial Decision-Making** (bills, donations, investments, real estate, wills, protect assets, resist fraud, etc.)

Level of Function:  Independent  Needs Support  Needs Assistance  Total Care  
Describe:

\_\_\_\_\_

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

Level of Function:  Independent  Needs Support  Needs Assistance  Total Care  
Describe:

\_\_\_\_\_

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

Level of Function:  Independent  Needs Support  Needs Assistance  Total Care  
Describe:

\_\_\_\_\_

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

Level of Function:  Independent  Needs Support  Needs Assistance  Total Care  
Describe:

\_\_\_\_\_

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

\_\_\_\_\_

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

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

\_\_\_\_\_

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

\_\_\_\_\_

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

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

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

- Locked facility  24-hr supervision  Some supervision  No supervision

Needs could be met by:  Limited Guardianship  Less Restrictive Alternative

If checked, Explain:

\_\_\_\_\_

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

Education, training, or rehabilitation  Yes  No  Uncertain

Mental health treatment  Yes  No  Uncertain

Occupational, physical, or other therapy  Yes  No  Uncertain

Home and/or social services  Yes  No  Uncertain

Assistive devices or accommodations  Yes  No  Uncertain

Medical treatment, operation or procedure  Yes  No  Uncertain

Other: \_\_\_\_\_  Yes  No  Uncertain

Describe any specific recommendations:

\_\_\_\_\_

7. **ATTENDANCE AT HEARING**

The individual can attend the hearing  Yes  No  Uncertain

If no, what are the supporting facts:

\_\_\_\_\_

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

\_\_\_\_\_

## 8. CERTIFICATIONS

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

Office Address:

Office Phone:

This form was completed based on:

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

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

- Yes  
 No

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

Time spent in examination:

Other sources of information for this examination:

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

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

\_\_\_\_\_

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

SIGNATURE of CLINICIAN

DATE

Print name

License type, number, and date

## Supplemental Attachment/Links for Clinical Evaluation Report

These rating categories MAY be used in more complex cases when more detail is DESIRED by the clinician or court.

### Cognitive Functioning

**1. Sensory Acuity** (detection of visual, auditory, tactile stimuli)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**2. Motor Activity and Skills** (active, agitated, slowed; gross and fine motor skills)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**3. Attention** (attend to a stimulus; concentrate on a stimulus over brief time periods)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**4. Working memory** (attend to verbal or visual material over short time periods; hold  $\geq 2$  ideas in mind)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**5. Short term/recent memory and Learning** (ability to encode, store, and retrieve information)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**6. Long term memory** (remember information from the past)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**7. Understanding** (“receptive language”; comprehend written, spoken, or visual information)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**8. Communication** (“expressive language”; express self in words, writing, signs; indicate choices)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**9. Arithmetic** (understand basic quantities; make simple calculations)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**10. Verbal Reasoning** (compare two choices and to reason logically about outcomes)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**11. Visual-Spatial and Visuo-Constructional Reasoning** (visual-spatial perception, visual problem solving)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**12. Executive Functioning** (plan for the future, demonstrate judgment, inhibit inappropriate responses)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

## Emotional and Psychiatric Functioning

**1. Disorganized Thinking** (rambling thoughts, nonsensical, incoherent thinking)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**2. Hallucinations** (seeing, hearing, smelling things that are not there)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**3. Delusions** (extreme suspiciousness; believing things that are not true against reason or evidence)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**4. Anxiety** (uncontrollable worry, fear, thoughts, or behaviors)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**5. Mania** (very high mood, disinhibition, sleeplessness, high energy)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**6. Depressed Mood** (sad or irritable mood)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**7. Insight** (ability to acknowledge illness and accept help)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**8. Impulsivity** (acting without considering the consequences of behavior)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:

**9. Noncompliance** (refuses to accept help)

Level of impairment:  None  Mild  Moderate  Severe  Not eval.

Describe:



## Values

### 1. Values about guardianship

Does the person want a guardian?

If yes, who does the person want to be guardian?

### 2. Preferences for how decisions are made

Does the individual prefer that decisions be made alone or with others?

### 3. Preferences for habitation

Where does the person want to live?

What is important in a home environment?

### 4. Goals and Quality of Life

What makes life good or meaningful for an individual?

What have been the individual's most valued relationships and activities?

### 5. Concerns, Values, Religious Views

What over-arching concerns drive decisions—e.g., concern for the well-being of family, concern for preserving finances, worries about pain, concern for maintaining privacy, desire to be near family, living as long as possible, etc.?

Are there important religious beliefs or cultural traditions?

What are the individual's strong likes, dislikes, hopes, and fears?

# Model Order for Guardianship of Person and Estate<sup>1</sup>

State of _____ County of _____	In the XXX Court of Justice XXX Division File No. _____
In the Matter of:	<b>I. Order on Petition For Adjudication of Incapacity And Order Appointing Guardian</b>
This matter is before the court on a petition for an adjudication of incapacity and appointment of a guardian for the individual. The court has read the petition and held a hearing to determine whether the court should enter the order requested in the petition.	
<b>THE COURT FINDS:</b>	
1. <b>JURISDICTION, VENUE, AND NOTICE.</b> A. This court has jurisdiction of the subject matter and of the person of the individual. B. This court is a proper venue. C. Notice was properly served.	
2. <b>MEDICAL CONDITION AND CAPACITY.</b> Upon presentation of ( <i>cite standard of evidence</i> ) evidence, the above named individual by reason of the following medical conditions:  ___ Is not incapacitated. The petition is dismissed.  ___ Is an incapacitated person ( <i>cite statutory standard for incapacity</i> ).  ___ Is a partially incapacitated person. <u>Care of Self</u> Retained Capacities:  <u>Financial Decisions</u> Retained Capacities:  <u>Health Care Decisions</u> Retained Capacities:  <u>Living in the Home and Community</u> Retained Capacities:  <u>Other Civil Matters</u> Retained Capacities:	
3. <b>VALUES AND PREFERENCES.</b> Relevant values, preferences, and patterns of past choices of the individual considered:  A reasonable effort was made to question the individual and he/she indicated: [ ] no preference as to who should be appointed guardian.  [ ] that he/she preferred _____ to serve as guardian.	

<sup>1</sup> This is a model form for guardianship of person and estate. For a model form for guardianship of estate, often called conservatorship, the form could include the same elements, but focus only on financial capacities and related actions of the conservator.

**IT IS ORDERED:**

4. **APPOINTMENT.** The court appoints (*name of guardian*) of (*address*) as guardian and directs issuance of letters of guardianship.

5. **LIMITATIONS AND POWERS.** The guardianship is

**Unlimited** (Plenary).

**Limited.** The above named individual shall retain the following legal rights and privileges (*cite all rights retained or removed*).

Further,

**Statutory Restrictions.** The guardian does not have the authority to (*cite any statutory or court-ordered restrictions, such as admission to mental health facility, modification of DNR, etc.*):

**Special Powers Granted.** The guardian has the authority to (*cite any powers being granted that require special court authority, such as admission to mental health facility, modification of DNR, etc.*):

6. **BOND**

The guardian must file a bond in the amount of \$ with the Clerk of the Court, Probate Register, before issuance of the letters.

Bond is not required and is waived.

7. **INVENTORY AND PLAN.** The guardian is instructed to

**Inventory and Appraisalment.** Within 90 calendar days, and with each required annual report, the guardian must prepare and file with the Clerk of the Court a detailed inventory of the individual's assets.

**Plan.** Within 90 calendar days, and with each required annual report, the guardian must prepare and file with the Clerk of the Court a plan detailing a plan of care for the individual and for the estate. The guardian shall consider the individual's values and preferences in making decisions.

**Report.** Annually the guardian must prepare and file with the Clerk of the Court a report.

8. **CHANGE OF ADDRESS.** The guardian shall immediately notify in writing to the court of any change in the address of him or herself or of the incapacitated person.

9. **REVIEW.** In addition to the annual review, it is further ordered, setting this matter for internal review within (no of days)  to determine

compliance with inventory and plan.

possible change in level of capacity.

10. **COSTS.** Pursuant to § , costs are:  waived  taxed to:  petitioner  individual

11. This order is the least restrictive alternative consistent with the court's finding, is necessitated by the individual's limitations and demonstrated need, and is designed to encourage the development of maximum self-reliance and independence.

Date:

Signature:

## Model Plan for Guardian of Person and Estate<sup>2</sup>

State of _____ County of _____	In the XXX Court of Justice XXX Division File No. _____
In the Matter of:	<b>I. Order on Petition For Adjudication of Incapacity And Order Appointing Guardian</b>

### Health Care Plan

1. Provide name of the person's physician:
2. Provide name(s) of other key healthcare professionals:
3. What instructions (such as advance directives) has this person provided about medical treatment?
4. Describe medical services to be provided (e.g., primary care visits, specialists, equipment, new medications, dental, etc.)

### Personal Care Plan

1. Where is the person residing now and what kind of facility is it? (For example, is it a private residence, assisted living, or nursing home, etc.?)
2. Do you anticipate needing to change the person's residence? If so, when and why?
3. Describe social services and activities to be provided (e.g., home care workers, religious services, visits with friends/family, education/recreation).

---

<sup>2</sup> This is a model form for a plan of guardianship of person and estate. For a plan for guardianship of estate, often called conservatorship, the form could focus only on financial capacities and related actions of the conservator.

**Financial Care Plan**

1. Describe the person's estimated monthly income, monthly expenditures, and estimate total assets (tangible and monetary):
  
  
  
  
  
  
  
  
  
  
2. Describe how the person's financial needs will be met:
  
  
  
  
  
  
  
  
  
  
3. In view of the needs of the protected person at this time, what assets will need to be sold in the coming year?
  
  
  
  
  
  
  
  
  
  
4. Are there debts owed to the person to be pursued? If so, how do you intend to pursue those claims (note whether litigation is necessary)?
  
  
  
  
  
  
  
  
  
  
5. Are there bills, claims, or debts by the person to another unpaid at this time? If so, how do you intend to discharge those obligations?
  
  
  
  
  
  
  
  
  
  
6. Describe how funds for the support, care, and welfare of others entitled to be supported by the protected person will be administered: (If not applicable, so state).
  
  
  
  
  
  
  
  
  
  
7. Describe the estate plan, if any, and how you intend to preserve it.

Signature of Guardian	Date
Address and Telephone of Guardian	

## Model Annual Report for Guardian of Person and Estate<sup>3</sup>

State of _____ County of _____	In the XXX Court of Justice XXX Division File No. _____
In the Matter of:	<b>I. Order on Petition For Adjudication of Incapacity And Order Appointing Guardian</b>

### 1. PERIOD OF REPORT

This is a full and true statement of account in the above matter, covering the period of

\_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year) to \_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year).

### 2. CONTACT

Approximate number of times the guardian had contact with the person during the reporting period:

Nature of those contacts (phone, in person, other):

Date last seen by the guardian:

### 3. ADDRESS OF INCAPACITATED PERSON

Street  
City, State, Zip Code  
Telephone

These living arrangements are best described as:

- Own apartment or home  
 Private home or apartment of  
     guardian  
     relative, whose name and relationship is:  
     non-relative, whose name is:

OR

- Foster, group, or boarding home  
 Nursing home  
 Assisted living  
 A medical facility or state institution

The name of the home, facility, or institution:

The name of an individual at the home, facility, or institution who has knowledge and is authorized to give information to the court:

The individual has been at the present residences since:

If moved within the past year, state the changes and reason for the change:

I rate the living situation as:      excellent    average    below average (explain:     )

I believe the adult is:            content    unhappy with the living situation

I recommend a more suitable living arrangement as follows:

<sup>3</sup> This is a model form for a report of guardianship of person and estate. For a model form for report on guardianship of estate, often called conservatorship, the form could focus only on financial capacities and related actions of the conservator.



<b>SUMMARY OF ASSETS AND EXPENDITURES</b>		
Beginning fair market value of non-cash assets	\$	
Beginning balance of cash (savings, checking, stocks, bonds, etc.) assets	+ \$	
Plus money received (pension, disability, interest, etc.) from any source on behalf of the person	+ \$	
<b>TOTAL</b>	<b>\$</b>	
Less total fees to other for care of person or estate	- \$	
Less assets transferred to guardian	- \$	
Less total fees paid to guardian	- \$	
<b>TOTAL CURRENT VALUE OF ESTATE</b>	<b>\$</b>	
The Guardian (or Conservator) represents that this account contains a correct statement of all receipts and disbursements and that its contents are true to the best knowledge and belief.		

