Judicial Determination of Incapacity

Erica Wood, JD
ABA Commission on Law and Aging

Daniel Marson, JD, PhD
Department of Neurology
University of Alabama at Birmingham
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Overview of Session

- National overview -- guardianship reform
- Introduction to Handbook
- Six pillars of capacity – MCFVRE
- Five Steps in judicial determination of capacity
- Clinician's role

Bird's Eye of Guardianship Reform

- Guardianship ancient roots; *parens patriae*
- Antiquated state laws
- 1987 *Associated Press Report* – "An Ailing System"
- Precipitated rush to reform
- Nationally
  - 1987 Congressional hearings
  - 1982, 1997 UGPPA
  - 1988 Wingspread; 2001 Wingspan
  - 1988 National Guardianship Association
  - 1993, 1999 NCPJ Standards
  - 2004 GAO Study
  - 2002, 2005 Senate hearings
  - 2007 UJGPPA

State Statutory Road to Reform

- Since 1988, almost every state revised guardianship code
- Close to half states enacted entirely new code
- http://www.abanet.org/aging/legislativeupdates/home.shtml – state statutory charts
- Four trends
  - Stronger procedural protections
  - Changes in determination of capacity
  - Emphasis on least restrictive alternative & limited orders
  - Enhanced guardian accountability/monitoring

Changing Perceptions of Incapacity

- 1980s – many states retained archaic definitions
- It was all about labels
- Statutory reform – three elements of capacity
  - Medical condition
  - Functional test -- – behavior that could put at risk
  - Cognitive test – ability to receive & evaluate information
- States mix ‘n match the three tests

UGPPA Definition of Incapacitated Person

Incapacitated person is an individual:

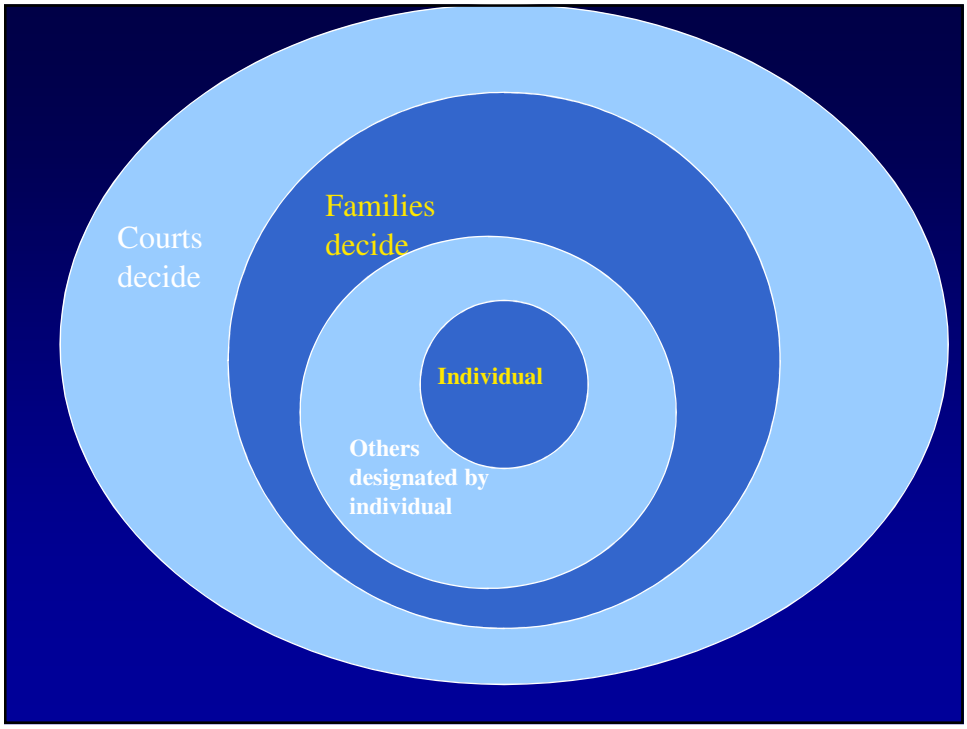
“who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance.”

Incapacity: Illusive Concept – What is it?

