April 14, 2019

Dear Workgroup Members,

This is the fourth installment of reading materials for our study. (See attachment.) It focuses on recommended "best practices" for capacity assessments conducted by psychologists.

The basis for these recommended practices is a 185-page *Guidebook for Psychologists* published in 2008 by a joint committee of the American Psychological Association and the American Bar Association. (https://www.apa.org/images/capacity-psychologist-handbook_tcm7-78003.pdf)

After reading the guidebook, I prepared a 20-page document containing the most relevant excerpts from it. While your reading of either the guidebook or the excerpts is optional, these guidelines give us a sense of what the legal and psychological professions believe is important for psychologists to keep in mind, and put into practice, when they conduct capacity assessments in the context of guardianship or conservatorship proceedings.

Nine conceptual elements are at the foundation of the best practices recommended in the guidebook.
(1) identifying the applicable **legal standard**(s)
(2) identifying and evaluating **functional elements** constituent to the capacity
(3) determining relevant medical and psychiatric **diagnoses** contributing to incapacity
(4) evaluating **cognitive functioning**
(5) considering **psychiatric and/or emotional factors**
(6) appreciating the **individual's values**
(7) identifying **risks** related to the individual and situation
(8) considering **means to enhance the individual's capacity**
(9) making a **clinical judgment of capacity**.

The guidebook reminds psychologists of the seriousness of the capacity assessment process and emphasizes how the procedures they use and the opinions they render can have very serious consequences for seniors and people with disabilities. The principles of necessity, less restrictive alternatives, and identifying methods to enhance or improve capacity, appear throughout the guidebook.

At a minimum, please consider skimming through the attached 20-pages of excerpts. The next installment of readings (fifth) will be excerpts from an ABA capacity assessment guidebook for attorneys, and the one after that (sixth) will be excerpts from an ABA capacity assessment guidebook for judges.

I believe these "best practices" guidelines will be helpful when we examine the capacity assessment process as it occurs in California and when we deliberate proposals to improve that process.

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p.s. You can find all previously sent reading materials at:
www.spectruminstitute.org/capacity/readings.htm

Excerpts From

Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists

American Bar Association/American Psychological Association
Assessment of Capacity in Older Adults Project Working Group

The ABA-APA Working Group on the Assessment of Capacity in Older Adults was established in 2003 under the auspices of the Task Force on Facilitating ABA-APA Relations. The workgroup has produced two volumes thus far, a handbook for attorneys and a handbook for judges. The current volume is **designed for psychologists evaluating civil capacities of older adults**. Contemporary probate law encourages **functional assessments** that describe task-specific deficits rather than global findings.

The specific goal of this handbook is to review psychological assessment of six civil capacities of particular importance to older adults, namely, **medical** consent capacity, **sexual** consent capacity, **financial** capacity, **testamentary** capacity, capacity to **drive**, and capacity to **live independently**. The handbook also addresses the important topic of **undue influence** and introduces emerging areas of interest, such as . . . the capacity to **vote.**

Chapter 3 lays out a nine part framework for conceptualizing capacity assessments. The framework expands on Thomas Grisso's conceptual model as it has evolved through discussion among working group members. Nine conceptual elements for conducting a capacity assessment are:

(1) identifying the applicable **legal standard**(s)
(2) identifying and evaluating **functional elements** constituent to the capacity
(3) determining relevant medical and psychiatric **diagnoses** contributing to incapacity
(4) evaluating **cognitive functioning**
(5) considering **psychiatric and/or emotional factors**
(6) appreciating the **individual's values**
(7) identifying **risks** related to the individual and situation
(8) considering **means to enhance the individual's capacity**
(9) making a **clinical judgment of capacity**.

The next two chapters, Chapter 4 and Chapter 5, move away from theoretical models and provide more practical guidance to the clinician. Chapter 4 addresses important pre-assessment considerations including understanding the "who", "what", "why", and "when" of a particular capacity referral. In general, capacity evaluations require a more extensive "pre-assessment" process; this chapter provides information regarding what type of data should be collected prior to meeting the older adult. It further discusses the various roles a psychologist may play as an expert in these types of cases. Chapter 5 provides an overview of functional, cognitive, and behavioral assessment tools that may be used in capacity evaluations, with the understanding that there is no "capacimeter" or standardized battery that will work for all cases.

Chapter 6 covers **in depth the assessment of each of the six specific capacities** (medical consent capacity, sexual consent capacity, financial capacity, testamentary capacity, capacity to drive, and

capacity to live independently). Each section reviews up-to-date **relevant clinical literature** and relevant assessment tools, walking through the nine-part framework in light of that specific capacity.

Chapter 7 introduces the related but also distinct concept of **undue influence** to the reader. Undue influence is a legal construct which refers to a dynamic in a confidential relationship where a stronger party exploits their influence of a weaker party, often for financial gain. This chapter covers **legal definitions, clinical frameworks, and an assessment strategy** for psychologists working with older adults that are potentially at risk or the victims of undue influence.

Chapter 8 provides psychologists with practical **advice for working with attorneys and the courts** on matters related to capacity cases.

In Chapter 9 emerging capacity areas are introduced. These include the capacity to consent to research, the capacity to mediate, and the capacity to vote.

In summary, the handbook seeks to provide a relatively concise yet also comprehensive reference in the area of civil capacity assessment of older adults by psychologists.

Purpose of Handbook. The purpose of the handbook is to promote sound assessment of older adults, which lead to appropriate interventions that balance promotion of autonomy and protection from harm. *This handbook is not a practice guideline and is not intended to establish a standard against which clinical practice is to be evaluated.* Rather, this handbook **provides a framework** and assessment examples that psychologists may find useful and effective in capacity evaluation.

Age Considerations. An evaluation of capacity may be utilized to resolve critical disagreements about individual decisions, and the need to **offer protection versus to promote autonomy**. In a civil capacity evaluation, these decisions may be about the most personal matters in one's life: what procedures will be done to your body, where you will live, who you are intimate with, how you spend your money. **All persons are presumed to have capacity**, and, when this is so, have the "right to folly" – that is – have **the right to make "bad" decisions**. The psychologist performing a civil capacity evaluation is often addressing just this issue: is this person making a decision we disagree with, but one we must respect because the person has capacity, or, because this person lacks the capacity to make the decision, must we step in to protect him or her. In these situations, psychologists may **need to guard against ageism** in themselves and others.