I have on file a surety bond approved by the court [ ] yes [ ] no  
 If yes, the penal sum of the bond is \$ \_\_\_\_\_ with the \_\_\_\_\_ company as surety.

**9. RECOMMENDATIONS**

The guardianship should be continued [ ] yes [ ] no  
 Because:

The guardianship should be modified as follows:

Other recommendations:

Signature of Guardian	Date
Address and Telephone of Guardian	

Sworn to me

Signature of Notary	Date
My Commission expires	

## Glossary<sup>4</sup>

“**Activities of Daily Living**” means the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring.

“**Accommodations**” means adjustments or modifications to enable people with disabilities to enjoy equal opportunities.

“**Acuity**” means acuteness of perception. It may also refer to the immediate seriousness of an illness.

“**Affect**” refers to the expression of a person’s feelings, tone, or mood. For example, a person may be sad if their mood is depressed.

“**Assistive Devices**” means items or equipment that is used to increase, maintain, or improve functioning of individuals with disabilities.

“**Autonomy**” means a person’s ability to make independent choices.

“**Clinical**” means pertaining to or founded on observation and treatment of individuals, as distinguished from theoretical or basic science.

“**Clinician**” refers to any healthcare professional.

“**Cognitive**” means relating to thinking and information processing in the brain.

“**Conservator**” means a person who is appointed by a court to manage the estate of a protected person. The term includes a limited conservator.

“**Court Investigator**” means a person appointed by the court to investigate the merits of the guardianship petition. In some states such a person may be referred to as a guardian ad litem.

“**Dementia**” means a medical condition characterized by a loss of memory and functioning.

“**Domain**,” when used in cognitive assessment, refers to a category of brain functioning, often associated with a specific region in the brain. For example a domain of cognitive assessment could be memory after a time delay, which is localized to the temporal lobe of the brain.

“**Guardian**” means a person who has qualified as a guardian of an incapacitated person pursuant to appointment by the court. The term includes a limited, emergency, and temporary substitute guardian, but not a guardian ad litem.

“**Guardian ad litem**” means a person appointed by the court to represent and protect the interests of an incapacitated person during a guardianship proceeding.

“**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.

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<sup>4</sup> This glossary is meant to define terms **as used in this** book, and is not meant to define terms more universally. The glossary uses definitions from the UGPPA where available, and otherwise definitions are based on the consensus of the working group. Definitions of common mental disorders appear in the fact sheet on medical conditions.

**“Instrumental Activities of Daily Living”** means activities related to independent living, and include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

**“Least Restrictive Alternative”** means an intervention that causes the least disruption or change in a person’s circumstances and that maximizes the person’s independence and freedom.

**“Limited Guardianship”** means a guardianship appointment in which the guardian is assigned only those duties and powers that the incapacitated or partially incapacitated individual is incapable of exercising, rather than the full authority that could be assigned by the court.

**“Person”** means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

**“Plenary Guardianship”** means a full guardianship of the person and property in which all duties and powers concerning an individual under state law are assigned by the court to the guardian.

**“Polypharmacy”** means the unwanted duplication of drugs, which often results when patients go to multiple physicians or pharmacies. Polypharmacy occurs when prescribed medications duplicate or interact with each other.

**“Prognosis”** means the probable outcome of a disease.

**“Psychopathology”** refers to the manifestation of a mental disorder.

**“Reality Testing”** refers to the ability of a person to distinguish between the real in the external world and their internal world. For example, a person who has delusional thoughts (e.g., false beliefs that a person is trying to harm him or her) and cannot distinguish this from reality is said to have poor reality testing.

**“Respondent”** means an individual for whom the appointment of a guardian or conservator or other protective order is sought. In this book, we use the word “individual” when referring to the respondent.

**“Transfer Trauma”** means relocation stress and accompanying symptoms resulting from a transfer from one environment to another—as from one community residence to another, from a community residence to an institution or from one institution to another.

**“Ward”** means an individual for whom a guardian has been appointed. In this book, we use the word “individual” or “person” when referring to the respondent.

## **APPENDIX 2: FACT SHEETS Available online**

These materials are available online at

<http://www.abanet.org/aging>

<http://www.apa.org/pi/aging>

[http://www.ncpj.org.](http://www.ncpj.org)

# Capacity

## Presumption of Capacity

While legal definitions of capacity vary by jurisdiction and by circumstances in which the question of capacity is raised, one stable cornerstone of the law has been the principle that all adults are presumed competent until proven otherwise.<sup>22</sup> Adults have the right—even when frail, vulnerable, or eccentric—to make their own decisions and to govern their own affairs, even if their decisions are unwise and their methods objectionable to the reasonable observer. The burden rests on the party questioning the capacity of an individual to establish the lack of capacity, and the nature and extent of harm resulting from the lack of capacity.

## Capacity Is Task-Specific, Not Global

The definition of “diminished capacity” in everyday legal practice depends largely on the type of transaction or decision under consideration.<sup>23</sup> The law recognizes that capacity is not an all-or-nothing phenomenon. One may lack the capacity to handle one’s financial affairs, for example, but still retain the capacity to make health care decisions or to vote in elections. The application of limited guardianship is tied directly to this recognition of the task-specific reality of capacity.

## Capacity Can Fluctuate

Capacity status can fluctuate over time. Capacities that were initially lost (e.g., as a result of a head injury, transient acute psychosis, severe depression that later remits) may be recovered over time. Dementias such as Alzheimer’s disease will result in fluctuating levels of capacity through the early and mid-stages of the disease. Also, cognitive deficiencies that suggest incapacity are often caused by treatable and reversible physical causes, such as overmedication, toxic combinations of medications, poor diet, vitamin deficiencies, infectious diseases, poor eyesight, or other conditions. By discovering and addressing medically treatable conditions first, capacity issues may be rendered moot or at least decreased.

## Capacity Is Situational

Appropriate capacity assessment never happens in a vacuum. It occurs in the context of the resources and support available to the individual. The supports may be social, such as a caregiver who can monitor the individual’s medication regimen; legal, such as a trust or durable power of attorney that enables appropriate management of one’s affairs; technological, such as an emergency help alert transmitter; or any other support.

## Capacity Is Contextual

The contextual element of capacity goes a step beyond the question of resources available to the individual and considers how the individuals interact with those resources and with their social and physical environment. Issues of undue influence, exploitation, or threat can directly affect the autonomy, functioning, and well being of the person with diminished capacity. Likewise, a home environment that is familiar and comfortable for the individual may enhance capacity, while a new and unfamiliar setting may undermine functional capacity.

## Clinical Professionals

A clinician is a general term for a healthcare professional who works with patients. A wide range of clinicians may bring expertise to the capacity evaluation process. *The information provided on this page is meant to highlight some of the strengths that varied professionals may bring to the capacity evaluation practice. It is not meant to define or limit the absolute, necessary, or full scope of practice for these professionals, but rather to highlight some potential strengths each discipline may bring to the capacity evaluation process.*

**Geriatricians, Geriatric Psychiatrists, or Geropsychologists**, practitioners with specialized training in aging, are experienced in considering the multiple medical, social, and psychological factors that may impact an older adult's functioning. A geriatric assessment team is comprised of multiple disciplines, each with advanced training in syndromes of aging.

**Neurologists**, M.D.'s with specialized training in brain function, may address how specific neurological conditions (e.g., dementia) are affecting the individual and his/her capacity.

**Neuropsychologists**, psychologists with specialized training in cognitive testing, may address relationships between neurological conditions, cognitive tests results, and an individual's functional abilities.

**Nurses** have medical expertise and some, such as visiting nurses in Area Agencies on Aging, may have in-depth information on how a person's medical condition is impacting functioning in the home. Geriatric nurse practitioners are advanced practice nurses with additional credentials to assess and treat the medical problems of aging.

**Occupational Therapists** are professionals with advanced degrees specializing in the assessment of an individual's functioning on everyday tasks, such as eating, meal preparation, bill paying, cleaning, and shopping.

**Physicians**, (primary care clinicians or internists) can provide a summary of the individual's major medical conditions. In some cases, the physician may have provided care to the individual over many years and can provide a historical perspective on the individual's functioning (although this cannot be assumed).

**Psychiatrists**, M.D.'s with specialized training in mental health, may address how specific psychiatric conditions (e.g., schizophrenia) and related emotional/mental systems may be affecting the individual and his/her capacity. Geropsychiatrists receive additional training in problems of aging; forensic psychiatrists receive additional training in mental health and the law.

**Psychologists**, clinicians with advanced training in behavioral health, may utilize standardized testing and in-depth assessment, useful when the judge wants detailed information about areas of cognitive or behavioral strengths or weaknesses. Geropsychologists receive additional training in problems of aging; forensic psychologists receive additional training in mental health and the law.

**Social workers**, are trained to consider the multiple determinants on an individual's social functioning, and are often knowledgeable about a wide range of social and community services that may assist the individual.

## Clinical Evaluation Report Instructions

### Explanation of the Form

- The model clinical evaluation form provides a framework for summarizing a clinical evaluation for the purposes of guardianship.
- This form was **based on**:
  - The 1997 Uniform Guardianship and Protective Proceedings Act.
  - Existing model forms in guardianship across the United States.
  - Review of drafts by physicians, psychiatrists, psychologists, and social workers.
- There were **several challenges** in developing this form:
  - To be appropriate across the range of severity – e.g., from the person in a coma to the person with mild impairment and mixed strength and weakness.
  - To accommodate the wide variation in approaches to clinical assessment used by different health care professionals.
- As a result, this form:
  - Uses legal language which may be atypical for some clinicians (e.g., “mental condition” instead of “DSM diagnosis”).
  - Follows the “six pillar” format presented in the judge’s book.
  - Offers major headings of assessment, leaving subheadings to clinicians’ discretion.
- Note that:
  - Additional information in complex cases can be provided in expandable text boxes or attached to the form (using supplemental form pages if desired).
  - Can be adapted and modified at will to clinical or jurisdictional needs.

### General Provisions for Clinical Evaluation

- A capacity evaluation is considered expert testimony, and should therefore meet standards of admissibility as applied within the clinician’s jurisdiction (referred to as “Daubert” standards in some jurisdictions). As such, clinicians may wish to indicate the evidence for each decision made or basis for the judgment made.
- An effort should be made to obtain **informed consent** or assent to the evaluation. A warning of the potential risks of participating in the evaluation should be provided, namely, that information will not remain confidential. Note that under the Health Insurance Portability and Accountability Act protected information can be provided to courts for guardianship proceedings. HIPAA protects the privacy of health information, but it cannot be used as a barrier to providing required information to a court. For information about HIPAA, see <http://www.hhs.gov/ocr/hipaa>
- The number of examination sessions required for the evaluation will vary based on the complexity of the evaluation. For complex cases, examination on **more than one occasion** is preferable to allow for assessment of potential variability in functioning from day to day.
- For situations where a clinical team is not required, input from multiple disciplines is still encouraged (e.g., occupational therapist assessment, social service evaluation). If used, those individual’s names should be listed on the signature page and associated reports may be attached.
- Note that the ultimate decision about the client’s capacities is a legal judgment.

## **1. Mental and Physical Condition**

Complete the categories noted. Information on prognosis and history is often left out clinical evaluations for guardianship purposes, but is key for the judge in determining any time limitations on orders. Also note that delirium can be confused with dementia, therefore describe whether potentially reversible causes of cognitive impairment have been considered.

## **2. Cognitive Limitations**

Describe the individual's level of alertness or arousal, cognitive functioning, and emotional or psychiatric functioning.