- Not global; decision-specific; time limited
- Never put a period after word "capacity."
- Fluctuating, questionable
- Influenced by external factors
- No "bright line" – no "capaci-meter"
- "Like a lava lamp" – can't pin down, keeps changing
- "More like a dimmer control" than on-off switch

Least Restrictive Alternative

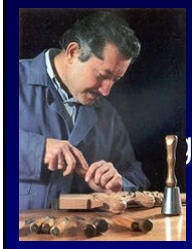
- Guardianship as last resort
- Constitutional doctrine of least restrictive alternative
- Limit paternalism; enhance autonomy
- Alternatives to guardianship
  - Advance directive
  - Durable power of attorney
  - State default surrogate consent law
  - Representative payment
  - Trust
- Substituted judgment standard of decision-making for guardians



Limited Guardianship

- Capacity not all or nothing
- Judge can craft limited order
- Guardian assigned only those duties & powers individual incapable of exercising
- Mixed areas of strengths and weaknesses – "judge as craftsman"

Crafting Limited Orders



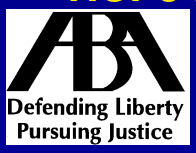
"Judges are not like baseball umpires, calling strikes and balls or merely someone competent or incompetent. Rather, the better analogy is that of a craftsman who carves staffs from tree branches. Although the end result – a wood staff – is similar, the process of creation is distinct to each staff. 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." Larry Frolik

Goals of Handbook on Capacity Determination

- **Provide conceptual framework**
- **Give practical tools**
- **Improve communication between judges and clinicians**
- **Assist in enhancing autonomy**
- **Assist in identifying less restrictive alternatives & crafting limited orders**
- **Highlight reversible causes of impairment**

Genesis of Handbook

- ABA-APA collaboration
- Working group on capacity determination
- Lawyers Handbook
- Advisory Panel for Judges Handbook
- NCPJ role



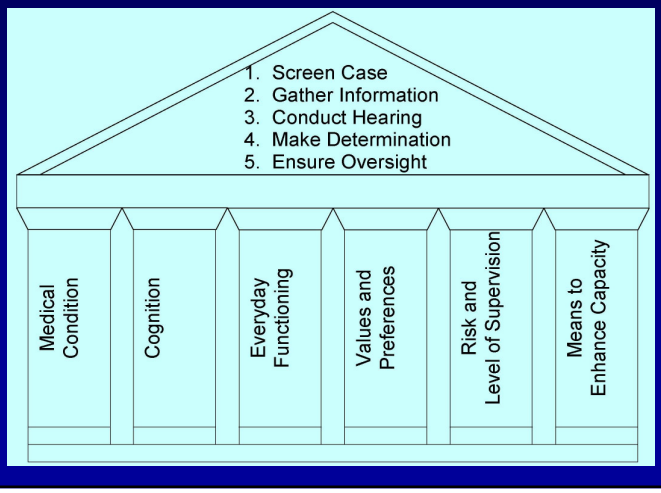
Scope/Overview of Handbook

- The book DOES:
  - Focus on determination of capacity
  - Focus on older adults
  - Focus on guardianship proceedings
  - Address needs of wide range of judges/judicial officers
  - Aim to be consistent with UGPPA
  - Get to the point
- The book does NOT:
  - Focus on younger adults with MR/MI/DD
  - Address all aspects of guardianship
  - Include background academic text; Not a "tome"

Core of Handbook

- Diagram p. 3 (& inside cover)– the "fall open page"
- Six pillars of capacity assessment
- Five steps in judicial determination
- Kernel idea: the six pillars to infuse each of the five steps
- "MCFVRE"

Six Pillars of Capacity Assessment



"MCFVRE"

- M = Medical condition
- C = Cognitive capacity
- F = Functional capacity
- V = Values
- R = Risks
- E = Means to Enhance capacity

Use of Handbook: "Layered Approach"

- 14-page book expands succinctly on pillars and steps

- Appendix includes key model orders and forms– adaptable

- Additional resources available online-- http://www.abanet.org/aging/docs/judgesbooksum.doc

Why do we need MCFVRE?

Medical, Cognition, Functional, Values, Risk, Enhance

Capacity Evaluation Research

Questions:

1) Are clinical evaluations reliable?
2) Does education help?
3) Do judges get what they need from clinicians?
4) Does legal reform help?