Confusion About the Term Capacity. Many psychologists may be more familiar with the term **competency rather than capacity**. Some recommend the term competency be used only to refer to a legal finding, with the term capacity to refer to clinical findings. While this is an excellent practice as far as it goes, it only goes so far, since many practitioners do not abide by the distinction. In practice many clinicians still refer to a patient's "competency," leading to ongoing confusion. One approach to avoid confusion is to simply **adopt the phrase "legal capacity" and "clinical capacity."**

Some use the term **decision-making capacity** interchangeably with capacity, or to describe capacity domains that are specifically and only decisional in nature. That is, a distinction may be drawn between **decisional capacity** (the capacity to decide) versus **executional capacity** (the capacity to implement a decision) (Collopy, 1988). For example, the capacity to make a health care decision may only involve cognitive processes of deciding, whereas the capacity to manage finances may involve

making decisions and executing actions in concordance with decisions (e.g., balancing a checkbook). Importantly, the mere presence of physical inability and loss of "executional capacity" does not constitute incapacity, as **the individual who retains decisional capacity may direct another to perform the task.**

Another distinction may be drawn between **global capacity versus specific capacities**. Both clinical and legal professionals have used the term "competency" to refer to a person's global ability to engage in a wide range of functions. It has traditionally been thought of as categorical—an individual either is competent or is not. However, within the global application of the term competency, there was little if any consideration of: (a) the ability to successfully perform specific functions; (b) intra-individual variance in performance across functional domains; or (c) potential methods of enhancing an individual's ability to perform a given function or functions.

Currently, the emphasis is shifting in both clinical and legal settings to the use of the term capacities to allow a **focus on the specific functional capacities**, and means of **maximizing those capacities**. This shift can be seen in civil law, particularly in guardianship and other surrogate decision-making areas in a preference for the term capacity. Guardianship is a relationship created by state law in which a court gives one person or entity (the guardian) the duty and power to make personal and/or property decisions for another (the incapacitated person) upon a court finding that an adult lacks capacity to make decisions for him or herself.

When a petition for guardianship is filed, psychologists may be asked to evaluate a broader set of capacities—can this person be independently responsible for his or her life? However, this question still does not translate into all-or-none "competency." Psychologists providing evaluations will offer a great deal to the courts by assessing specific domains, and **identifying areas of retained strengths**, which will enable the judge to craft a **"limited order,"** that is, to limit the authority of the guardian to only those areas where the person needs assistance (American Bar Association Commission on Law and Aging et al., 2006).

Legal Standards of Diminished Capacity

Historically, the law's approach to incapacity reflects a long-standing paradox. On the one hand, our legal system has always recognized the situation-specific nature of capacity, depending on the particular event or transaction—such as capacity to make a will, marry, enter into a contract, vote, drive a car, stand trial in a criminal prosecution, and so on (Parry, 1985). A finding of incapacity in any of these matters could nullify or prevent a particular legal act.

On the other hand, at least until very recently, determinations of incapacity in the context of guardianship or conservatorship proceedings **were routinely quite global**, absolute determinations of one's ability to manage property and personal affairs. A finding of incapacity under guardianship law traditionally justified intrusive curtailments of personal autonomy and resulted in a virtually complete loss of civil rights (Frolik, 1981; Horstman, 1975).

In the last few decades, most states have moved away from the all or nothing approach to guardianship and moved toward a preference for—or at least recognition of—a **limited guardianship model** that appoints a guardian for the person with incapacity only in those areas of functioning in which capacity is shown to be lacking. One result of this more finely tuned approach to capacity assessment is a fundamental change in terminology in the law.

Historically, it was common to use the term "incompetency" to refer to the legal finding of incapacity, and the term "incapacity" to refer to the clinical finding. That distinction no longer works, as most states have moved away from the terminology of "incompetency" in favor of function-specific "capacity" and "incapacity." Therefore, to avoid confusing the legal and clinical concepts of capacity, we articulate the distinction very simply as either "**legal capacity**" or "clinical capacity."

Standards of Capacity for Specific Legal Transactions

The starting point in the law is **a presumption that adults possess the capacity** to undertake any legal task they choose, unless they have been adjudicated as incapacitated to perform the task in the context of guardianship or conservatorship, or where a party challenging their capacity puts forward sufficient evidence of incapacity in a legal proceeding to meet a requisite burden of proof. The definition of "**diminished capacity**" in everyday legal practice **depends on the type of transaction** or decision under consideration, **as well as upon the jurisdiction** in which one is located (Walsh, 1994; Parry & Gilliam, 2002). Across jurisdictions, legal capacity has multiple definitions, set out in either state statutory and/or case law.

Diminished Capacity in State Guardianship Law

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

The law of guardianship has evolved extensively from its **English roots**. Originally, the law required a finding that the alleged incapacitated person's **status** was that of an "idiot," "lunatic," "person of unsound mind," or "spendthrift."

Present day notions of incapacity instead use a combination of more finely-tuned **medical and functional criteria**. A common post- World War II paradigm for the definition of incapacity under guardianship laws was a two-pronged test that required: (1) a finding of a **disabling condition**, such as "mental illness," "mental disability," "mental retardation," "mental condition," "mental infirmity," or "mental deficiency;" and (2) a finding that such condition causes an **inability to adequately manage** one's personal or financial affairs (Sabatino & Basinger, 2000). Under this definition, the disabling condition prong of the test was quite broad. Many states included "physical illness" or "physical disability" as a sufficient disabling condition, and some opened a very wide door by including "advanced age" and the catch-all "or other cause."
Such **amorphous and discriminatory labels** invited overly subjective and arbitrary judicial determinations. Over time, states sought to refine both prongs of this test to make the determination of incapacity less label-driven, more specific, and **more focused on how an individual functions** in society.

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

condition language in the definition of incapacity:

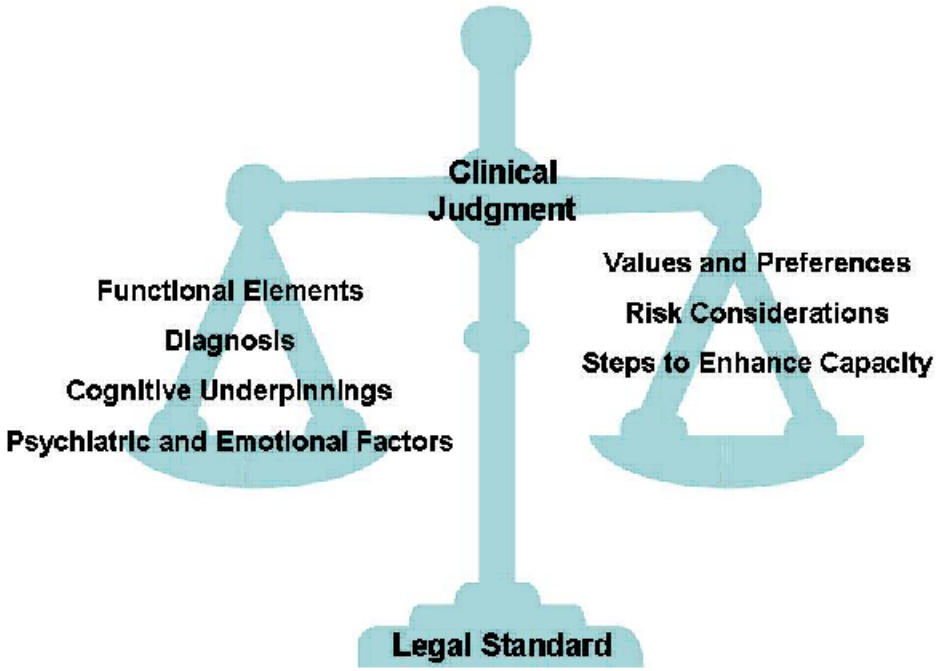
> "Incapacitated person" means an individual who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance (Uniform Guardianship and Protective Proceedings Act, 1997).