- Cognitive skills can be assessed with screening tools or more in-depth neuropsychological assessment.
- [Supplemental pages](#) may be used to provide more information on specific cognitive skills or affective symptoms. [For more information on cognitive assessment, click here.](#)

## **3. Functional Limitations**

- To support limited orders when appropriate, provide detailed information about the individual's functional abilities. Emphasize strengths and retained abilities—even if small in scope—that the judge may reserve as a right to the individual.
- The specific functional abilities should be assessed through direct observation, reports of caregivers (professional or family), direct functional assessment, and/or direct interviewing of testing of specific abilities.
- In describing decision-making abilities within functional domains, consider whether the individual can: express a choice regarding a given situation and do so consistently; re-state basic information about the decision, risks and benefits, and the effects of these on every day life; justify decisions based on risks and benefits; reason consistently with his or her lifestyle and values. Remember eccentric or risky choices in and of themselves are not grounds for guardianship.
- [Supplemental pages](#) may be used to provide more information on specific functional abilities. [For more information on functional assessment, click here.](#)

## **4. Values and Preferences**

- Assessments that focus purely on the technical aspects of decision making miss the larger context of individual values.
- Views on what defines quality of life, how decisions are made, and values most crucial in weighing options, vary widely between individuals. A person's age, cohort, and ethnicity may strongly impact preferences, and these factors and related values often differ from those of evaluators, investigators, and judges.
- Interview the individual, and if appropriate, others who have known the individual over time, to determine the values and preferences regarding the matters under consideration.
- Evaluating the consistency of a choice with such long-held values and perspectives is one important indicator of capacity. In addition, such information is useful to the judge and guardian

in planning for the individual's care under guardianship.

- [Supplemental pages](#) on values may be used to provide categories of values questions, and more detailed lists are also available. [For more information on values assessment, click here.](#)

## **5. Risk and Level of Supervision**

- The clinician should provide a professional opinion about the least restrictive level of supervision needed to address the impairments noted, given the person's current circumstances.
- A clinical assessment is incomplete if it does not match an individual's cognitive and functional strengths and weaknesses to the person's social situation and environment. This contextual or interactive component of a clinical assessment balances the diagnostic, cognitive, and functional findings with 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, thus, never merely a diagnostic statement or report of test results, but an integration of these findings with the particulars of the client's life and situation, and the level of risk given those factors.

## **6. Treatments**

- Describe any resources, treatments, or accommodations that will enhance the individual's functioning.
- Sometimes a treatment may abrogate the need for a guardian as capacity is restored. If so, indicate when capacity should be re-evaluated.
- Other times, a treatment may maximize the individual's functioning and well-being while under guardianship and, thus, needs to be considered in the ongoing care plan.
- In many states, a proposed guardian is required to state whether guardianship will be used for nursing home placement, thus, a clinical opinion about the appropriate living situation is useful.

## **7. Hearing**

- Individuals subject to guardianship petitions may be required or encouraged to attend the hearing under state law. Since the individual stands to lose many critical rights, efforts should be made to have the individual attend the hearing, if the individual wants to do so, and his or her mental status permits useful participation.
- Judges often desire a clinical opinion on whether the individual can attend the hearing, and if they can, how to best accommodate the individual's needs.

## Cognition and Cognitive Testing<sup>5</sup>

### Cognitive Screening

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

Acronym	Screening Test Name	Screening Test Description
BIMC	Blessed Information Memory Concentration Test	33-point scale with subtests of orientation, personal information, current events, recall, and concentration. There is a short version with six items.
Cognistat	The Neurobehavioral Cognitive Status Examination	This screening test examines language, memory, arithmetic, attention, judgment, and reasoning.
MMSE	Mini Mental State Examination	30-point screening instrument that assesses orientation, immediate registration of three words, attention and calculation, short-term recall of three words, language, and visual construction.
MSQ	Mental Status Questionnaire	10-item, 10-point scale assessing orientation to place, time, person, and current events. It has low to modest sensitivity for detecting neurological illness.
7MS	The Seven Minute Screen	This screening instrument combines four tests, each with separate scores of various ranges: recall, verbal fluency, orientation, and clock drawing.
SPMSQ	Short Portable Mental Status Questionnaire	10-point scale scored as a sum of errors on subtests of orientation, location, personal information, current events, and counting backwards. High scores (8-10) equals severe impairment. Race and age corrections to scores are available.

### Neuropsychological Testing

A neuropsychological evaluation typically assesses various areas called “domains” with neuroanatomic correlates (see table below). Some of these areas are assessed through observation of the client’s presentation and communication during a clinical interview. Most are assessed through tests that have standard instructions, standard scoring, and are referenced to adults of similar age and education to provide performance range that is “norm-referenced.”

<sup>5</sup> This section provides an overview of cognitive functioning and neuropsychological assessment, and is based on information available in key clinical references (see end of the book), and the consensus of the working group.

There are a number of neuropsychological “batteries” that assess, either briefly or in great depth, a wide range of domains using various “subtests.” Examples of neuropsychological batteries are:

Halstead-Reitan Neuropsychological Battery

Kaufman Short Neuropsychological Assessment

Luria-Nebraska Neuropsychological Battery

Microcog

Repeatable Battery for the Assessment of Neuropsychological Status

Wechsler Adult Intelligence Scale—III

Examples of specific neuropsychological tests are provided in the table.

## Common Neuropsychological Domains

Domain	Description	Relevance to Capacity	Methods of Assessment
Appearance	<ul style="list-style-type: none"> <li>Grooming, weight, interaction with others</li> </ul>	<ul style="list-style-type: none"> <li>Appearance, orientation, and interaction indicate general mental condition and may reveal problems with judgment</li> </ul>	<ul style="list-style-type: none"> <li>Observation</li> </ul>
Sensory Acuity	<ul style="list-style-type: none"> <li>Ability to hear, see, smell, touch</li> </ul>	<ul style="list-style-type: none"> <li>Sensory deficits impact functioning in the environment.</li> <li>Sensory deficits may make performance on neuropsychological tests worse and, therefore, should be considered in interpreting scores</li> </ul>	<ul style="list-style-type: none"> <li>Observation</li> <li>Structured hearing tests</li> <li>Structured vision tests</li> </ul>
Motor Activity	<ul style="list-style-type: none"> <li>Motor activity (active, agitated, slowed)</li> <li>Motor skills (gross and fine) detection of visual, auditory, tactile stimuli</li> </ul>	<ul style="list-style-type: none"> <li>Motor deficits impact functioning in the environment</li> <li>Motor deficits may make performance on neuropsychological tests worse and therefore should be considered in interpreting scores</li> </ul>	<ul style="list-style-type: none"> <li>Observation</li> <li>Finger Tapping</li> <li>Grooved Pegboard</li> <li>Finger Oscillation Test</li> <li>Tactual Performance Test</li> </ul>
Attention	<ul style="list-style-type: none"> <li>Attend to a stimulus</li> <li>Concentrate on a stimulus over brief time periods</li> </ul>	<ul style="list-style-type: none"> <li>Basic function necessary for processing information</li> </ul>	<ul style="list-style-type: none"> <li>Digit Span Forward and Backward</li> <li>Working Memory (from the WMS-III)</li> <li>Paced Auditory Serial Attention Test (PASAT)</li> <li>Visual Search and Attention Test (VSAT)</li> <li>Visual Attention (from the Dementia Rating Scale (DRS))</li> <li>Trails A of the Trail Making Test</li> <li>Continuous Performance Test</li> </ul>
Memory	<ul style="list-style-type: none"> <li>Working memory: attend to verbal or visual material over short time periods; hold two ideas in mind</li> <li>Short-term/recent memory</li> </ul>	<ul style="list-style-type: none"> <li>Some memory is important for all decision making. Although memory aids can be used, individuals must be able to hold ideas in mind (“working</li> </ul>	<ul style="list-style-type: none"> <li>Memory Assessment Batteries (from the WMS-III or the Memory Assessment Scales (MAS))</li> <li>Auditory Verbal Learning Test</li> <li>Recognition (from the DRS)</li> <li>Fuld Object Memory Evaluation</li> </ul>

	<p>and learning: ability to encode, store, and retrieve information</p> <ul style="list-style-type: none"> <li>• Long-term memory: remember information from the past</li> </ul>	<p>memory”)</p> <ul style="list-style-type: none"> <li>• Memory is especially important for functioning at home and remembering to perform critical activities (like take medications) and be safe (like turn off stove)</li> </ul>	<ul style="list-style-type: none"> <li>• California Verbal Learning Test (CVLT)</li> <li>• Hopkins Verbal Learning Test (HVLTL)</li> <li>• Rey Auditory Verbal Learning Test</li> </ul>
<p>Communication (also called expressive language)</p>	<ul style="list-style-type: none"> <li>• Express self in words or writing</li> <li>• State choices</li> </ul>	<ul style="list-style-type: none"> <li>• Basic function necessary to convey choices in decision making</li> </ul>	<ul style="list-style-type: none"> <li>• Communication during testing</li> <li>• Controlled Oral Word Association Test (commonly called the verbal fluency)</li> <li>• Boston Diagnostic Aphasia Examination (BDAE)</li> <li>• Multilingual Aphasia Examination</li> <li>• Boston Naming Test (BNT)</li> </ul>
<p>Understanding (also called receptive language)</p>	<ul style="list-style-type: none"> <li>• Understand written, spoken, or visual information</li> </ul>	<ul style="list-style-type: none"> <li>• Important when making decisions, especially regarding new problems or new treatments</li> <li>• Critical to understanding the options</li> </ul>	<ul style="list-style-type: none"> <li>• Understanding during testing</li> <li>• Boston Diagnostic Aphasia Examination (BDAE)</li> <li>• Multilingual Aphasia Examination</li> </ul>
<p>Arithmetic or Mathematical skills</p>	<ul style="list-style-type: none"> <li>• Understand basic quantities</li> <li>• Make simple calculations</li> </ul>	<ul style="list-style-type: none"> <li>• Important for financial decision making</li> <li>• Important for day to day financial tasks</li> </ul>	<ul style="list-style-type: none"> <li>• Arithmetic subtest of WAIS-III</li> </ul>
<p>Reasoning</p>	<ul style="list-style-type: none"> <li>• Compare two choices</li> <li>• Reason logically about outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Critical in almost all decision making</li> </ul>	<ul style="list-style-type: none"> <li>• Verbal subtests from the WAIS-III, such as Similarities, Comprehension</li> <li>• Proverbs</li> </ul>
<p>Visual-Spatial and Visuo-Constructional Reasoning</p>	<ul style="list-style-type: none"> <li>• Visual-spatial perception</li> <li>• Visual problem solving</li> </ul>	<ul style="list-style-type: none"> <li>• Important for functioning in the home and community</li> <li>• Essential for driving</li> </ul>	<ul style="list-style-type: none"> <li>• Performance subtests from WAIS-III, such as Block Design, Object Assembly, Matrix Reasoning</li> <li>• Hooper Visual Organization Test</li> <li>• Visual Form Discrimination Test</li> <li>• Clock Drawing</li> <li>• Rey-Osterrieth Complex Figure</li> <li>• Line Bisection</li> <li>• Bender Visual Motor Gestalt Test</li> </ul>

			<ul style="list-style-type: none"> <li>• Tactual Performance Test</li> </ul>
Executive Functioning	<ul style="list-style-type: none"> <li>• Plan for the future</li> <li>• Demonstrate judgment</li> <li>• Inhibit inappropriate responses</li> </ul>	<ul style="list-style-type: none"> <li>• Essential for most decision making</li> <li>• Important to avoid undue influence</li> </ul>	<ul style="list-style-type: none"> <li>• Similarities (from the WAIS-III)</li> <li>• Trails B of the Trail Making Test (TMT)</li> <li>• Wisconsin Card Sorting Test</li> <li>• Stroop Color Word Test</li> <li>• Delis-Kaplan Executive Function System (DKEFS)</li> <li>• Mazes</li> <li>• Tower of London</li> </ul>
Insight	<ul style="list-style-type: none"> <li>• Acknowledge deficits</li> <li>• Acknowledge the potential benefit of intervention</li> <li>• Accept help</li> <li>• Often considered a part of “executive function”</li> </ul>	<ul style="list-style-type: none"> <li>• Critical to the use of less restrictive alternatives</li> <li>• An individual needs to be able to recognize they have a deficit and be willing to accept help in order to use home services</li> </ul>	<ul style="list-style-type: none"> <li>• Interview</li> <li>• Comparing observed deficits with the individual’s reports of deficits</li> <li>• Informant reports</li> </ul>

## Everyday Functioning and Functional Assessment

### What Is “Function”? How do Judges and Clinicians Think Differently?

A comprehensive assessment of capacity should include a “functional assessment.” **Of note:** when the law refers to “function” it often means someone’s thinking and decision-making, as well as everyday behavior where the person lives. When clinicians refer to “function” they usually mean only the everyday behavior, where as thinking and decision making is assessed separately as “cognition.”