Studies of Clinical Judgment

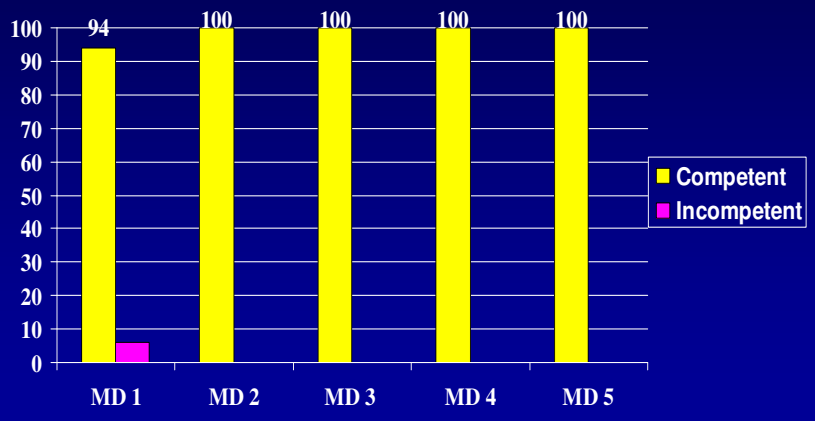
- Low reliability of clinical capacity judgments
- Clinicians do not know legal standards or how to apply them
- Disciplinary differences in clinician approach
- Clinicians rely on mental status tests, general impressions, “risk tolerance” or “ageism”
- Huge problem of subjectivity of judgments

Education improves low reliability

Research Question

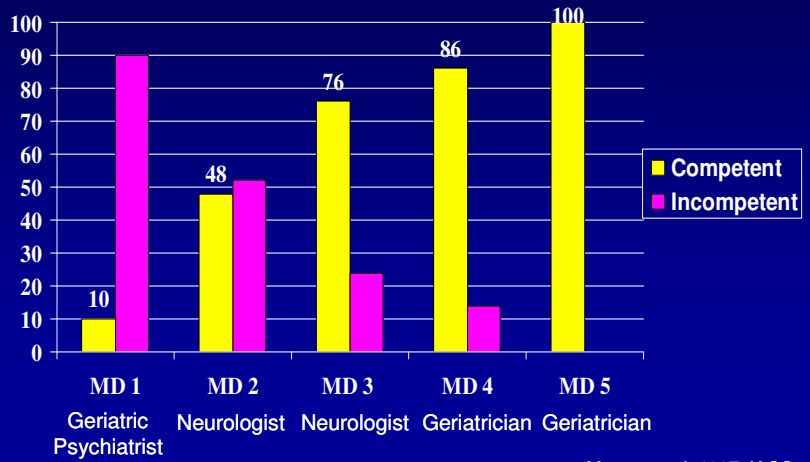
“How consistent are experienced physicians in judging the medical decision-making capacity of patients with dementia?”

Physician Competency Judgments (%)
Normal Controls [n=16]



Marson et al. 1997 JAGS

Physician Competency Judgments (%)
Mild AD Patients [n=29]