The three tests—disabling condition, functional behavior, and cognitive functioning—have been "mixed and matched" by states in a variety of ways (Sabatino et al., 2000). Some combine all three (Hurme & Wood, 2006). More importantly, the majority of states have added significant additional requirements as thresholds for guardianship intervention—most commonly a finding that the guardianship is "**necessary**" to provide for the essential needs of the individual (i.e., there are no other feasible options) or, stated alternatively, that the imposition of a guardianship is "**the least restrictive alternative**" (Sabatino et al., 2000). . . . Under the principle of the least restrictive alternative, the objective is to leave as much in the hands of the individual as possible.\

Undue Influence

Capacity assessment focuses on an individual's cognitive, functional, and decisional abilities relative to the complexity and risk of the legal transaction at hand. Undue influence refers to a **dynamic between an individual and another person**. It describes the **bending of one person's will** to the extent that the will of the perpetrator is substituted for that of the victim.

Conceptual Framework for Capacity Assessment



A clinical judgment about capacity of an older adult is exactly that—a professional clinical decision. There is no equation, cookbook, or test battery for the assessment of capacity. A one-size fits all approach is doomed to failure because of the varying domains of capacity, legal standards used to define specific capacities, and the need to integrate multiple sources of data in complex clinical situations. It is, however, **useful to have a framework** of the critical elements in capacity assessment, which may function to guide the psychologist in the assessment process.

A Framework for Capacity Assessment
1. Legal Standard
2. Functional Elements
3. Diagnosis
4. Cognitive Underpinnings
5. Psychiatric or Emotional Factors
6. Values
7. Risk Considerations
8. Steps to Enhance Capacity
9. Clinical Judgment of Capacity

Legal Standard. Clinical evaluations of capacity are grounded in a clinician's opinion about a person's ability to make a decision or perform a task that has a specific definition in the law. Therefore, the legal standard for the capacity in question forms the foundation of a capacity assessment. . . . The language in legal standards may not be consistent with clinical concepts, and may be so vague as to not provide much clarification for the clinical task. To locate legal standards, a psychologist may consult statutory and case law precedent within his or her state. Most likely, the psychologist will then want to consult with an attorney to discuss the legal standard and its meanings from a legal perspective.

Functional Elements. Functional assessment is a common component of gerontological assessment, and has been appreciated by clinicians (Scogin & Perry, 1987) who categorize functioning into the activities of daily living (ADLs) (e.g., grooming, toileting, eating, transferring, dressing) and the instrumental activities of daily living (IADLs) (e.g., abilities to manage finances, health, and functioning in the home and community). In the context of capacity assessment, an assessment of "**everyday functioning**" means some sort of tailored evaluation—with interview questions and, when possible **direct assessment and observation** of the individual's functioning—on the specific task in question.

Neuropsychological assessment may only assess cognition and may not include specific standardized functional assessment; therefore one difference between capacity assessment and most neuropsychological assessment is this **focus on functioning**, and the inclusion of some method to assess the specific capacity in question using **direct assessment**.

Diagnoses. Documentation of the medical diagnoses is a key element in capacity determination as they may be the causative factors explaining any functional disability. Grisso refers to the condition producing the disability as the "**causal factor**" in his model of capacity assessment (Grisso, 2003).

Some of these conditions may be **temporary and even reversible** if treated, including delirium, depression, bipolar disorder, and psychotic disorders, therefore in addition to identifying the cause of the functional problem, it is important to describe the prognosis and possibility of improvement

with time or treatment. The identification of the causes of any cognitive or behavioral impairment leads to an understanding of the likely course of the problem, prognosis, and identification of any treatments that may help. Because legal professionals are not clinically trained, it is critical to spell out information on **prognosis in plain language**—is the condition likely to get better, get worse, or stay the same, and if a change is likely to occur, when might that be?

Cognitive Underpinnings. In Grisso's model the "functional" element encompasses all facets of the individual's thinking and functioning. In our framework for clinical assessment we emphasize **three elements of functioning** to be separately addressed in clinical evaluation through interview or direct objective measures: **cognitive** functioning, psychiatric or **emotional** functioning, and **everyday** functioning. . . . In terms of guardianship, cognitive functioning is a component of statutory standards for capacity in many states (Sabatino & Basinger, 2000).

Psychiatric or Emotional Factors. An individual could have symptoms of depression, anxiety, or psychotic disorder and still be quite able to process information. However, when psychiatric or emotional disturbance is significant, such as severe depression, paranoia, or disinhibition, it may limit reasoning and judgment, and therefore impair capacity (Grisso et al., 1995). Many individuals with psychiatric or emotional disturbance **may improve with time and treatment**, and therefore it is especially critical in the capacity report to recommend treatment interventions and a time frame for reconsidering capacity.

Values and Preferences. A person's race, ethnicity, culture, gender, sexual orientation, and religion may impact his or her values and preferences (Blackhall, Murphy, Frank, Michel, & Azen, 1995; Hornung et al., 1998), and these lay the foundation for decisions. Age, cohort, and life experience are critical in forming values and preferences. Sexual orientation may not only influence values, but may have special implications in surrogate decision making (who is the person's family and who is the person's legally recognized decision maker). Cultural beliefs and practices may inform decisional preferences including the manner in which decisions are made (individual as decision maker versus family). Therefore all of these factors are crucial to consider in capacity assessment.

In this handbook we use the term "**values" to refer to an underlying set of beliefs, concerns, and approaches that guide personal decisions**, where as we use "**preferences" to refer to the preferred option of various choices** that is informed by values. For example, a person may value not being a burden on others, so may have a treatment preference that results in less caregiving burden.