### How Do Clinicians Divide Everyday Functioning? ADLs and IADLs

Clinicians often divide everyday function into the “Activities of Daily Living” (ADL) and the “Instrumental Activities of Daily Living” (IADL). There is fairly good agreement on the ADLs as comprising dressing, eating, toileting, transferring or moving from one sitting position to another, walking or mobility, and bathing. There is less agreement on what are the main categories of IADLs and how to divide them. For the purpose of this book, we have described several broad categories commonly encountered in guardianship proceedings, namely financial, medical, and home/community.

### How Is Functioning Assessed by Clinicians? Informal and Formal Assessment

Functioning can be assessed through **informal** means, such as observing the individual, and asking the individual, family, and staff questions, or through **formal testing**, such as that performed by an occupational therapist. Nurses, social workers, and psychologists are often prepared to assess everyday functioning.

### What Tests Are Used to Assess Everyday Functioning? ADL Rating Scales and Capacity Tools

There are two main ways that functioning is formally assessed. One way is through ADL and IADL rating scales. These are often used by nurses and social workers and are usually brief check lists for categorizing everyday functioning. Similar and more sophisticated tools are used by occupational therapists who tend to directly assess and observe ADL/IADL performance in their evaluations. ADL and IADL rating scales have been available for more than 30 years.

#### Names of some ADL/IADL Rating Scales include:

Adult Functional Adaptive Behavior Scale (AFABS)  
Barthel Index  
Direct Assessment of Functional Status (DAFS)  
Functional Independence Measure (FIM)  
Index of ADL (“Katz”)  
Kenny Self Care Evaluation  
Multidimensional Functional Assessment Questionnaire (MFAQ)  
Philadelphia Geriatric Center Multilevel Assessment Inventory (MAI)  
Physical Self-Maintenance Scale

Information about these scales is easily found online and in various textbooks.

Another approach to functional assessment is instruments designed specifically to assess legal capacities. These are formal testing instruments designed specifically to assess capacity in terms of legal definitions. Such tools have only recently been developed, since the 1990s, and are summarized in the following table. They are called “tools” because it is not possible to have an exact “test” of capacity. Capacity is a professional, clinical, and, ultimately, legal judgment. Since some of these tests are newly developed, not all meet the “Daubert standard” of scientific admissibility. Refer to the articles and test manuals for specific information on test properties.

Acronym	Capacity Tool Name	Description
ACE <sup>24</sup>	Aid to Capacity Evaluation	Semi-structured interview for capacity to consent to treatment; Developed in Canada.
CAT <sup>25</sup>	Capacity Assessment Tool	Structured interview to assess capacity to choose between two treatment options.
CCTI <sup>26</sup>	Capacity to Consent to Treatment Interview	Two clinical vignettes are used to assess capacity to consent to medical treatment in terms legal standards of understanding, appreciation, reasoning, and expression of choice.
CIS <sup>27</sup>	Competency Interview Schedule	A 15-item interview for capacity to consent to electroconvulsive-therapy (ECT).
DAM <sup>28</sup>	Decision Assessment Measure	Assesses capacity to consent to medical treatment through a vignette regarding blood draw. Developed in England.
DIG <sup>29</sup>	Decision-Making Instrument for Guardianship	Eight vignettes evaluate capacity to make decisions about hygiene, nutrition, health care, residence, property acquisition, routine money management in property acquisition, major expenses in property acquisition, and property disposition.
FCI <sup>30</sup>	Financial Capacity Instrument	Structured instrument assesses six domains of financial activity: basic monetary skills, financial conceptual knowledge, cash transactions, checkbook management, bank statement management, and financial judgment.
HCAI <sup>31</sup>	Hopemont Capacity Assessment Interview	Semi structured interview for medical and financial decisions. Uses two vignettes for each.
ILS <sup>32</sup>	Independent Living Scales	Structured instrument with 70 items in five subscales: memory/orientation, managing money, managing home and transportation, health and safety, and social adjustment. Can be summed to reflect the capacity to function independently.
MacCAT-T <sup>33</sup>	MacArthur Competence Assessment Tool - Treatment	Semi-structured interview to assess medical decision making in terms of four legal standards.

## Guardianship Monitoring Practices

### Ten Steps to Enhance Guardianship Monitoring<sup>34</sup>

1. A requirement for the guardian to **report on the individual's status**;
2. A requirement for a **written guardianship plan**;
3. **Court actions** to facilitate the guardian's reporting and accounting (such as stating the responsibility to report in the order; providing the guardian with reporting forms; making available samples of prepared reports; providing clear instructions regarding the guardian's duty to report);
4. **Court enforcement** of required statutory reporting requirements (by establishing computer tickler systems on report due dates; notifying the guardian promptly when a report is overdue; entering a show cause order if the guardian has not responded promptly to the notice to file; imposing financial penalties for late filings; sending the bar grievance committee a copy of delinquency notices sent to any guardian who is an attorney);
5. **Procedures for review** of reports and accountings (designating someone to review reports and audit accountings; establishing criteria for review);
6. **Procedures for investigation of complaints** or to verify information in reports and accounts using court investigators or trained volunteers to assess the individual's condition, environment, and services; sending reports and accounting to interested third parties to verify or object;
7. **Periodic hearings** on the need to continue the guardianship;
8. **Sufficient revenue** for monitoring (through state appropriations, county or municipal funds, filing fees);
9. Clear **ethical guidelines** for attorneys representing the petitioner, guardian and individual; and
10. Encouragement efforts of other **community groups** and agencies that monitor the individual's well-being (adult protective services, long-term care ombudsman, Area Agencies on Aging, protection and advocacy agencies).

## **Promising Practices for Guardianship Monitoring**

Source: “Best Practices in Guardianship Monitoring: Working List from May 2001 NCPJ Meeting.” For standards on guardianship monitoring, see *National Probate Court Standards*, §§3.3.13 through 3.3.18, and for conservatorship (guardianship of the property) monitoring, see §§3.4.13 through 3.4.19.

### A. Reporting

- Re-examine form for guardian to report on individual’s status and condition. Make it simple, yet comprehensive. Review or create a separate form for guardian plan for future care of individual, due at time of appointment or shortly after, and to be updated regularly with status report. The first form would be a status report and the second would be a general plan for the conduct of the guardianship/conservatorship.
- Re-examine form for inventory and annual accounts. Review or create a separate form for a financial plan to meet the respondent’s needs and allocate resources. The financial information could be incorporated in the general plan.
- Require that original bank statements and brokerage account statements be filed with each accounting. Alternatively, require that the nature of each account and the amount in each account be listed on letterhead stationary from the financial institution.
- Establish an effective database of guardianship cases.
- Develop a computerized tickler system to show due dates of reports and accounts.
- Consider using e-mail to contact guardians who have outstanding reports or accounts, as a supplement to written notice.
- Require guardians to inform the court of two points of contact in case the guardian moves or changes the location of the incapacitated person. This could be part of the petition for guardianship.
- Have a process for sending out inquiries regarding late reports and accounts, before issuing show cause orders.
- Consider routinely fully bonding for liquid assets and annual income. Waive requirement sparingly. Do not hesitate to “call the bond in” when the guardian has been incompetent with the individual’s assets or has taken them.
- If no response to inquiries about late reports, issue subpoenas; or alternatively issue automatic show cause orders.
- Develop a form that guardians can use to inform the court of the death of individual.
- Provide training to guardians on reporting and accounting requirements, and offer samples of prepared reports.

- Mail statutory reporting form to guardians shortly before due date, as a reminder.
- Include language in initial order concerning guardian's responsibility to report.

B. Review and Investigation

- Designate qualified staff to review reports and accounts.
- Appoint attorneys to investigate questionable situations.
- Use volunteers to review reports and investigate condition of individuals, or to supplement court staff. Consider using trained university student interns, especially law, nursing, and social work students. Explore recruitment of AARP members, bar association senior lawyer or young lawyer section members, others.
- Appoint vibrant local coordinators to motivate volunteer monitors.
- Monitor and assess public, as well as private, family/professional/agency guardianships.
- Refer guardians to freelance probate paralegals to help shape up messy, incomplete, or suspicious accountings. In some cases, detailed audits, including receipts and cancelled checks, will be needed. Surcharge the guardian for this expense.
- Establish procedures for receiving and timely responding to guardianship complaints, including letters and anonymous telephone calls. Recognize reticence of public to complain to court.
- Send reports and accounts to interested persons so they can verify or object.
- Use bonding company investigations to supplement court monitoring.

C. Funding

- Seek funding from county commissioners for monitoring costs.
- In particular, seek county funding for costs of mileage for volunteers.
- Have county commissioner accompany a volunteer on a visit, to strengthen understanding of need for monitoring.
- Charge individual's estate for part or all of costs of monitoring.

D. Training

- Prepare a 1- to 4-page instruction sheet or brochure on duties of guardians, and hand it to guardian at time of appointment. Material coming directly from the judge in the courtroom has an impact.
- Develop slide presentations to instruct guardians on their role and responsibilities.
- Don't reinvent the wheel. Review existing guardian training curricula from other jurisdictions.
- Have guardians watch videos after appointment, or after two to three months, when they may have more questions. (See list of guardianship videos to be distributed through NCPJ.)
- Consider requiring lay guardian training by court order. Make training free of charge and offered at convenient location and times. Require a certificate of completion be filed, and institute a tickler system to be sure training is completed. Ensure that guardians are aware of community resources, including the Area Agency on Aging.
- Use community resources (such as Area Agencies on Aging, schools of social work, state guardianship association) to aid in developing guardian training programs and to train guardians. Attorneys and/or private professional conservators may be willing to contribute to the training pro bono as a service to the court.

#### E. Community Links

- Develop relationships and protocols with state and Area Agencies on Aging and their long-term care ombudsman programs for assistance in monitoring.
- Develop protocol for sending the state bar grievance committee copies of any notices or show cause orders issued to guardians who are attorneys.
- Explore possible use and recruitment of volunteers with universities, bar groups, aging organizations.
- Work with state guardianship association.
- Develop relationship with prosecutors so that egregious/criminal cases of elder abuse and neglect can be referred to the criminal justice system.

## Hearing: Maximizing Participation

Can any of these strategies be implemented to increase the participation of the individual?

### Ensure Access to the Courthouse and Courtroom

- Do accessibility check of your courthouse and courtroom.<sup>35</sup>
- Get a local disability group to visit the court and make recommendations for removing accessibility barriers.

### Consider Alternative Locations for Hearing

- Move the hearing site (e.g., to a nursing home) to understand in greater depth individual's circumstances.

### Reduce Intimidation; Respect Privacy

- Conduct hearings at the bench or in private chambers.

### Address Hearing Loss

- Minimize background noise and use auditory amplifiers when available.
- Look at the individual when speaking so individuals can read lips.
- Speak slowly and distinctly, but do not over-articulate or shout as this can distort speech and facial gestures.
- Use a lower pitch of voice for common problems with high frequency tone hearing loss.

### Address Vision Loss

- Increase lighting.
- Format documents in large print, if possible (e.g., 14- or 16-point font) and double-spaced.
- Give individual additional time to read documents.
- Allow extra time to refocus when shifting between reading and viewing objects at a distance.

### Address Cognitive Impairments

- Begin with simple questions requiring brief responses.
- Use a slower pace to allow the individual to process and digest information.
- Allow extra time for responses to questions, as “word-finding” can decline with age.
- Break information into smaller, manageable segments, focusing on one issue at a time.
- Provide cues (lists, reminders) to assist recall.
- Repeat, paraphrase, and summarize periodically, as well as check for accuracy comprehension.

## **Hearing: Examination of the Healthcare Professional**

**These questions can be used to examine the healthcare professional or others providing information on the individual's condition and level of functioning.**

### **1. Medical Condition**

What is causing the problem?

Is it temporary or permanent?

What are the physical diagnoses? How severe are they? Might they improve? When? How (what treatment)?

What are the mental diagnoses? How severe are they? Might they improve? When? How (what treatment)?

When did the problem start? How long has it been going on? Are there any recent medical or social events? What treatments and services have been tried?

What medications is the individual on, including dosage? Could the medications make capacity worse?