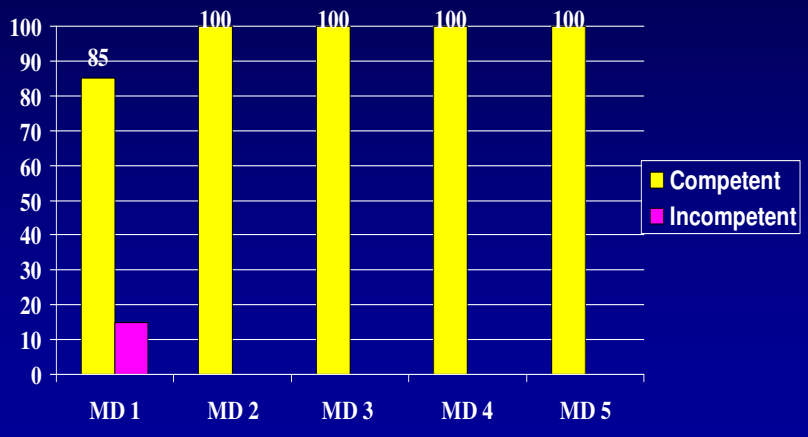


Marson et al. 1997 JAGS

Research Question

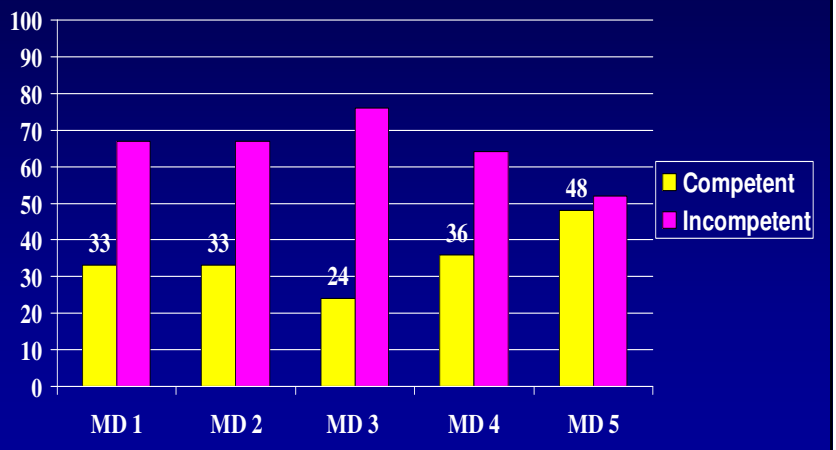
"If they first receive **training** in competency assessment, how consistent are experienced physicians in judging the medical-decision making capacity of patients with dementia?"

Physician Competency Judgments (%) Normal Controls [n=10]



Marson et al. JAGS 2000

Physician Competency Judgments (%) AD Patients [n=21]



Marson et al. JAGS 2000

Guardianship File Study (Dr. Moye)

1. 4 courts in MA, 2 courts each in PA & CO
2. Adult guardianship
3. Age 55+
4. No MR/DD diagnosis
5. Hearing between 1/1/02 and 6/1/05
6. Goal 150 MA, 75 each for PA & CO
7. Petitions, Clinical Evaluations, Orders scanned, de-identified, coded.

Respondents

	MA	PA	CO
# Cases	154	75	70
Mean Age	77	80	76
Female	62%	65%	47%
Dementia	63%	44%	63%

Judicial Hearings and Orders

	MA	PA	CO
Respondent in Court	1%	1%	40%
Plenary	99%	97%	66%
Limited	1%	3%	34%
Person & Estate	71%	96%	90%

Clinical Reports Admitted

	MA	PA	CO
# Words	84	244	924
Typed	25%	86%	89%
Illegible (if handwritten)	65%	25%	88%

Mrs. XX is an 82 year old formerly healthy woman who broke her hip at work. She has a history of severe COPD and developed bilateral pneumonia and respiratory failure. She has been on mechanical ventilation and has had a gastric tube and JJ tube placed. I am able to get her to follow simple commands but otherwise I do not believe she is capable of making informed decisions. Her daughter YY has been regularly at the bedside and has a good handle of the medical problem.

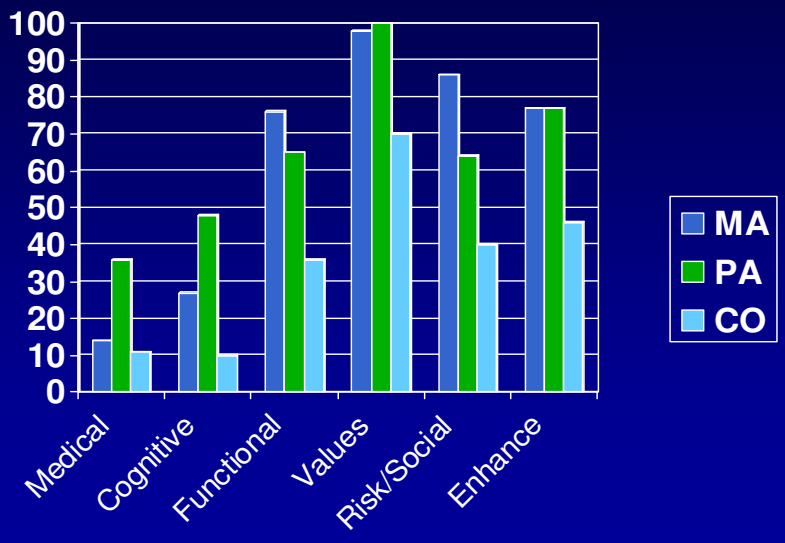
Or fewer words …

Patient has a history of stroke complicated by confusion. Patient is mentally and physically ill patient and is not able to make any decisions.

Or even fewer words …

Patient has dementia Alzheimer's type confirmed by multiple MDs and consultants.