Even when cognitive functioning may be compromised, for instance by dementia, a person may still be able to express important deep-rooted values underlying their decisions (Karel, Moye, Bank, & Azar, 2007). Further, **choices that are linked with lifetime values may be rational for an individual even if outside the norm**. For example, a choice to live in what many might consider substandard housing (e.g., a cabin in the woods without running water) may reflect a long-standing preference to live in such housing.

Risk of Harm and Level of Supervision Needed. Many capacity evaluations are **at heart a risk assessment** (Ruchinskas, 2005). Thus, the evaluation of the person and his or her medical conditions, cognitive and functional abilities, personal values and preferences, all elements that affect their day to day functioning, must be analyzed in reference to the **risk of the situation at hand**.

The **level of intervention** or supervision recommended as a result of the capacity assessment must **match the risk of harm** to the individual and the corresponding level of supervision required to mitigate such risk, and must include a full exploration of the least restrictive alternatives (Sabatino & Basinger, 2000).

Means to Enhance Capacity. An essential component of a capacity assessment is a consideration of **what can be done to maximize the person's functioning**. Practical **accommodations** (such as vision aids, medication reminders) and medical, psychosocial, or educational interventions (such as physical or occupational therapy, counseling, medications or training) may enhance capacity.

Clinical Judgment. As illustrated in the scales figure, the fulcrum of a capacity assessment is the clinical judgment. . . . [A]n individual may have advanced dementia with severe impairment across a range of functioning, and, therefore, clearly lack capacity for the issue in question. Or, an individual may have no or minimal impairments in assessed functional abilities and clearly have capacity for the task in question. However, the most challenging situation is that of individuals whose capacity impairment is not obvious—and these are the cases that psychologists are most likely to be asked to assess. These individuals in the "**middle ground**" of capacity may have moderate impairments in many areas, or significant impairment in some areas but not others, or, significant impairment, concerns about that are mitigated by consideration of the person's values, preferences, social supports, and risks.

In some situations, it may help to further delineate the capacity task—e.g., the person has the capacity to make a simple medical decision but not a complex or high-risk one. There are situations in which the psychologist may believe he or she cannot provide a strict "yes or no" answer, and may say the person has marginal capacity, if this can be supported by the evidence.

Planning Your Approach

Capacity assessments require more attention on the "pre-assessment" phase to determine what is being assessed and how the assessment should be planned. Therefore, a capacity assessment starts long before the psychologist sits down with the older adult.

Guardianship Proceedings. In some situations, it is clear from the outset that the reason for the capacity evaluation is to determine the need for a guardian. . . A psychologist's role in this case is to offer information as an expert to be used by the court in making the determination. . . The psychological evaluation for guardianship also has the potential to identify areas of retained functioning, and to therefore recommend domains in which a guardianship order may be limited.

What Functional Capacity Is in Question? Because it is the goal to craft a report that describes the older adult's specific strengths and weaknesses, it is necessary to take time to **ascertain exactly what domain is in question**. Answers to this question may include: medical consent, financial abilities, independent living, the ability to engage in binding contracts, the ability to buy or sell property, testamentary capacity, the capacity to drive, and the capacity to consent to sexual activity.

Who Are the Interested Parties or "Players" Involved in the Case? No matter what the context, there can be widely varying opinions and motivations surrounding the older adult's capacity. Be familiar with all of those with potential interest in the case and try to assess the motivations of the different participants.

Are There Less Restrictive Alternatives. Ideally, the clinician will work to put into place the least restrictive alternative that provides the older adult protection (if needed).

Reviewing the Records. A thorough clinical assessment includes a review of available medical records. . . . In guardianship cases, there may be conflicting expert opinions regarding the need for a guardian. Accessing previous assessments and legal records can help the clinician to organize the current assessment. In other types of capacity cases, for example those regarding financial capacity, it can be helpful to access banking statements and other financial information to determine if the older adult's report is accurate.

Clinical Interview. Although psychologists bring important abilities in the application of objective testing, the clinical interview remains an essential part of any capacity evaluation. . . It is important to **obtain functional information through interviews with the patient, and if appropriate, family and staff**. Discrepancies between older adult reports of their IADLS and ADLs and collateral or objective reports can be especially revealing. . . . An interview might include a history of the presenting problem, course, medical history, psychiatric history, substance/alcohol abuse, review of medications, and a review of symptoms.

Although cognitive testing will provide the standardized data to determine the presence or absence of impaired cognition, interview data can also provide a wealth of information regarding the nature and extent of the impairment. Many clinicians will begin with a brief mental status screening using an interview format or specific screening test to obtain a ballpark estimate of level of functioning.

Objective Testing: Functional. Capacity assessments involve the **integration of data from cognitive and functional sources.** In the past, older adult and/or collateral reports were primarily employed to examine the functional piece of the assessment. However, those reports may be biased by lack of insight or motivational issues. Newer approaches to functional capacities include **direct observation of older adult's abilities**, the use of functional measures abilities and functioning abilities, and structured interviews. Direct assessment of functional abilities can be performed by a psychologist as well as many allied health professionals. Occupational therapists have special training in assessing everyday functioning.

Capacity Assessment Tools. More recently, a number of clinicians and researchers have developed assessment tools that attempt to operationalize the legal standards for specific capacities into direct functional assessment instruments. Medical Consent Capacity. Capacity to consent to medical treatment has seen the most instrument development . . . Sexual Consent Capacity. There are currently no standardized tools to assess sexual consent capacity. Financial Capacity. Several tools exist for the psychologist to assess financial capacity . . . Testamentary Capacity. There are currently no standardized tools to assess testamentary capacity. Independent Living. In addition to IADL/ADL tools, some instruments have been developed to assess independent living in the context of capacity questions.

Objective Testing: Cognitive. Psychologists may employ a variety of tasks in the assessment of cognition. [These include tests for attention, language, memory, visual-perceptual, speed of processing, executive functioning, judgment, and reasoning.]

Objective Testing: Psychopathology. A variety of objective measures of psychopathology can be used to supplement information obtained via the interview and mental status examination. . .

Lengthy, comprehensive assessment instruments (e.g., MMPI) can be helpful, but often exact the costs of fatigue and diminished attention with older adults. This can be particularly problematic with individuals whom one already suspects may have compromised cognitive skills. The use of more targeted assessment instruments based on available information and the initial interview results is likely to prove more efficient and less taxing.

The Role of Collateral Interviews. Clinicians accustomed to working with older adults already know the value of conducting collateral interviews in order to ascertain the older adult's insight and areas of concern. In the capacity interview, these interviews take on added importance as a source of potentially objective data regarding the older adult's functional abilities. Multidisciplinary team members may serve as collaterals. It is necessary to obtain the older adult's permission to interview collaterals.