Have all temporary or reversible causes of cognitive impairment been evaluated and treated?

Have conditions that may mimic dementia been ruled out (e.g., depression, malnutrition, dehydration, delirium, transfer trauma, polypharmacy, alcohol use, etc.)?

Are there any mitigating factors (e.g., hearing loss, vision loss, bereavement) that may cause the person to appear incapacitated and could improve with time or treatment?

### **2. Cognitive Functioning**

What is the individual's level of alertness/arousal, orientation, memory and cognitive abilities, psychiatric and emotional state? How well can this individual make decisions?

### **3. Everyday Functioning**

What can the individual do in terms of taking care of self? Making financial decisions? Making medical decisions? Taking care of the home environment and functioning independently in the community?

What is the level of functioning related to any other specific legal matters in this case (e.g., sale of home, move to nursing home)?

### **4. Values**

What are some of the individual's key values? Are current choices consistent with those values? In the future, how might care be provided or decisions made in a manner that respects these values?

### **5. Risk of Harm and Level of Supervision Needed**

Is there immediate or ongoing risk of substantial harm? What level of supervision is needed to protect the individual? Are there any abilities—even if small in scope—that the individual retains?

### **6. Means to Enhance Capacity**

In the future, would any education, training, treatment, assistive device, or housing arrangement benefit the individual?

If these treatments might help the individual, when should he or she be re-evaluated?

## Jury Instructions<sup>6</sup>

1. In the petitioner's claim that Mrs. X is an incapacitated person and needs a guardian, the petitioner has the burden of proving by clear and convincing evidence that:
  - i. She lacks the ability to receive and evaluate information.
  - ii. She lacks the ability to make or communicate decisions.
  - iii. She lacks the ability to meet essential requirements for her physical health, safety, or self-care.
  - iv. There is no technical assistance or accommodation that can make up for the lack of these abilities.
  - v. There is no less restrictive alternative to guardianship that would suffice to meet her needs. For example, advance directives for health care and Social Security representative payees are considered less restrictive alternatives to guardianship.
  - vi. She would be harmed without the protection of a guardian.
  
2. Capacity is task-specific. If you think she lacks some, but not all, abilities, you must specify the kinds of actions or decisions for which she has capacity and the kinds of actions or decisions for which she does not have capacity. This may make it possible to limit any guardianship order, removing only some of her rights and autonomy, but not all. Think about her specific abilities in the following areas:
  - i. Financial
  - ii. Health care
  - iii. Personal safety and hygiene
  - iv. Living arrangements; using community resources
  
3. Sickness, eccentricity, and old age do not, of themselves, amount to incapacity.
  
4. People have the right to make foolish or eccentric decisions and to govern their own affairs, unless they lack decision-making capacity and cannot understand the consequences of their decisions.

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<sup>6</sup> Example is based on provisions in the Uniform Guardianship and Protective Proceedings Act. For materials on jury instructions specific to Texas law, see Smith, Darlene Payne, *Jury Questions and Instructions: No Pattern for Probate*, Chap. 10, State Bar of Texas Advanced Estate Planning and Probate Institute, Houston TX (June 2001).

## Less Restrictive Alternatives to Guardianship

The expeditious management of a guardianship case begins soon after the petition has been presented. While some courts have formal *diversion programs* by which the problems leading to the guardianship petition may be successfully addressed, in most courts the responsibility falls on the shoulders of the judge to ensure that only cases with genuine issues of capacity and probable need for guardianship proceed. The court should have investigatory and expert services to assist in exploring viable alternatives to guardianship. A finely tuned evaluation is a key tool.

The constitutional principle of the least restrictive alternative was first articulated by the U.S. Supreme Court<sup>36</sup> and was applied to mental health<sup>37</sup> in a case in which the court said that a person could not be subjected to a mental health commitment of unspecified time without an exploration of all alternatives.

The following checklist for less restrictive alternatives to guardianship was prepared by Professor Joan O’Sullivan, University of Maryland School of Law. Some of the alternatives provide functional assistance, while others are legal tools that provide decisional assistance. Legal tools vary by state.

**Caution: Less restrictive alternatives have risks, as well as benefits. They lack the judicial oversight inherent in the guardianship process, and there may be a potential for abuse.**

### If the person needs medical treatment, but is not able to consent:

***Health Care Advance Directive***

Any written statement a competent individual has made concerning future health care decisions. The two typical forms of advance directive are the *living will* and the *health care power of attorney*.

***Surrogate decision making by an authorized legal representative, a relative, or a close friend***

In many states, the next of kin are authorized to make some or all medical treatment decisions in the absence of a health care advance directive or appointed guardian.

### If the problem involves litigation against or by the disabled person:

***Appointment of Guardian ad litem***

The court in which litigation is proceeding has authority to appoint a guardian ad litem solely for the purpose of representing the best interests of the individual in the litigation.

### If the problem involves a family dispute:

***Mediation***

Referring a case to mediation before a hearing offers a personal, confidential, and less intimidating setting than the courtroom, as well as an opportunity for exploring underlying issues privately.

**If the person needs help with financial issues:**

***Bill paying services***

Also called *money management services*, these assist persons with diminished capacity through check depositing, check writing, checkbook balancing, bill paying, insurance claim preparation and filing, tax and public benefit preparation, and counseling.

***Utility company third party notification***

Most utility companies permit customers to designate a third party to be notified by the utility company if bills are not paid on time.

***Shared bank accounts (with family member)***

The use of joint bank accounts is a common strategy for providing assistance with financial management needs. However, if the joint ownership arrangement reaches most of the individual's income or assets, it also poses risk in its potential for theft, self-dealing, unintended survivorship, and exposure to the joint owner's creditors. A more secure arrangement is a multiple-party account with the family member or friend designated as agent for purposes of access to the account.

***Durable Power of Attorney for finances***

This legal tool enables a principal to give legal authority, as broadly or as narrowly as desired, to an agent or attorney in fact to act on behalf of the principal, commencing either upon incapacity or commencing immediately and continuing in the event of incapacity. Its creation requires sufficient capacity to understand and establish such an arrangement.

***Trusts***

Trusts can be established to serve many purposes, but an important one is the lifetime management of property of one who is or who may become incapacitated. They are especially useful where there is a substantial amount of property at stake and professional management is desired. Special or supplemental needs trusts and pooled income trusts are recognized under federal Medicaid and Social Security laws as permissible vehicles for managing the funds of persons with disability who depend on government programs for their care needs.

***Representative Payee***

A person or organization authorized to receive and manage public benefits on behalf of an individual. Social Security, Supplemental Security Income (SSI), veterans' benefits, civil service and railroad pensions, and some state programs provide for appointment of a "rep payee." Each program has its own statutory authorization and rules for eligibility, implementation, and monitoring.

***Adult protective services***

The term protective services encompasses a broad range of services. It includes various social services voluntarily received by seniors in need of support (e.g., homemaker or chore services, nutrition programs). It also includes interventions for persons who may be abused, neglected, or exploited, and which may lead to some form of guardianship.

**If the person is living in an unsafe environment:**

***Senior shared housing programs***

In shared housing programs, several people live together in a *group home* or apartment with shared common areas. *Congregate housing* refers to complexes with separate apartments (including kitchen), some housekeeping services, and some shared meals. Many congregate care facilities are subsidized under federal housing programs. Personal care and health oversight are usually not part of the facility's services, but they may be provided through other community social services.

***Adult foster care***

Adult foster care is a social service that places an older person, who is in need of a modest amount of daily assistance, into a family home. The program is similar to foster care programs for children. The cost varies and may be covered in part by the state social services program.

***Community residential care***

These are small supportive housing facilities that provide a room, meals, help with activities of daily living, and protective supervision to individuals who cannot live independently, but who do not need institutional care.

***Assisted living***

Assisted living facilities provide an apartment, meals, help with activities of daily living, and supervision to individuals who cannot live independently, but who do not need institutional care.

***Nursing home***

Nursing homes provide skilled nursing care and services for residents who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons.

***Continuing Care Retirement Communities (CCRCs)***

CCRCs, also called life care communities, usually require the payment of a large entry fee, plus monthly fees thereafter. The facility may be a single building or a campus with separate independent living, assisted living, and nursing care. Residents move from one housing choice to another as their needs change. While usually very expensive, many guarantee lifetime care with long-term contracts that detail the housing and care obligations, as well as its costs.

**If the person needs help with activities of daily living or supervision:**

***Care management***

This is provided by a social worker or health care professional, who evaluates, plans, locates, coordinates, and monitors services for an older person and the family.

***Home health services***

If the person needs medical care or professional therapy on a part-time or intermittent basis, a *visiting nurse* or *home health aide* from a *home health agency* may meet that need. Some services may be covered by Medicare or Medicaid, private insurance, or state programs

***Home care services***

*Homemaker* or *chore services* can provide help with housework, laundry, ironing, and cooking. *Personal care attendants* or *personal assistants* may assist an impaired person in performing *activities of daily living*, (i.e., eating, dressing, bathing, toileting, and transferring), or with other activities instrumental to daily functioning.

***Adult day care services***

These are community-based group programs designed to meet the needs of functionally and/or cognitively impaired adults through an individual plan of care. Health, social, and other related support services are provided in a structured, protective setting, usually during normal business hours. Some programs may offer services in the evenings and on weekends.

***Respite care programs***

“Respite” refers to short-term, temporary care provided to people with disabilities in order that their families can take a break from the daily routine of caregiving. Services may involve overnight care for some period of time.

***Meals on wheels***

Volunteers deliver nutritious lunchtime meals to the homes of people who can no longer prepare balanced meals for themselves. The volunteers also provide daily social contact with elders to ensure that everything is okay.

***Transportation services***

Because many elders cannot afford a special transit service, and are too frail to ride the bus, senior transportation services volunteers drive clients to and from medical, dental, or other necessary appointments, and remain with them throughout the visit.

***Food and prescription drug deliveries***

Either volunteer-based or commercially-based delivery services for food or prescription drugs, may assist those who are unable to leave their home regularly.

***Medication reminder systems***

This may include a weekly pill organizer box, or another pill distribution system, or telephone reminder calls.

***Telephone reassurance programs***

These services use volunteer to provide a daily telephone call to older persons living alone.

***Emergency call system (“lifeline”)***

Usually includes equipment added to the telephone line, plus a wireless signal button worn by the older adult. Trained responders provide emergency assistance in the event of a medical emergency in the home, such as a fall.

***Home visitors and pets on wheels***

Elder service agencies and other volunteer agencies may match elders with home visitors, including visiting pets, which provide social interaction and a form of monitoring.

***Daily checks on the person by mail carriers***

Many mail carriers, if notified that an elder at risk is living at an address, will monitor the home to insure that mail has been picked up daily, and if not, notify a designated individual.

## Limitations to Guardianship<sup>7</sup>

### Care of Self

Ms. Xxx retains the right to be responsible for bathing, dressing, toileting, and dental care (with assistance).

Mr. Xxx retains the right to choose and determine his daily meals.

### Financial Decision Making and Management

Mr. Xxx retains the rights to have and spend \$20 of cash per week.

Ms. Xxx retains the rights to manage and use her checkbook (with a monthly limit).

Mr. Xxx retains the right to plan a budget, including monthly expenditures, and to direct the guardian in expenditures.

Ms. Xxx retains the rights to purchase and give gifts to individuals of her choosing (not to exceed xxx per month).

Mr. Xxx retains the right to make gifts or donations to organizations of his choosing (not to exceed xxx per donation).

Ms. Xxx retains the right to make or modify a will.

Ms. Xxx retains the right make decisions concerning purchase or sale of her home. (Her home at Yyy Street is not to be sold without prior authorization of the court.)

Mr. Xxx retains the right to deposit, withdraw, dispose, or invest monetary assets.

Ms. Xxx retains the right to establish and use credit.

Mr. Xxx retains the right to pay, settle, prosecute, or context a claim.

Ms. Xxx retains the right to enter into a contract, financial commitment, or lease arrangement

Mr. Xxx retains the right to continue or participate in the operation of a business.

Mr. Xxx retains the right to manage his property and investments.

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<sup>7</sup> These limitations are phrased as rights reserved. In some states, orders are written to specify rights removed.

## **Medical Decision Making and Management**

Mr. Xxx retains the right to make and communicate decisions about his health care, including the continuance or withdrawal of life-sustaining treatment.