Missing Information--MCFVRE



Capacity Evaluation

Are clinical evaluations reliable? **NO**

Does education help? **YES**

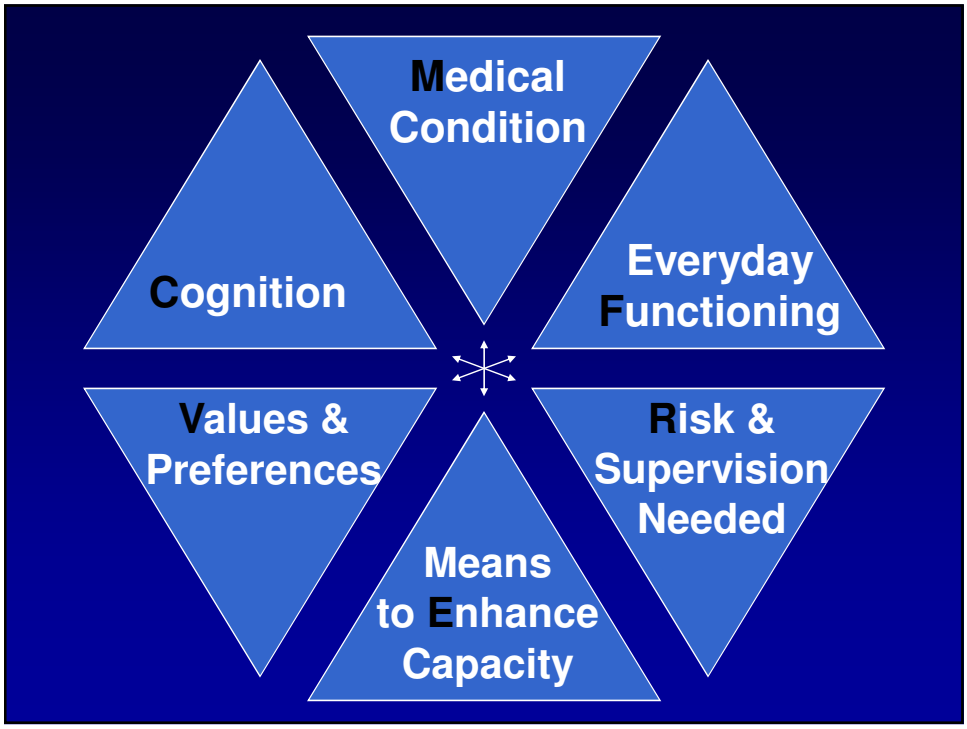
Do judges get what they need from clinicians? **NO**

Does legal reform help? **MAYBE**

What Do We Need?

A common framework for guardianship evaluation:

- Rooted in law and clinical practice
- Useable by judges, lawyers, court investigators, and clinicians
- Helps establish the essential clinical facts necessary for capacity judgments



The Origins of MCFVRE

- ABA-APA Working Group on Capacity Issues in Older Adults
- Review of statutory definitions of capacity
- Review of statutory requirements for evaluation of capacity
- Review of clinical models for capacity evaluation
- Group discussion and consensus

Help with MCFVRE

- Relevant Model Forms, Appendix 1
- Relevant Fact Sheets, Appendix 2

MCFVRE ?s for Judges = Appendix 2, #8

MCFVRE ?s for Investigators = Form 2 Supplement

MCFVRE Form for Clinicians = Form 4

Medical, Cognition, Functional, Values, Risk, Enhance

"M" Medical Condition

- What medical problem is causing the functional problem?
- How severe is it?
- How long has it been going on?
- Will it get better, worse, stay the same?
- Have all reversible causes of confusion and mitigating factors been considered?

Relevant Fact Sheets: #14 Medical Conditions

#17 Temporary/Reversible Causes of Confusion

Highlighted Issue: Misdiagnosis of Dementia

- Danger: Delirium is misdiagnosed as dementia
- Modern term is acute confusional state (ACS)
- Delirium/ACS is a reversible condition
- Many medical conditions and also medications may cause confusion
- 25-60% of elderly patients are delirious post surgery
- 10% of elderly patients remain semi-delirious 6 months after surgery
- Capacity judgments not be made until ACS has cleared

Reversible Causes of Confusion

- **Step 1: Confusion Assessment Method**
  - Acute onset
  - Fluctuating course
  - Inattention
  - Rambling/disorganized or lethargic/stuporous
- **Step 2: Determine Cause of Confusion**
  - History
  - Labs, urinalysis
  - Vitals
  - Other tests as indicated