However, with any particular case, there may be family members with strongly differing opinions and motives regarding the outcome of the assessment. For example, in cases involving potential guardianship, there may be some family members who oppose such an action and others advocating for the protection. It is the clinician's role to ascertain the motives of the family members involved in the case and the implications for the collateral data.

Post Evaluation

At the completion of the assessment, the psychologist must now **form an opinion** regarding an individual's capacity. In doing so, the psychologist will consider a wide range of evidence, including functional skills relevant to the capacity in question, cognitive functioning, psychiatric functioning, medical diagnoses and prognosis, the individual's values, and situational risks relevant to the capacity. This requires a **careful weighing of these factors** in order to arrive, if possible, at a clear yes/no opinion regarding capacity. However, there will occasionally be borderline cases in which clinically the best judgment may be a finding of marginal capacity." Marginal capacity findings have value as long as they are based on evidence and not on the clinician's reluctance to offer a clear opinion on the matter. A court (if involved) will be able to consider a clinical finding of marginal capacity in its overall calculus in arriving at a legal capacity judgment.

In weighing the different sources of evidence, it is best for the clinician to focus initially on evidence regarding the **functional abilities** constituent to the capacity, as this is the evidence that is most capacity specific. Secondary levels of evidence include cognitive and psychiatric functioning, and medical diagnosis and prognosis, which are each relevant to capacity but not by themselves dispositive of capacity issues. . . As part of formulating a capacity judgment, consideration should be given to the individual's values and their relation to his/her behavior, and also to the specific risks inherent to the capacity situation. It is also **important to describe available means of enhancing an individual's capacity**, if such means are available and feasible.

Assessing Specific Capacities

Medical Consent.

The doctrine of **informed consent** requires clinicians to obtain voluntary and competent agreement to a medical intervention prior to performing the intervention, and only after the patient has been informed of the material risks, benefits, and other facts of the condition and procedure. In the area

of health care a variety of capacities might be raised—such as the capacity to consent to a specific medical treatment, the capacity to manage one's healthcare and medications, and the capacity to appoint a healthcare proxy (a decision maker for one's healthcare in the event of incapacity).

Capacity to Appoint a Health Care Proxy. [T]he capacity to execute an advance directive for health care is quite different than the capacity to make specific medical decisions, thought to be parallel to the capacity to contract. That is, it does not involve understanding and consenting to medical treatment but identifying a person to speak on one's behalf. . . . There is limited legal, conceptual, or empirical data on this topic (Allen et al., 2003).

Legal Standard [for medical capacity]. The ability to consent to medical treatment involves "functional" abilities that are cognitive in nature. Generally, in describing the functional elements of consent capacity, four case law standards commonly recognized to convey capacity are used . . [expressing a choice, understanding diagnostic and treatment information provided, relate treatment information to one's personal situation, and process this information in a logical or rationally consistent manner].

Risk Considerations. A "sliding scale" for capacity has been proposed when balancing risk considerations and the threshold for intervention. A relatively low level of capacity may be needed for a relatively low risk procedure. For example, a cognitively impaired patient in a nursing home may be more likely to be viewed as having the capacity to consent to a low-risk procedure, such as a standard blood draw, as compared to a high risk procedure, such as an invasive surgery.

Steps to Enhance Capacity. As with any psychological evaluation, and any capacity evaluation, the evaluator should strive to maximize the person's abilities during assessment by addressing sensory deficits and, when possible, evaluating the individual when most alert and awake.

Sexual Consent

Under American law, all individuals who have reached the age of consent have the right, and are assumed to have the capacity, to consent to sexual relations. The age of consent varies across states from 16 to 18 years of age. The nature of sexual behaviors requiring consent can range from touching to sexual intercourse. . . . Consent is the cardinal element in the determination of the legality of sexual relations (Stavis, 1991).

Unique aspects of sexual consent capacity differentiate it from other forms of consent capacity (Kennedy, 1999). For example, an individual facing a medical treatment decision is given information upon which a decision is to be made. There are opportunities for one to discuss this information with others and obtain advice from one's physician and significant others. There are often opportunities to weigh the risks and benefits of decisions with other individuals. In contrast, the individual facing a decision regarding sexual activities is often alone, with the exception of the sexual partner(s), often without the opportunity, or desire, to consult with others, and in a situation that often requires a relatively rapid response. Finally, there can be no surrogate decision maker for sexual relations.

Considerably more attention has been paid to the issue of sexual consent among intellectually disabled individuals in both the legal and clinical literatures, than to cognitively impaired older adults. Kennedy (1999) has argued that the sexual consent capacity standards applied to individuals with intellectual or developmental disabilities are applicable to individuals with dementia.

Legal Standard. There are no universally accepted criteria for capacity to consent to sexual relations (Lyden, 2007). The legal standards and criteria for sexual consent vary across states (Lyden, 2007; Stavis et al., 1999). The most widely accepted criteria, which are consistent with those applied to consent to treatment, are: (1) knowledge of relevant information, including risks and benefits; (2)understanding or rational reasoning that reveals a decision that is consistent with the individual's values (competence); and (3) voluntariness (a stated choice without coercion) (Grisso, 2003; Kennedy, 1999; Stavis, 1991; Stavis et al., 1999; Sundram et al., 1993). In light of the variation in standards across jurisdictions, the reader is encouraged to read relevant state law.

Functional Elements. Sexual consent is a complicated construct, with knowledge, capacity, and voluntariness, intertwined.

Knowledge . . . requires that an individual be able to demonstrate a basic knowledge of the sexual activities in question, potential risks (e.g., pregnancy, sexually transmitted diseases) and how to prevent them, the responsibilities of pregnancy and parenthood, illegal sexual activities (e.g., sexual assault, coercion, sexual activities with incapacitated individuals, sexual activities with under-age individuals), how to determine whether sexual activities are not desired by the partner, and appropriate times and places for sexual activities. . . . Possible cognitive abilities include attention, semantic memory for basic biological information regarding conception, pregnancy, sexually transmitted diseases, methods of preventing risks, social mores concerning sexual behavior, and illegal sexual activities.

Capacity . . . comprises the abilities of decision-making capacity (Appelbaum et al., 1988; Roth et al., 1977). They include the ability to understand the options related to the sexual behavior, appreciate the consequences of various courses of action, and express a choice that is based on a rational or logical consideration of relevant knowledge, including the personal benefits and risks of the sexual activity, and is consistent with the individual's values and preferences. . . . Possible cognitive abilities [relating to capacity] include attention, verbal comprehension of information presented by a potential partner, semantic memory for presented information, historical information that pertains to the current situation, and information pertaining to the risks and benefits of various sexual activities. These abilities also may include abstraction and executive functions required for the logical or rational consideration of the benefits and risks of the sexual activity, episodic memory for related experiences, personal values, and preferences.