Ms. Xxx retains the right to choose a health or long-term care facility.

Mr. Xxx retains the right to choose and direct home health care providers.

Ms. Xxx retains the right to manage her medications (with assistance).

## **Home and Community Life**

Ms. Xxx retains the right to determine her residence/live at home.

Ms. Xxx retains the right to be responsible for maintaining and cleaning her home (with assistance).

Mr. Xxx retains the right to be left alone (with time limit).

Ms. Xxx retains the right to drive.

Mr. Xxx retains the right to use public transportation independently.

Ms. Xxx retains the right to make and communicate choices about roommates.

Mr. Xxx retains the right to select and plan a schedule of daily and leisure activities.

Ms. Xxx retains the right to smoke at a time and place of her determination, within the law.

Mr. Xxx retains the right to seek and obtain employment.

Ms. Xxx retains the right to travel.

Ms. Xxx retains the right to determine with whom she has friendships and visitation.

Mr. Xxx retains the right to determine his or her degree of participation in religious activities.

Ms. Xxx retains the right to use the telephone (without supervision).

Mr. Xxx retains the right to correspond with others and to use mail/e-mail (without supervision).

## **Other Civil and Legal Matters**

Ms. Xxx retains the right to retain legal counsel.

Mr. Xxx retains the right to vote.

Ms. Xxx retains the right to make and communicate decisions regarding legal documents.

## Means to Enhance Capacity

Cause of Confusion	Possible Intervention
Alcohol or other substances intoxication	Detoxification; supplement diet or other intake needs
Altered blood pressure	Treat underlying cause of blood pressure anomaly with medication or other treatment
Altered low blood sugar	Management of blood sugar through diet or medication
Anxiety	Treatment with medications and/or psychotherapy; support groups
Bereavement; Recent death of a spouse or loved one	Support; counseling by therapist or clergy; support group; medications to assist in short term problems (e.g., sleep, depression)
Bipolar disorder	Treatment with medications and/or psychotherapy; support groups
Brain tumor	Surgery and medication
Delirium	Obtain standard labs; obtain brain scan if indicated; assess vitals; treat underlying cause; monitor and reassess over time
Dementia	Treatment with medications for dementia; simplify environment; provide multiple clues within environment; use step-by-step communication
Depression	Treatment with medications and/or psychotherapy; add pleasurable activities to day; ECT if indicated; support groups
Developmental disability	Education and training
Difficulty hearing	Use hearing amplifiers; have hearing evaluated; provide hearing aids; write information down; repeat information; slow down speech; speak clearly and distinctly
Difficulty seeing	Use magnifying glass; have sight evaluated; provide glasses; provide spoken information; repeat information; ensure sufficient lighting; use large print; have access to Braille materials
Difficulty understanding English	Use translator
Head injury	Treatments for acute effects (e.g., bleed, pressure, swelling) as necessary; monitoring over time; rehabilitative speech, physical, occupational therapies
Infection (e.g., urinary, influenza, pneumonia, meningitis)	Treat underlying infection with antibiotic or other treatment
Insomnia	Sleep hygiene practices (e.g., limit caffeine, light exercise, limit naps); medications
Liver or kidney disease	Treatment of underlying illness with medication, dialysis, surgery
Loneliness	Social and recreational activities; support groups
Low educational or reading level; illiterate	Provide information in simple language without “talking down”; provide information in multiple formats
Malnutrition or dehydration	IV fluids; fluid/food by mouth; food supplements; food by feeding tube
Mania	Treatment with medications and/or psychotherapy; support groups

Medications and sudden medication withdrawal	Review of medications by clinical pharmacist or specialist; slow one-by-one tapers or changes of medications
Poor heart or lung function (e.g., hypoxia)	Treatment of underlying condition with medication, surgery, supplemental oxygen
Post surgical confusion (usually related to anesthesia or pain medicines)	Monitoring and reassessment over time; try alternative medications and treatments for pain management
Recent stressful event; Depression and anxiety	Support, counseling by therapist or clergy; support group; medications to treat symptoms
Religious, cultural, or ethnic background	Sensitivity to religious, cultural, and ethnic traditions; inquire about views and needs; involve professional from similar background
Schizophrenia; hallucinations or delusions	Treatment with medications for schizophrenia; simplify environment; provide support
Transfer trauma (a recent move that has the individual disoriented)	Monitoring over time; re-orientation to environment
Transient ischemic attacks (TIA)	Treatment of risk factors to prevent future recurrence
Urinary or fecal retention	Treat underlying cause of retention through medication or surgery
Vitamin deficiency; Imbalances in electrolytes and blood levels	Vitamin or electrolyte supplement; balanced diet; diet supplements

## Medical Conditions Affecting Capacity<sup>8</sup>

**Dementia** is a general term for a medical condition characterized by a loss of memory and functioning. Primary degenerative dementias are those with disease processes that result in a deteriorating course, including Alzheimer’s disease, Lewy Body Dementia, and Frontal Dementia (each associated with a type of abnormal brain cell).

Condition	Source	Symptoms	Treatability
Alcoholic Dementia	A fairly common form of dementia, caused by long-term abuse of alcohol, usually for 20 years or more. Alcohol is a neurotoxin that passes the blood-brain barrier.	Memory loss, problem solving difficulty, and impairments in visuospatial function are commonly found in patients with alcohol dementia.	Alcohol dementia is partially reversible, if there is long term sobriety—cessation of use. There is evidence to suggest that some damaged brain tissue may regenerate following extended sobriety, leading to modest improvements in thinking and function.
Alzheimer’s disease (“AD”)	Most common type of dementia, caused by a progressive brain disease involving protein deposits in brain and disruption of neurotransmitter systems.	Initial short-term memory loss, followed by problems in language and communication, orientation to time and place, everyday problem solving, and eventually recognition of people and everyday objects. In the early stages, an individual may retain some decisional and functional abilities.	Progressive and irreversible, resulting ultimately in a terminal state. Medications may improve symptoms and cause a temporary brightening of function in the earlier stages.
Bipolar Disorder or Manic Depression	A psychiatric illness characterized by alternating periods of mania and depression.	Affects functional and decisional abilities in the manic stage or when the depressed stage is severe.	Can be treated with medications, but requires a strong commitment to treatment on the part of the individual. Varies over time; periodic re-evaluation is needed.

<sup>8</sup> This list is meant to define terms **as used in this book**, and is not meant to define terms more universally. The glossary uses definitions from the Diagnostic and Statistical Manual of Mental Disorders, where available, and where not, definitions are based on the consensus of the working group.

Condition	Source	Symptoms	Treatability
Coma	A state of temporary or permanent unconsciousness.	Minimally responsive or unresponsive, unable to communicate decisions and needs a substitute decision maker.	Often temporary; regular re-evaluation required.
Delirium	A temporary confusional state with a wide variety of causes, such as dehydration, poor nutrition, multiple medication use, medication reaction, anesthesia, metabolic imbalances, and infections.	Substantially impaired attention and significant decisional and functional impairments across many domains. May be difficult to distinguish from the confusion and inattention characteristic of dementia.	Often temporary and reversible. If untreated may proceed to a dementia. It is important to rule out delirium before diagnosing dementia. To do so, a good understanding of the history and course of functional decline, as well as a full medical work-up, are necessary.
Frontal or Frontotemporal Dementia (Pick’s disease is one example)	Broad category of dementia caused by brain diseases or small strokes that affect the frontal lobes of the brain.	Problems with personality and behavior are often the first changes, followed by problems in organization, judgment, insight, motivation, and the ability to engage in goal-oriented behavior.	Early in their disease, patients may have areas of retained functional ability, but as disease progresses they can rapidly lose all decisional capacity.
Jacob-Creutzfeldt Disease	A rare type of progressive dementia affecting humans that is related to ‘mad cow’ disease.	The disease usually has a rapid course, with death occurring within two years of initial symptoms. These include fatigue, mental slowing, depression, bizarre ideations, confusion, and motor disturbances, including muscular jerking, leading finally to a vegetative state and death.	There is no treatment currently and the disease is relentlessly progressive.

Condition	Source	Symptoms	Treatability
Diffuse Lewy Body Dementia (DLB)	A type of dementia on the Parkinson disease spectrum.	DLB involves mental changes that precede or co-occur with motor changes. Visual hallucinations are common, as are fluctuations in mental capacity.	This disease is progressive and there are no known treatments. Parkinson medications are often of limited use.
Major Depression	A very common psychiatric illness.	Sad or disinterested mood, poor appetite, energy, sleep, and concentration, feelings of hopelessness, helplessness, and suicidality. In severe cases, very poor hygiene, hallucinations, delusions, and impaired decisional and functional abilities.	Treatable and reversible, although in some resistant cases electroconvulsive therapy (ECT) is needed.
Developmental Disorders (“DD”) including Mental Retardation (“MR”)	Brain-related conditions that begin at birth or childhood (before age 18) and continue throughout adult life. MR concerns low-level intellectual functioning with functional deficits that can be found across many kinds of DD, including autism, Down syndrome, and cerebral palsy.	Functioning tends to be stable over time but lower than normal peers. MR is most commonly mild. Some conditions such as Down syndrome may develop a supervening dementia later in life, causing decline in already limited decisional and functional abilities.	Not reversible, but everyday functioning can be improved with a wide range of supports, interventions, and less restrictive alternatives. Individuals with DD have a wide range of decisional and functional abilities and, thus, require careful assessment by skilled clinicians.
Parkinson’s Disease (PD)	Progressive brain disease that initially affects motor function, but in many cases proceeds to dementia.	PD presents initially with problems with tremors and physical movement, followed by problems with expression and thinking, and leading sometimes to dementia after a number of years.	PD is progressive, but motor symptoms can be treated for many years. Eventually, medications become ineffective and most physical and mental capacities are lost. Evaluation of capacity must avoid confusion of physical for cognitive impairment.

<b>Condition</b>	<b>Source</b>	<b>Symptoms</b>	<b>Treatability</b>
Persistent Vegetative State (PSV)	A state of minimal or no responsiveness following emergence from coma.	Patient is mute and immobile with an absence of all higher mental activity. Cannot communicate decisions and requires a substitute decision maker for all areas.	Cases of PSV usually lead to death within a year's time.
Schizophrenia	A chronic brain-based psychiatric illness	Hallucinations and delusions; poor judgment, insight, planning, personal hygiene, and interpersonal skills. May range from mild to severe, and impact on functional and decisional abilities, are likewise variable.	Many symptoms can be successfully treated with medication. Capacity loss often occurs when patients go off their medications.
Stroke or Cerebral Vascular Accident ("CVA")	A significant bleeding in the brain, or a blockage of oxygen to the brain.	May affect just one part of the brain, so individuals should be carefully assessed to determine their functional and decisional abilities.	Some level of recovery and improved function over the first year; thus a temporary guardianship might be considered if the stroke is recent.
Traumatic Brain Injury ("TBI")	A blow to the head that usually involves loss of consciousness.	Individuals with mild and moderate TBI may appear superficially the same as before the accident, but have persisting problems with motivation, judgment, and organization. Those with severe TBI may have profound problems with everyday functioning.	Usually show recovery of thinking and functional abilities over the first year; thus a temporary guardianship should be considered if the injury is recent.
Vascular Dementia ("VaD")	Multiple strokes that accumulate and cause dementia.	Decisional and functional strengths and weaknesses may vary, depending on the extent and location of the strokes.	May remain stable over time if underlying cerebrovascular or heart disease is successfully managed.

## Role of Judges in Capacity Determinations

### Protecting Rights

The underlying aim of guardianship is to protect the well-being of vulnerable individuals. The reality is, however, that the appointment of a guardian results in the partial or complete loss of liberty and a potential litany of legal rights that adults enjoy, including the right to contract, vote, travel at will, and decide where to live. The potential loss of these rights may be further exacerbated by ageist stereotypes. Moreover, losing rights to make choices can be a self-fulfilling prophesy: “taking away people’s rights to make decisions on their own makes them less competent.”<sup>38</sup> Identifying the choices and rights that should remain intact depends directly on the quality of the capacity determination process.

### Promoting Self Determination

Along with identifying deficits in functioning, a careful determination of capacity identifies the individual’s strengths and the circumstances or environment that can maximize the individual’s capacities.