"C" Cognition

- What is the individual's level of alertness?
- Short term memory?
  -verbal and visual
- How is their information processing?
  - memory, communication, reasoning, planning, etc
- What is their emotional state?
  - hallucinations, delusions, anxious, manic, depressed

Relevant Fact Sheet = #4 Cognition

Highlighted Issue: Use of MMSE

- 30 point mental status examination
- Gross evaluation of mental status
- Pros: Quantifies mental status
  Indicates crude level of impairment
- Cons: Limited detail
  Score cannot determine capacity
  False Positives: false 'incompetence'
  False negatives: false 'competence'

"F" Everyday Functioning

What is the individual's ability to …

- Care for self?
- Make financial decisions?
- Make medical decisions?
- Function at home and in the community?
- Vote?
- Function is a critical component of MCFVRE

Relevant Fact Sheet: #5 Everyday Functioning

Highlighted Issue:
Why Everyday Functioning Is Not Enough To Decide Capacity

- Information on medical diagnosis explains
  - The cause, the prognosis, the treatments
- Information on cognition also explains
  - Is complementary to functional assessment
  - Cognitive changes drives functional loss
  - Informs the diagnosis

Conclusion: Get information on all MCFVRE elements

"V" Values and Preferences

- Consideration of individual's personal values an aspect of right of self-determination
- Does he/she want a guardian, if so who?
- Does this person prefer decisions be made alone or with others?
- For this person, what is important in a home?
- What makes life good or meaningful? (activities, abilities, relationships, goals)
- What main concerns drive decisions?

Relevant Fact Sheet=#19 Values (3 sets of ?s)

Highlighted Issue: Values--The Missing Link?

- Absent:
  - in statutory definitions of capacity
  - in statutory requirements for assessment
- Make it present:
  - in directions to guardian
  - in judicial actions and decisions

"R" Risk of Harm and Level of Supervision Needed

- What are the main risks of retaining capacity, and from where do they come?
- What social factors increase/decrease risk?
- How severe is the risk?
- How likely is the risk?
- What level of supervision is needed to enhance capacity?

Highlighted Issue: Limitations of Clinicians

- Clinical assessment of risk
  - Is subjective
  - Difficult to predict
  - Depends on knowledge of patient
  - Not a legal opinion

Conclusion: Get multiple perspectives on risk

"E" Enhance Capacity

- Consider ways to improve/maximize capacity
- Improve medical condition through treatment?
- Even if medical condition stays the same, can one improve person's level of function?
- If so, when to re-evaluate capacity?

Relevant Fact Sheets:

#7 Maximizing Participation in Hearing
#10 Less Restrictive Alternatives
#13 Means to Enhance Capacity

Highlighted Issue: Judicial Concerns

- The Hearing
  - how to maximize participation of person?
- Reporting Time Frames
  - when should the judge re-visit person's capacity?
- Guardianship Plans
  - instructions/guidance to guardian/conservator

Conclusion: Use MCFVRE as your guide

Highlights of Appendices

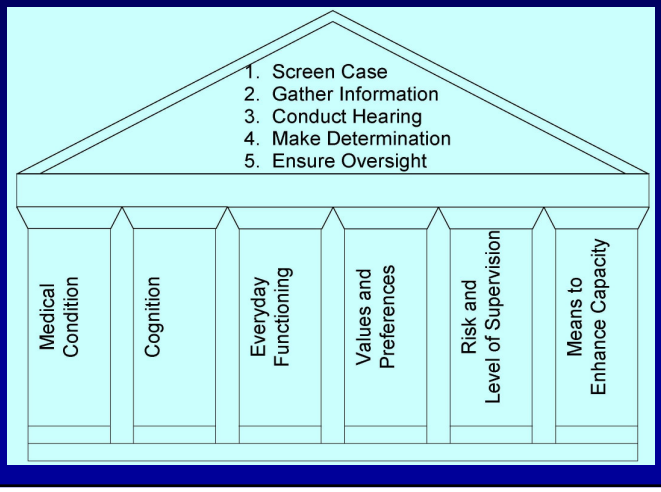
- Form/worksheet for judicial notes
- Court investigator report
- Clinical evaluation order
- Clinical evaluation report
- Model order for guardianship
- Annual report form
- Guardian care plan form

Review and adapt for North Carolina

Highlights of Handbook Online Resources

- Cognitive & functional testing instruments; and neuropsychological "domains"
- Maximizing participation at hearing
- Reversible causes of confusion
- Limitations to guardianship
- Conditions affecting capacity
- Checklist of less restrictive alternatives
- Values questions

Six Pillars of Capacity Assessment



Using "MCFVRE" in Five Steps

1. Overview of Five Steps
2. Discussion of Application to Cases

Step One: Screen Case

- **Trigger** – what brought case to court?
- **Due process** –Have procedural requirements been met?
- **Emergency** –Is there immediate risk of harm?
- **Exhaustion** – Have less restrictive alternatives been considered?