Voluntariness . . . requires that an individual have the ability to make a decision regarding sexual activity that does not result from coercion, unfair persuasion, or inducements (Lyden, 2007; Moye, 2003). There are differences across jurisdictions regarding what constitutes illegal influence (Wertheimer, 2003). . . . Possible cognitive abilities [pertaining to voluntariness] include attention, abstraction, and executive functions for the consideration of factors that could imply coercion, unfair persuasion, or inappropriate inducements. Semantic and episodic memory may be required for contrasting the current circumstances with those previously experienced (directly or indirectly).

Steps to Enhance Capacity. Most of the abilities required for demonstrating sexual consent capacity are cognitive in nature. Sex education materials can be provided when deficits in knowledge are identified. Assistive devices can be provided for sensory deficits and physical disabilities. Depending upon the nature of memory deficits, memory aids can be created. Problem solving skills can be taught to augment an individual's ability to identify potential inappropriate or coercive situations, generate effective approaches to addressing these situations, and methods for selecting among the

alternatives generated. Rules of thumb, or heuristics, could be taught for avoiding or escaping such situations.

Clinical Judgment of Sexual Consent Capacity. Sexual behavior varies along several dimensions, including risk to the individual. Thus, the determination of capacity **need not require a binary judgment**. One should consider clinical judgments that include outcomes that vary along a dimension of potential risk to the resident and the partner. Recommendations can be made that would permit varying levels of sexual contact, intimacy, and risk.

Clinical Approaches. There are no generally accepted approaches or criteria for the assessment of consent to sexual activity. Stavis et al., (1999) suggest that the following be considered by the examining clinician, with the understanding that some individuals with capacity to consent would not meet all of these criteria:

> Is an adult, as defined by state law; demonstrates an awareness of person, time, place, and event; possesses a basic knowledge of sexual activities; possesses the skills to participate safely in sexual activities; i.e., whether the person understands how and why to effectively use an appropriate method of birth control, and whether the person chooses to do so; understands the physical and legal responsibilities of pregnancy; is aware of sexually transmittable diseases and how to avoid them; demonstrates an awareness of legal implications concerning wrongful sexual behaviors (e.g., sexual assault, inappropriateness of sex with minors, exploitation, etc.); can identify when others' rights are infringed; learns that 'no' from another person means to stop (i.e., understands that it is always inappropriate to have sex or engage in other activities with someone who says no or otherwise objects by words or action)s; knows when sexual advances are appropriate as to time and place (e.g., different places and times may apply to dancing, touching, sexual intercourse); does not allow his or her own disability to be exploited by a partner; knows when both parties are agreeing to the same sexual activity; does not exploit another person with a lower functioning who might not be able to say no or defend oneself; expresses understandable responses to life experiences (i.e., can accurately report events); can describe the decision-making process used to make the choice to engage in sexual activity; demonstrates the ability to differentiate fantasy and reality; possesses a reasoning process that includes an expression of individual values; can reasonably execute choices associated with a judgmental process; is able to identify and recognize the feelings expressed by others, both verbally and nonverbally; expresses emotions consistent with the actual or proposed sexual situation; rejects unwanted advances or intrusions to protect oneself from sexual exploitation; identifies and uses private areas for intimate behavior; is able to call for help or report unwanted advances or abuse (Stavis et al., 1999, p. 63-64).

Financial Capacity

Financial capacity is a medical-legal construct that represents the ability to independently manage one's financial affairs in a manner consistent with personal self-interest and values (Marson & Hebert, 2008a). Financial capacity, thus, involves not only performance skills (e.g., counting coins/currency accurately, completing a check register accurately, paying bills), but also judgment skills that optimize financial self-interest, and values that guide personal financial choices.

From a legal standpoint, financial capacity represents the financial skills sufficient for handling one's

estate and financial affairs, and is the basis for determinations of conservatorship of the estate (or guardianship of the estate, depending on the state legal jurisdiction).

From a clinical standpoint, financial capacity is a highly cognitively mediated capacity that is **vulnerable to neurological, psychiatric, and medical conditions that affect cognition** (such as dementia, stroke, traumatic brain injury, and schizophrenia).

Legal Elements/Standards.

[The] Uniform Guardianship and Protective Proceedings Act (UGPPA), . . . states that a court may appoint a conservator if the court determines that "the individual is **unable to manage property and business affairs because of an impairment in the ability to receive and evaluate information or make decisions, even with the use of appropriate technological assistance**" and the individual has **property that will be wasted or dissipated unless management is provided** or money is needed for the support, care, education, health, and welfare of the individual or of individuals who are entitled to the individual's support and that protection is necessary or desirable to obtain or provide money.

Functional Elements. Financial capacity is a complex, multidimensional construct representing a broad range of conceptual, pragmatic, and judgmental skills (Marson et al., 2005). Specific Abilities and Tasks. The first functional element is specific financial abilities or tasks, each of which is relevant to a particular domain of financial activity. In the model, many general domains can be further broken down into component tasks or abilities that emphasize understanding and pragmatic application of skills relevant to a specific domain. For instance, the domain of financial conceptual knowledge involves understanding concepts, such as loans and savings, and also using this information to select advantageous interest rates. Similarly, bill payment involves not only understanding what a bill is and why it should be paid, but accurately reviewing a bill and preparing it for mailing. General Domains. The second functional level is general domains of financial activity . . . In this model, core domains include basic monetary skills, financial conceptual knowledge, cash transactions, checkbook management, bank statement management, financial judgment, bill payment, knowledge of personal assets and estate arrangements, and investment decision making. Overall Capacity. The third functional level is overall financial capacity, or a global level. The global level of the model considers overall financial capacity . . . Such global judgments involve an integration of information concerning an individual's task and domain level performance, his/her judgment skills, and informant reports of financial abilities. Such global clinical judgments are particularly relevant to conservatorship hearings. The model has informed instrument development and served as the basis for several empirical studies of financial capacity in dementia (Marson et al., 2000; Griffith et al., 2003, Martin et al., 2008). However, these studies notwithstanding, there is **not yet a clear consensus as to the functional elements that comprise financial capacity**.

Diagnostic Considerations. Financial capacity is a multi-dimensional and highly cognitive mediated capacity. Accordingly, it is a capacity that is very sensitive to medical conditions that affect cognitive and behavioral functioning.

Cognitive Underpinnings. Due to the functional complexity of the financial capacity construct, it is not surprising that there are a wide variety of cognitive abilities that inform financial capacity. Preliminary conceptual work has suggested that financial capacity is comprised of three types of

knowledge: declarative knowledge, procedural knowledge, and judgmental abilities.