### Identifying Less Restrictive Alternatives

Closely related to the goal of promoting self-determination is the identification of intervention strategies short of guardianship that protect an individual’s well-being with as little intrusion as possible into legal rights and autonomous functioning.

### Providing Guidance to Guardians

The guidance provided by a high-quality capacity determination process assists the guardian after his or her appointment. By articulating the specific areas of functional deficit *and* areas of functional strength, along with the environmental features that may enhance functioning, the guardian can better prepare and implement a guardianship plan that permits and encourages the maximum self-functioning of the individual.

### Making Determinations of Restoration

Not all losses of functional capacity are permanent or progressive. A thorough understanding of the individual’s diagnosis, prognosis, and pattern of functional strengths and weaknesses helps identify those who may improve, and suggests a possible timetable for re-determination.

### Crafting Limited Guardianships

The ethical and conceptual preference for limited guardianship has been a core element of guardianship reform for a quarter century.<sup>39</sup> Limited guardianship seeks to attain an optimal balance of care and protection with autonomy and dignity. Today, limited guardianship is available in every state. Yet, the reality persists that it is underutilized.<sup>40</sup> The inadequacy of the clinical assessment process and its review in judicial proceedings often contributes to the under-use of limited guardianship. Without a thorough and discriminating mapping of functional strengths and weaknesses, limited guardianship has no feet to stand on.

## Overcoming Perceived Barriers to Limited Guardianship

- **Perceived barrier:** Limited guardianship is not an efficient use of judicial resources—as the person’s needs change, the guardian will be back in court for a modification of the order.

**Response:** Many [conditions](#) are stable or progress slowly. Moreover, preserving rights should not be compromised by convenience or cost-effectiveness.

- **Perceived barrier:** Unlike persons with mental retardation, elders with cognitive problems may be continually losing mental capacity and would require multiple modifications.

**Response:** While this may be true for some, it is not true for all. Alzheimer’s disease can progress rather quickly or may progress slowly over many years, stroke victims have long periods of stabilization, and some causes of cognitive impairment are [reversible](#).

- **Perceived barrier:** It causes ambiguity for third parties, who may not know exactly what authority the guardian has.

**Response:** The guardianship is for the benefit of the individual, not third parties. Clarity in court orders and [guardianship plans](#) will help the guardian in dealing with others.

- **Perceived barrier:** Judges may lack knowledge of what persons can and cannot do.

**Response:** A good [clinical](#) or [court](#) report describes the person’s specific functional abilities.

- **Perceived barrier:** With overcrowded dockets, judges do not have the time to craft individualized orders.

**Response:** [Semi-standard court orders](#) or [templates for limited guardianships](#) can provide a ready basis and allow the judge to individualize further when necessary. Judges may craft orders around the five functional domains: (1) care of self, (2) financial, (3) medical, (4) home and community, (5) other civil matters.

## Strategies for Improving Practice in Your Court

**H**ow do the procedures for clinical evaluation described in this book compare to contemporary practice? In a study funded by the Farnsworth Foundation, clinical evaluations from 308 guardianship files in eight courts from three states (Massachusetts, Pennsylvania, and Colorado) were reviewed. Colorado has had the most recent and most extensive reform modeled after the UPC; Massachusetts has not substantially revised its guardianship code; Pennsylvania has had an intermediate degree of guardianship reform. The mean length of reports (in words) across the states varied considerably, with Colorado having the longest clinical evaluations (M=924.03). The other states were considerably shorter: Pennsylvania (M=244.29); Massachusetts (M=82.62). Clinical reports in Colorado tended to provide more comprehensive clinical information, but in general, detailed information was missing from most clinical evaluation reports. For example, information on ADLs was provided only 38 % of the time in reports in Colorado (compared to 19% of reports in Massachusetts and 10% of reports in Pennsylvania). Information on the prognosis for the medical condition was provided only 54% of the time in Massachusetts (compared to 23% in Massachusetts and 22% in Pennsylvania).

Judges in Colorado were more likely to use limited orders: 34% of guardianships were limited. Limited guardianships were rarely used in Massachusetts (1.3%) or Pennsylvania (2.7%). Limitations in Colorado often concerned specific financial transactions, medical decisions, or removal from the judicial district. Qualitative analysis revealed some confusion regarding the use of a time limited guardianship (time limited, but based on a finding of incapacity) versus emergency guardianship (circumvents due process in the event of risk of substantial harm). **These analyses suggest that guardianship reform may be associated with improved quality of clinical evaluations and the use of limited orders. However, much more work is needed to educate clinicians so they provide judges the detailed information needed to craft limited orders.**

### **How can we improve the process of capacity assessment by clinical professionals?**

#### *Reform within the Healthcare Professions*

Within healthcare, there is an emerging recognition of the need to train professionals to provide better assessments of older adults for the purposes of guardianship. Many professional healthcare organizations are working to improve clinical practice in this area.

#### *Reform at the Statutory Level*

Further, much of guardianship law continues to evolve and as guardianship law becomes more consistent with modern understandings of the human brain, it is likely to exert an influence on the process of capacity assessment.

#### *Reform at the Individual Court Level*

Some of the most potent reform has come through the leadership of individual judges who work to improve guardianship practices within their court to better protect the rights and to provide for the needs of older adults under guardianship. Judges have developed innovative case management systems, paid or volunteer-based court investigator programs, paid or volunteer-based guardian monitor programs, all of which contribute to improved capacity assessment and monitoring.

Some specific strategies judges can use to improve the quality of clinical evaluation in their courts are:

- Provide [orders](#) with specific information needed in a clinical evaluation.
- Provide [forms](#) for clinicians to use in completing a clinical evaluation.
- In examination of clinicians, ask about overlooked areas in clinical evaluations, such as [everyday functioning](#), [values](#), whether [reversible causes of dementia](#) have been ruled out, [treatments](#) that might enhance functioning, and the prognosis for future functioning.
- Make [court investigator reports](#) available to clinicians.
- Have court investigators review clinical reports to ensure adequate quality and to determine if an independent medical examination would help.
- Sponsor joint educational conferences or networking groups bringing together key legal professionals in the area of guardianship with healthcare professionals.

## Temporary and Reversible Causes of Confusion

If any of these are present:

→ Provide appropriate treatment or accommodations.

→ Re-assess capacity after treatment or accommodation.

### Common Medical Causes

#### Causes of Delirium

Look for:

Did the evaluator consider how long the problem has been going on?  
Were standard lab tests and vitals done?

<input type="checkbox"/> Drugs <sup>9</sup>	> 6 meds or > 3 new meds or use of drugs that cause confusion
<input type="checkbox"/> Electrolytes	Low sodium, blood sugar, calcium, etc
<input type="checkbox"/> Lack of Drugs, Water, Food	Pain, malnutrition, dehydration
<input type="checkbox"/> Infection or Intoxification	Sepsis, urinary track infection, pneumonia; alcohol, metals, solvents
<input type="checkbox"/> Reduced Sensory Input	Impaired vision, hearing, nerve conduction
<input type="checkbox"/> Intracranial Causes	Subdural hematoma, meningitis, seizure, brain tumor
<input type="checkbox"/> Urinary Retention//Fecal Impaction	Drugs, constipation
<input type="checkbox"/> Myocardial	Heart Attack, heart failure, arrhythmia

#### Other Causes of Confusion

<input type="checkbox"/> Liver or kidney disease	Hepatitis, diabetes, renal failure
<input type="checkbox"/> Vitamin deficiency	Folate, nicotinic acid, thiamine, vitamin B12
<input type="checkbox"/> Post surgical state	Anesthesia, pain

### Common Psychosocial Causes

Look for: Was a careful case history taken?

- Transfer trauma (a recent move that has the individual disoriented)
- Recent death of a spouse or loved one
- Recent stressful event
- Depression and anxiety
- Insomnia

### Common Miscommunication Problems

Look for: Did the evaluator assess whether the person could see, hear, and understand questions?

- Difficulty understanding English
- Decisions impacted by religious, cultural, or ethnic background
- Low educational or reading level; illiterate
- Difficulty hearing or seeing

<sup>9</sup> The Delirium mnemonic is adapted from a chapter by Rudolph JL and Marcantonio ER.

<b>Medications That May Commonly Cause Confusion</b>		
<b>Class</b>	<b>Uses</b>	<b>Examples of More Problematic Medicines</b>
Anticholinergic	Block the action of the neurotransmitter acetylcholine	Atropine, Scopolamine, and many Antihistamines such as Chlorpheniramin, Cyproheptadine, Dexchlorpheniramine, Diphenhydramine, Hydroxyzine, Promethazine
Antidepressants	Depression	Amitriptyline, Doxepin
AntiParkinson drugs	Parkinson's disease symptoms	Levodopa (L-dopa or Sinemet), Bromocriptine
Antipsychotics	Hallucinations, Delusions	Chlorpromazine, Haloperidol, Thioridazine Thiothixene
Barbiturates	Sleep and Anxiety	Phenobarbital, Secobarbital
Benzodiazepines	Sleep and Anxiety	Chlordiazepoxide, Diazepam, Flurazepam, Nitrazepam
Histamine-2 (H2) Blockers	Block the action of gastric acid secretion	Cimetidine, Famotidine, Nizatidine, Ranitidine
Nonsteroidal antiinflammatory drugs (NSAIDs)	Pain	Ibuprofen, Indomethacin
Opioids	Pain	Morphine, Propoxyphene, Meperidine
Steroids	Inflammation, Pulmonary disease	Predisone, Dexamethasone, Methylprednisolone

<b>Distinguishing Delirium from Dementia</b>		
<b>Characteristics</b>	<b>Delirium</b>	<b>Dementia</b>
Onset	Acute	Insidious
Course	Fluctuating	Stable and deteriorating
Duration	Hours to weeks, sometimes longer	Months to years
Attention	Poor	Usually normal
Perception	Hallucinations and misperceptions	Usually normal
Consciousness and orientation	Clouded; disoriented	Clear until late stages
Memory	Poor memory after 1 minute or more	Poor memory after 15 minutes or more, but may be okay in shorter time periods

Note: The most critical factors in distinguishing a temporary cause of impairment from dementia are: **comes on rather suddenly, fluctuates between good and bad, problems with attention.**

## Useful Websites

Administration on Aging	<a href="http://www.aoa.gov">http://www.aoa.gov</a>
Alzheimer's Association	<a href="http://www.alz.org">http://www.alz.org</a>
AARP	<a href="http://www.aarp.org">http://www.aarp.org</a>
American Bar Association Commission on Law and Aging	<a href="http://www.abanet.org/aging">http://www.abanet.org/aging</a>
American College of Trust & Estate Counsel	<a href="http://www.actec.org/">http://www.actec.org/</a>
American Medical Association	<a href="http://www.ama-assn.org/">http://www.ama-assn.org/</a>
American Psychological Association	<a href="http://www.apa.org">http://www.apa.org</a>
American Psychiatric Association	<a href="http://www.psych.org/">http://www.psych.org/</a>
Centers for Medicaid & Medicare Services	<a href="http://www.cms.hhs.gov">http://www.cms.hhs.gov</a>
Conference of State Court Administrators	<a href="http://cosca.ncsc.dni.us/">http://cosca.ncsc.dni.us/</a>
First Gov for Seniors (Federal clearinghouse)	<a href="http://www.firstgov.gov/Topics/Seniors.shtml">http://www.firstgov.gov/Topics/Seniors.shtml</a>
Medicare	<a href="http://www.medicare.gov">http://www.medicare.gov</a>
National Academy of Elder Law Attorneys	<a href="http://www.naela.com/">http://www.naela.com/</a>
National Association of Area Agencies on Aging	<a href="http://www.n4a.org/">http://www.n4a.org/</a>
National Association for Court Management	<a href="http://www.nacmnet.org/">http://www.nacmnet.org/</a>
National Association of Professional Geriatric Care Managers	<a href="http://www.caremanager.org/">http://www.caremanager.org/</a>
National Association of Social Workers	<a href="http://www.naswdc.org">http://www.naswdc.org</a>
National Association of State Judicial Educators	<a href="http://nasje.org/">http://nasje.org/</a>
National Association of	