Step 1

Less Restrictive Alternatives

- **Legal tools**
  - Health care advance directive
  - Proxy decisions under default surrogate consent laws
  - Financial power of attorney
  - Trust
  - Representative payment; more
- **Mediation-address family disputes/dynamics**
- **Functional assistance**
  - Long-term care facility
  - Home health/home care
  - Care management
  - Medication management
  - Community based services through aging network

Step 1

Step Two: Gather Information

- Court investigator report
- Red flags signaling need for more information
- Clinical evaluation report

Step 2

Court Investigator Role

- Eyes & ears of court
- Ideally has independent overview of case
- Identify less restrictive alternatives
- Identify immediate risk of harm
- Determine if counsel required (some states)
- Recommend accommodations for hearing
- Identify appropriate cases for mediation

Step 2

Court Investigator Role - More

- Run through six pillars
- Identify “red flags” for more information
- Check for temporary or reversible conditions/mitigating factors
- Identify values of respondent
- Investigate means to enhance autonomy
- Check need for more clinical evaluation
- Recommending limitations on order
- Make suggestions for guardianship plan

Step 2

Strengthening Role of Court Investigator

- **Review report form**
- **Training**
  - Six pillars (example: delirium vs dementia)
  - Red flags
  - Least restrictive alternatives; limitations on order
  - Community resources
  - Court access; accommodations
  - Means to enhance capacity
- **Make investigator report available to clinician; vice versa**
- **High expectations; encourage independence**

Step 2

Red Flags = More Information Needed

- "Six D's"
  - Diet, malnutrition
  - Dehydration
  - Depression, grief
  - Drugs, polypharmacy; recent changes
  - Disorientation, transfer trauma
  - Diagnosis – missing diagnosis and prognosis
- Alcohol use
- Cultural/language differences
- Hearing or vision loss
- Mixed areas of strengths and weaknesses
- One-sided clinical evaluation

Step 2

Need for Additional Clinical Evaluation

- **Consider further clinical input if:**
  - Initial clinical report insufficient, fails to address six pillars
  - Red flags identified
  - Court investigator recommends
- **Order for independent clinical evaluation: Ask for:**
  - All six pillars
  - Severity of illness, prognosis, history, medications
  - Any temporary or reversible cause of impairment
  - How comports with state statutory standard for incapacity
  - Possible limitations on order
  - Attendance at hearing; accommodations

Step 2

Clinical Evaluation Report

- Range of clinical professionals
- Handbook's clinical evaluation form:
  - Addresses six pillars
  - Notes severity of cognitive & functional impairments
  - Asks about treatments/placements
  - Sets out tests used; time spent
  - Additional ratings for more complex cases
  - Reviewed by clinicians from many disciplines
  - Is designed to maximize information but minimize burden on clinical professional

Step 2

Step 3: Conducting the Hearing

- Judicial notice of existing reports
  - GAL
  - Court investigator
  - Clinician report (physician, psychologist)
- Receive testimony
  - Medical
  - Legal professional
  - Lay
- Accommodate/observe/engage individual (respondent)
- Using MCFVRE during hearing

Step 3

Receive Additional Evidence/Testimony

- Hearing provides opportunity to receive additional medical, professional, and lay testimony on capacity
- "Brings to life" pleading and documentary evidence
- Evidence filtered through adversarial process and judicial questioning
- Permits refinement, clarification of MCFVRE issues

Step 3

Receive Additional Evidence/Testimony

- Clinicians can clarify diagnoses and conclusions concerning cognitive abilities and everyday functioning
- Social workers, court investigators describe individual's living situation, community function, coping skills, values, risk profile, possible enhancements to capacity
- Lay witnesses provide insight into individual's long term values, community function, coping, risk, enhancements

Step 3

Accommodating/Observing/Engaging Individual (Respondent)