Psychiatric and Emotional Factors. Psychiatric and emotional factors can often play a significant role in the assessment of a patient's financial capacity. In some instances, clinical depression or psychotic thinking may affect an individual's ability to carry out basic financial tasks. More commonly, however, such psychiatric conditions will adversely affect an individual's judgment in managing their financial affairs.

Values. In assessing financial capacity, it is important to obtain information regarding an individual's lifelong values and approach to managing money and finances. As possible examples, has an individual during her adult life been scrupulous and detail oriented regarding her finances, or has she adopted a laissez faire approach and a dependence on others that has sometimes led to financial difficulties? Such information can help the psychologist determine whether an individual's recent problems managing money represent a departure from her premorbid baseline, or are simply an extension of a prior "lifestyle" regarding the management of money. This information in turn can inform the interpretation of evidence and the outcome of the capacity assessment.

Risk Considerations. The capacity to manage one's own finances is a core aspect of personal autonomy in our society, on a par with autonomy to drive a motor vehicle. Accordingly, the tension between **autonomy and protection** is high with respect to financial capacity: autonomy is highly desirable, but the potential negative consequences for individuals and families of failing capacity are equally strong. Risks of failing financial capacity include poor financial decisions, unintentional self-impoverishment, victimization and exploitation by others, and vulnerability to undue influence.

In assessing financial capacity, an **assessment of the relative risks** involved in a situation is important. The divorced investment banker with mild dementia who possesses a large stock portfolio and multiple assets presents a different risk profile than the married man with mild dementia living on a fixed income and who has a caring and involved family. Although financial capacity may be impaired in both situations, the outcome of the assessment and the specific intervention(s) recommended can differ substantially based on the risks presented.

Steps to Enhance Capacity. Because financial capacity is such a broad construct, a cognitively or otherwise impaired individual may have preserved financial skills as well as areas of impairment. **Supervision** regarding financial matters in the home setting may extend and support functioning for a period of time in areas, such as bill payment or checkbook management. However, caution must be exercised with respect to supporting autonomy, insofar as a cognitively impaired individual, despite periodic support, can continue to be highly vulnerable to undue influence and financial predation.

Clinical Judgments of Financial Capacity. Unlike treatment consent capacity, there are currently no published studies of clinician judgments of financial capacity. In large part this paucity reflects the **absence of well-accepted conceptual models and instruments for assessing this capacity**, and associated empirical research. At the present time, judgments of financial capacity are based on subjective clinical judgment using interview information, capacity remote neuropsychological tests, and in some cases limited props examining basic monetary and other skills or an objective functional assessment instrument.

Judgments of overall financial capacity can be framed using the categorical outcomes of capable,

marginally capable, and incapable. Findings regarding specific financial domains and tasks can be referenced as evidence for the overall finding. The potential outcome of **marginally capable** (to manage financial affairs) is important and implies limited capacity. It suggests that an individual may retain financial skills in some areas but not others.

Clinical Approaches to Assessing Financial Capacity. As is true with other capacities, financial capacity should be evaluated within the context of a general evaluation of an individuals' cognitive and emotional functioning. At present there are two potential approaches to assessing financial capacity: **clinical interview** and **direct performance** instruments.

Clinical Interview. The clinical interview is the traditional and currently by far the most widely used method for evaluating financial capacity. At the outset of an interview with patients (and family members), it is important that a clinician first determine the patient's prior or premorbid financial experience and abilities. For example, it would be inappropriate to assume that a person who on testing demonstrates difficulty writing a check has suffered decline in this area, if she has never performed this task, and/or has traditionally delegated this task to a spouse. Once premorbid experience level is established, clinicians need to identify the financial tasks and domains that comprise the patient's current financial activities, and differentially consider those required for independent living within the community.

Functional Assessment Instruments. Performance-based instruments represent a second approach to assessing financial capacity. In contrast to clinical interview formats, performance-based instruments are **not subject to reporter bias**. Instead, individuals are asked to perform a series of pragmatic tasks equivalent to those performed in the home and community environment. Performance-based measures are standardized, quantifiable, repeatable, and norm referenced, and thus results can be generalized across patients and settings. These measures can provide clinicians and the courts with objective information regarding performance of specific financial tasks that can be highly relevant to formulation of recommendations and treatment strategies.

Independent Living

Evaluations for capacity to determine independent living are often done by psychologists. They may be the sole evaluator or part of a team of professionals. These assessments use various measures to determine cognitive abilities, decision-making abilities, physical/functional abilities, and whether or not the factors are reversible. In some cases, these evaluations are done in the context of determining whether the individual needs a guardian of person.

Legal Elements/Standards. In most states, there is unlikely to be a specific standard for "the capacity to live independently." Instead, the most relevant legal standards for the capacity to live independently are likely those which are defined in guardianship law. . . . [S]tate statutes for incapacity under guardianship vary widely, but that many cite one or more of four "tests": 1. The presence of a disabling condition; 2. A functional element—sometimes defined as the inability to meet essential needs to live independently; 3. A problem with cognition; 4. A necessity component—that is that guardianship is necessary because less restrictive alternatives have failed.

[A] psychological evaluation relevant to the capacity to live independently needs to determine if an individual is a significant danger to her or himself due to limited functional abilities, or due to cognitive or psychiatric disturbances, and also cannot accept or appropriately use assistance that

would allow him or her to live independently.

Functional Element

Understanding. Does the adult understand the day-to-day requirements of taking care of self and home? ***Application***. If the adult has an understanding of general requirements of living independently, is the individual able to either perform the tasks required for managing home and health or direct another person to assist them? ***Judgment***. Does the presence of a cognitive disorder, emotional disorder, or thought disorder affect the person's judgment as it relates to care of self or the home?

Risks

When weighing the functional data for independent living, the clinician will consider not only the person's values, but the risks. These include estimating the risk to the individual should she or he remain living independently and without a guardian (should the case be considered for guardianship) and the benefits to the person of a supervised living situation. In addition, the risk of imposing a restrictive supervised environment on an older adult which results in the loss of the enjoyment and autonomy must be weighed. Obviously, the most useful source of data for considering these risks is the history of highly undesirable outcomes for the person because of his or her difficulty with self care. When weighing the risks, it is important to consider the seriousness of the risk, the likelihood of the risk, and whether any and all supports that will enhance this individual's capacity to remain independent have been tried.

Steps to Enhance Capacity

There is a huge array of social, medical, and legal interventions that may assist a person in living independently. These are described in Appendix F, and will vary to some extent according to the local Area Agency on Aging, the individual's Medicare or other insurance coverage, and the state elder care framework. The level of assistance that a person requires will depend on various factors, such as cognitive deficits, physical deficits, and medical problems.