State Units on Aging	<a href="http://www.nasua.org/">http://www.nasua.org/</a>
National Center for State Courts	<a href="http://www.nasua.org/">http://www.nasua.org/</a>
National College of Probate Judges	<a href="http://www.ncpj.org/">http://www.ncpj.org/</a>
National Council on Aging	<a href="http://www.ncoa.org">http://www.ncoa.org</a>
National Committee to Preserve Social Security & Medicare	<a href="http://www.ncpssm.org">http://www.ncpssm.org</a>
National Disability Rights Network	<a href="http://www.napas.org/">http://www.napas.org/</a>
National Guardianship Association	<a href="http://www.guardianship.org/">http://www.guardianship.org/</a>
Social Security Administration	<a href="http://www.socialsecurity.gov">http://www.socialsecurity.gov</a>

## Values

**This form provides a guide for asking individuals about their core values. This form may be used in a capacity evaluation to understand how choices relate to values, and can be used to form the basis of a guardianship plan.**

### **Your Values and Your Medical Decisions<sup>41</sup>**

1. First, think about what is most important to you in your life. What makes life meaningful or good for you now?
2. Now, think about what is important to you in relation to your health. What, if any, religious or personal beliefs do you have about sickness, health care decision-making, or dying?
3. Have you or other people you know faced difficult medical treatment decisions during times of serious illness?
4. How did you feel about those situations and any choices that were made?
5. Some people feel a time might come when their life would no longer be worth living. Can you imagine any circumstances in which life would be so unbearable for you that you would not want medical treatments used to keep you alive?
6. If your spokesperson ever had to make a medical decision on your behalf, are there certain people you would want your spokesperson to talk to for advice or support (family members, friends, health care providers, clergy, other)?
7. Is there anyone you specifically would NOT want involved in helping to make health care decisions on your behalf?
8. How closely would you want your spokesperson to follow your instructions about care decisions, versus do what they think is best for you at the time decisions are made?
9. Should financial or other family concerns enter into decisions about your medical care? Please explain.
10. Are there other things you would like your spokesperson to know about you, if he or she were ever in a position to make medical treatment decisions on your behalf?

### **Your Values and Your Financial Decisions**

1. What is your financial history? Are you in any debt? Do you live week to week? Are you able to plan ahead and save for the future?
2. Do you have enough money to provide for yourself in your retirement?
3. Have you made a will?
4. How knowledgeable are you about financial investments? What, if any, types of investments do you currently have?
5. What are the things you like to spend money on? In spending money, what are your highest priorities?
6. Are there people or organizations to whom you generally make gifts or contributions?
7. How would you like to invest and manage your money in the future? Do you want to stick with what you know, or are you open to new investment options?
8. Do you prefer higher-risk investments with a possibility of higher return, or lower-risk investments with a smaller, guaranteed return?
9. If you needed help with your finances, who would you like to help you? Who can you trust to ensure your best interests?
10. How well does this person handle his or her own finances? Is he/she in debt? Does he/she have a good credit record? Is he/she knowledgeable about financial investments?
11. Do you currently have or would you like to obtain a financial advisor? Would this person be a more objective spokesperson than a relative or close friend?
12. Are there certain people with whom you would like your spokesperson to discuss financial decisions on your behalf (family, financial advisors, other)?
13. Is there anyone you specifically would NOT want to be involved in helping to make financial decisions on your behalf?
14. How closely would you want your spokesperson to follow your instructions about financial decisions, versus what he or she thinks is best for you at the time decisions are made?
15. Are there other things you would like your spokesperson to know about you, if he or she were ever in a position to make financial decisions on your behalf?

### **Your Values and Your Home and Community**

1. Where are you living now? How long have you been there?
2. Does anyone live there with you? If not, do you have any fears or concerns about living alone?
3. Does anyone visit on a regular basis?
4. What family and/or friends live in your community who are important to you?
5. What is most important to you about where you live? What makes it “home”?
6. What kind of personal activities do you enjoy doing at home?
7. Are there community activities in which you enjoy participating?
8. What do you like about your house/apartment?
9. What do you not like about your house/apartment? What does not work well for you and why?
10. Do you feel that you can manage the house/apartment on your own? Have you noticed any changes in your abilities to manage?
11. Are there areas of your life that you feel you may need some assistance managing? For instance, do you have any trouble with housekeeping, yard work, preparing meals, shopping, driving, using the telephone, the mail, your health, taking medications, managing your money, or paying bills on your own?
12. Is there someone helping you with any of these things?
13. If you needed help, who would you like to help you?
14. Have you had any safety concerns at home? For instance, have you ever accidentally left the stove or oven on, fallen and been unable to get up by yourself, left your doors unlocked, or invited a stranger into your home?
15. Where would you like to live in the future?
16. Have you ever considered moving to a place where there would be more help for you, such as senior housing, assisted living, or a nursing home? How do you feel about that? What fears or concerns do you have?
17. If you were to move to senior housing, assisted living, or a nursing home, what would make it okay for you? Is there anything important that you would want to take or do in a different living situation?



## End Notes

- <sup>1</sup> Lawrence A. Frolik, *Promoting Judicial Acceptance and Use of Limited Guardianship*, 31 *Stetson L. Rev.* 735 (Spring 2002).
- <sup>2</sup> *Uniform Guardianship and Protective Proceedings Act* (1997).
- <sup>3</sup> Bruce D. Sales, Matthew Powell, Richard Van Duizend & Associates, *Disabled Persons and the Law: State Legislative Issues* (ABA 1982).
- <sup>4</sup> *Supra* n. 2.
- <sup>5</sup> Commission on National Probate Court Standards and Advisory Committee on Interstate Guardianships, *National Probate Court Standards* (1999) (which directs probate judges to “detail the duties and powers of the guardian, including limitations to the duties and powers, and the rights retained by the respondent”).
- <sup>6</sup> Sally Balch Hurme, *Current Trends in Guardianship Reform*, 7(1) *Maryland J. of Contemporary Legal Issues: Guardianship* 143-189 (1995-96); Frolik, *supra* n. 1; Mary Joy Quinn, *Guardianships of Adults: Achieving Justice, Autonomy, and Safety* (Springer 2005).
- <sup>7</sup> Peggy Dervitz, Shashi Jain & Joan Kakascik, *Preference/Choice/Decision: A Model for Limited Guardianship* (Guardianship Assoc. of N.J. 2003).; Peggy Dervitz, Shashi Jain & Joan Kakascik, *Assessing Capacity for People with Developmental Disabilities: Implementing the Model for Limited Guardianship* (Guardianship Assoc. of N.J. 2004).
- <sup>8</sup> *Supra* n. 2, at § 102(5).
- <sup>9</sup> Mass. Gen. Laws Ann. ch. 201, § 6 (West 1999).
- <sup>10</sup> N.Y. Mental Hyg. Law, § 81.02(b) (McKinney 1999).
- <sup>11</sup> Ohio Rev. Code Ann. § 2111.01(D) (Anderson 1999).
- <sup>12</sup> 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).
- <sup>13</sup> *Supra* n. 2, at § 314(a).
- <sup>14</sup> Charles P. Sabatino & Susanna L. Basinger, *Competency: Reforming Our Legal Fictions*, 6 *J. of Mental Health and Aging* 119 (2000).
- <sup>15</sup> *Supra* n. 1, at 737-738.
- <sup>16</sup> Quinn, *supra* n. 6, at 133.
- <sup>17</sup> *Supra* n. 2, at § 312.
- <sup>18</sup> *Supra* n. 5, at Standard 3.3.6.
- <sup>19</sup> Michael Mayhew, *Survey of State Guardianship Laws: Statutory Provisions for Clinical Evaluations*, 26 *Bifocal*, (newsletter of the ABA Comm’n on Law and Aging) 1 (Oct. 2005).
- <sup>20</sup> Sally Balch Hurme & Erica Wood, *Now and Then: Factoids on Adult Guardianship Statutory Reform* (2001) (unpublished paper available through the ABA Comm’n on Law and Aging).
- <sup>21</sup> 42 C.F.R. § 483.20.
- <sup>22</sup> See R. Kevin R. Wolff, *Determining Patient Competency in Treatment Refusal Cases*, 24 *Ga. L. Rev.* 733, 743 (1990); Barry R. Furrow et al., *Health Law*, §17-11 to §17-14 (West 1995).
- <sup>23</sup> Arthur C. Walsh et al., *Mental Capacity* (2d ed., Thompson West 1994); see also, John Parry & F. Phillips Gilliam, *Handbook on Mental Disability Law* (ABA 2002).
- <sup>24</sup> Edward Etchells et al., *Assessment of Patients Capacity to Consent to Treatment*, 14 *J. of Gen. Internal Med.* 27-34 (1999)
- <sup>25</sup> Maria T. Carney, Judith Neugroschl, R. Sean Morrison, Deborah Marin & Albert L. Siu, *The Development and Piloting of a Capacity Assessment Tool*, 12 *J. of Clinical Ethics* 17-23 (2001).
- <sup>26</sup> Daniel C Marson, Kellie K. Ingram, Heather A. Cody & Lindy E. Harrell, *Assessing the Competency of Patients with Alzheimer’s Disease Under Different Legal Standards*, 52 *Arch Neurol.* 949-954 (1995).
- <sup>27</sup> G. Bean, S. Nishisato, N.A. Rector & G. Glancy, *The Assessment of Competence to Make a Treatment Decision: An Empirical Approach*, 41 *Canadian J. of Psych.* 85-92 (1996).
- <sup>28</sup> J.G. Wong, I.C.H. Clare, A.J. Holland, P.C. Watson & M. Gunn, *The Capacity of People with a “Mental Disability” to Make a Health Care Decision*, 30 *Psychol. Med.* 295-306 (2000).
- <sup>29</sup> Stephen J. Anderer, *Developing an Instrument to Evaluate the Capacity of Elderly Persons to Make Personal Care and Financial Decisions* (unpublished Ph.D. dissertation, Allegheny Univ. of Health Sciences 1997) (on file with Allegheny University).
- <sup>30</sup> Daniel C. Marson, Stephen M. Sawrie, Scott Snyder, Bronwyn McInturff, Tracey Stalvey, Amy Aldridge, Anjan Chatterjee, & Lindy.E. Harrell, *Assessment of Financial Capacity in Patients with Alzheimer’s Disease: A Prototype Instrument*, 57 *Arch. Neurol.* 877, 887 (2000)

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- <sup>31</sup> Barry. Edelstein, Margaret Nygren, Lynn Northrop, Natilie Staats & David Pool, Presentation, *Assessment of Capacity to Make Financial and Medical Decisions* (Meeting of the American Psychological Association, Toronto, Aug. 1993).
- <sup>32</sup> Patricia A. Loeb, *Independent Living Scales* (Psychological Corp. 1996).
- <sup>33</sup> Thomas Grisso & Paul S. Applebaum, *Assessing Competence to Consent to Treatment Oxford* (Oxford 1998).
- <sup>34</sup> Sally Balch Hurme, *Steps to Enhance Guardianship Monitoring* (ABA 1991).
- <sup>35</sup> See ABA Comm'n on Mental and Physical Disability Law & Comm'n on Legal Problems of the Elderly, *Opening the Courthouse Door: An ADA Access Guide for State Courts* (ABA 1992).
- <sup>36</sup> In *Shelton v. Tucker*, 363 U.S. 479 (1960).
- <sup>37</sup> Proceedings in *Lake v. Cameron*, 364 F. 2d 657, 658 (D.C. Cir. 1966).
- <sup>38</sup> *Supra* n. 7, *Preference/Choice/Decision: A Model for Limited Guardianship*.
- <sup>39</sup> See e.g., Lawrence A. Frolik, *Plenary Guardianship: An Analysis, a Critique, and a Proposal for Reform*, 23 Ariz. L. Rev. 599, 652-660 (1981).
- <sup>40</sup> See Sally Balch Hurme, *Limited Guardianship: Its Implementation Is Long Overdue*, 28 Clearinghouse Rev. 660, 661 (1994); Pat M. Keith & Robbyn R. Wacker, *Guardianship Reform: Does Revised Legislation Make a Difference in Outcomes for Proposed Wards?* 4 J. of Aging and Soc. Policy 139 (1992).
- <sup>41</sup> Michele J. Karel, Jeanne Powell & Michael Cantor, M.D., *Using a Values Discussion Guide to Facilitate Communication in Advance Care Planning*, 55 Patient Ed. and Counseling 22-31 (2004).