- **Important opportunity for judge**
- **See the "real person" behind the pleadings**
- **Consider person in light of MCFVRE:**
  - Medically -Values
  - Cognitively -Risks presented
  - Functionally -Enhancing capacity
- **Value of judicial questioning of individual**

Step 3

Accommodating/Observing/Engaging Individual (Respondent)

- Respondent has a right to be at hearing
- UGPPA and 50% of state jurisdictions require individual to be at hearing unless good cause shown
- Advantages of involvement and having "day in court"
- Value of judicial encouragement of attendance

Step 3

Accommodating/Observing/Engaging Individual (Respondent)

- **Determining appropriateness of attendance:**
  - Petition
  - Clinical report
  - Court investigator or GAL report
- **Questions to consider:**
  - Does R want to be present?
  - Would presence be harmful to R in some way?
  - Does R have sufficient understanding/communication to participate in some meaningful way?
  - What accommodations are needed to maximize R's participation?

Step 3

Step 4: Making the Capacity Determination

- Integrate capacity evidence using MCFVRE
- Analyze evidence of capacity in relation to relevant elements of state law
- Make capacity findings
- Categorize overall capacity judgment
- Limited order: identify rights retained/removed
- All orders: identify statutory limits of guardians' authority

Step 4

Integrate Evidence Using MCFVRE

- **Medical condition:**
  - What is the medical cause of alleged incapacity(ies)?
  - Will condition improve, remain stable, or worsen?
- **Cognitive functioning:**
  - In what areas are thinking abilities impaired?
  - In what areas are emotional capacities impaired?
- **Everyday functioning:**
  - Care of self
  - Medical/health care
  - Home and community life
  - Civil or legal
  - *Financial

Step 4

Integrate Evidence Using MCFVRE

- **Consistency of choices with values, patterns, preferences:**
  - Evidence of capacity/incapacity must be weighed in light of individual's history of choices and values
  - Eccentricity not the same as diminished capacity
  - Are lifetime beliefs and values involved?
- **Risk of harm and level of supervision needed:**
  - How great is risk of harm to individual?
  - What is the level of supervision needed?
- **Means to enhance functioning and capacity?**
  - Are there treatments that could enhance functioning?
  - Are there other interventions? Eg., assistive devices, home services

Step 4

Make Findings and Categorize Judgment

- Make findings related to MCFVRE components
- Categorize capacity judgment
- Different judgment outcomes available:
  - **Minimal or no incapacity:**
    - Guardianship petition not granted
    - Use less restrictive alternative
  - **Severely diminished capacity, or when less restrictive alternatives fail**
    - Plenary guardianship indicated
  - **Mixed intact and diminished capacities:**
    - Limited guardianship indicated

Step 4

Limited Orders

- Cases with mixed findings of capacity
- Present the opportunity for tailored limited orders that preserve autonomy but also protect
- Arguably involve the greatest level of judicial skill
- "Judge as craftsman" per Larry Frolik

Step 4

Statutory Limits on Guardian Authority

- Statutes vary by state in extent of rights and duties automatically extended to guardian
- In some states, rights are transferred to guardian unless explicitly retained by incapacitated person
- Conversely, in other states, rights are retained by the individual unless specifically transferred by court order
- Some basic rights often survive guardianship:
  - Testamentary capacity
  - Voting rights

Step 4

Step Five: Ensure Court Oversight

- **Monitoring has many functions**
- **Capacity determination bears directly on two aspects of monitoring**
  - Time Frame for Review of Capacity
  - Instructions for the Guardian

(for more on enhancing guardianship monitoring in general, refer to Fact Sheet #6)

Step 5

Time Frame for Review of Capacity

Considering

1) Prognosis
2) Whether temporary/reversible identified
3) What treatments identified

Establish time period for review

Short term review (or time-limited g-ship)

Annual review

Step 5

Instruct Guardian

Guardianship Plans

- Establish a baseline
- Reflect care planning of NH residents
- Allows for minor changes without consulting the court
- Provides an alternative to limited guardianship when it fits with value and risk considerations

Step 5

Guardianship Plan

Health Care Plan

- Provider names, Previous instructions by person, Planned treatment

Personal Care Plan

- Where Living, Planned changes, Planned social services and activities

Financial Care Plan

- Income, expenses, Planned sales, Planned pursuit of claims owed to/from, Care of dependents, Estate plans

Step 5