Collaboration with speech therapists and/or cognitive rehabilitation specialists, as well as occupational therapists and physical therapists for adults with cognitive decline and/or physical impairments, can be crucial in assisting them to identify areas of potential improvement.

Clinical Judgment of Capacity for Living Independently

Once the evaluation is completed the clinician will need to integrate the data and come to a clinical decision about the adult's capacity for living independently. It is important for the clinician to consider the adult's culture and support system. Premorbid lifestyle choices should also be considered.

The threshold for capacity to live independently will vary if the person is to live in his or her home or in a shelter; if there are family or friends that can check in on the person or not; if there is only one medication once a day versus multiple medications for life-threatening conditions. The clinical judgment of capacity for living independently is exceedingly difficult. It must integrate all of the assessment data and come to a determination that balances a respect for the individual's autonomy

and cultural values, as well as consider the legal standards and social requirements that safeguard not just the individual but communities, as an unsafe individual could potentially cause harm not just to him or herself, but to others and their property.

Clinical Approaches to Assessing Capacity for Living Independently

Clinical approaches to assessing such a broad capacity will likely utilize a wide array of traditional cognitive measures, as well as behavioral, psychiatric, and functional measures. Incorporating both subjective (i.e., what adult self-reports he or she can do) and objective (i.e., performance-based or direct observation) assessments of functional abilities is recommended because they can significantly vary from each other (Glass, 1998). An example of an approach and battery that incorporates the above dimensions follows: a review of medical records, clinical interview, Neurobehavioral Cognitive Status Examination (NCSE) (a.k.a., Cognistat), Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), Wechsler Memory Scale—third edition (WMS-III), Wechsler Abbreviated Scale of Intelligence (WASI), Independent Living Scale (ILS), observation/data collection of in vivo decision-making activities, Geriatric Depression Scale (GDS), and review of medical/pharmacological evaluation to determine if cognitive factors (e.g., confusion) are reversible. Assessment of substance use and misuse of prescription medications can be conducted in order to determine if these are present and potentially affect judgment. This is not an exhaustive list, but rather a list of potential measures that might be incorporated into the evaluation of an older person's capacity to live independently.

Undue Influence

Legal Standards of Undue Influence.

The *Restatement of Contracts*, an authoritative secondary legal source, defines undue influence as follows: Undue influence is unfair persuasion of a party who is under the domination of the person exercising the persuasion or who by virtue of the relation between them is justified in assuming that that person will not act in a manner inconsistent with his welfare ("Restatement (Second) of Contracts," 1981).

The doctrine is akin to doctrines of fraud and duress and may be alleged in legal transactions, such as executing a will, entering a contract, or conveying property to another, as well as cases of financial abuse, sexual abuse, and even homicide. Other definitions stress the psychological component of undue influence, the intentional and improper use of power or trust in a way that deprives a person of free will and substitutes another's objective.

Consent to a contract, transaction, or relationship, or to conduct, is voidable if the consent is obtained through undue influence (Black's Law Dictionary, 2004). While diminished capacity may make one more vulnerable to undue influence, it is not a necessary component of the dynamic. Therefore, undue influence can be present even when the victim clearly possesses mental capacity.

Relationships Based on Trust and Confidence

Keeping in mind the wide variability across states, courts often require **two elements** to be proven in a case of undue influence involving a contract: (1) a **special relationship** between the parties based on **confidence and trust**; and (2) intentional and **improper influence or persuasion** of the

weaker party by the stronger. Psychologists performing assessments of undue influence must therefore determine if a confidential relationship exists that would provide the opportunity for undue influence to occur.

Summary of Undue Influence Models			
Singer/Nievod Model	Blum IDEAL Model	Bernatz SCAM Model	Brandle/Heisler/Stiegel Model
Factors: 1. Isolation 2. Dependency 3. Creating Siege Mentality 4. Sense of Powerlessness 5. Sense of Fear/Vulnerability 6. Staying Unaware	*Factors:* 1. **I**solation 2. **D**ependency 3. **E**motional manipulation and/or **E**xploitation of a vulnerability 4. **A**cquiescence 5. **L**oss	*Elements:* 1. **S**usceptibility 2. **C**onfidential Relationship 3. **A**ctive Procurement 4. **M**onetary Loss	*Goal:* • Financial Exploitation *Typical Perpetrator Tactics:* 1. Isolate from others and information 2. Create fear 3. Prey on vulnerabilities 4. Create dependency 5. Create lack of faith in own abilities 6. Induce shame and secrecy 7. Perform intermittent acts of kindness 8. Keep unaware

Working with the Court in Judicial Proceedings

Guardianship Proceedings

Guardianship is a relationship created by state law in which a court gives one person or entity (the guardian) the duty and power to make personal and/or property decisions for another (the ward or incapacitated person). The appointment of a guardian occurs when a judge decides an adult individual lacks capacity to make decisions on his or her own behalf (Quinn, 2005). Each state has an adult guardianship statute providing for a specific process and procedural protections for the alleged incapacitated individual. State terminology varies.

Statutes in the vast majority of states provide for a clinical examination as evidence of incapacity, and some 31 state laws specifically include a psychologist in the range of clinical experts . . . (Other examiners named by state statutes include physicians, psychiatrists, mental health professionals, social workers, nurses and "other qualified professionals.") In approximately 30 states a clinical examination is required, while some 15 states leave this to the discretion of the judge, and the remainder of states give no statutory direction.

Clinical evaluation is critical to the judge's determination of capacity and appointment of a guardian. However, historically assessments frequently have been limited. Sometimes a clinician simply and briefly states a conclusion about capacity, rather than offering a detailed and nuanced description of the findings. . . The practice of submitting a conclusory or "short shrift" statement may be due to

lack of direction from statute or from the court as to the format, content, and scope of the assessment— or lack of conceptual models and instruments for assessing capacity in guardianship. If clinicians provide information on all of the nine elements in the model set out in Chapter 3 in reports submitted to court in guardianship proceedings, the quality of information judges have before them will be greatly enhanced.

It is useful when the psychologist's report:

- Makes the judge aware of any possible **reversible causes** of impairment —such as delirium, depression, or the effects of medications.

- Indicates any possible mitigating factors that might be **masquerading as impairment** —such as hearing loss, grief, malnutrition, or educational or cultural barriers.

- Indicates any possible **less restrictive alternatives** to guardianship. For example, perhaps the individual maintains the ability to execute a health care advance directive or a financial power of attorney.

The complete handbook is found online on the website of the American Psychological Association at:

https://www.apa.org/images/capacity-psychologist-handbook_tcm7-78003.pdf