

Elder Law Practice

Assessing Clients with Diminished Capacity

By Charles P. Sabatino

Although lawyers seldom receive formal capacity assessment training, they make capacity judgments on a regular basis. Practitioners make an initial determination of each client's capacity to engage in an attorney-client relationship, although for the typical adult client, capacity is presumed. It is only when signs of questionable capacity present themselves that an initial determination becomes deliberate. Lacking training in capacity assessment, the average practitioner may prefer not to perform capacity assessments at all. Instead, the safer course is to refer all cases of questionable capacity to mental health professionals. Yet, to decide whether a formal assessment is needed in the first place, the lawyer is already exercising judgment about the client's capacity on an informal or preliminary level. The exercise of judgment, even if it is merely the incipient awareness that "something is not right," is itself an assessment.

The ABA Model Rules of Professional Conduct only obliquely acknowledge lawyers' assessment functions. Rule 1.14, "Client Under a Disability," recognizes that a lawyer may take protective action with respect to a client "only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest."¹ The comment goes a step further in recognizing "intermediate degrees of competence," but nowhere is there any guidance for making a preliminary determination, other than recognizing that "[t]he lawyer may seek guidance from an appropriate diagnostician."²

What Is Capacity?

The functional activity at the heart of capacity for an individual receiving legal services is the ability to make and

communicate decisions with respect to whatever particular legal task is at hand.³ Capacity is task-specific and time-specific, and despite continuous striving by the mental health professions for objectivity and consensus, no universal definition of decisionmaking capacity exists.⁴ Nevertheless, the basic parameters of decisionmaking capacity can be described. Perhaps the clearest and most enduring articulation remains that of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, enunciated in their seminal 1982 report: "Decisionmaking capacity requires, to greater or lesser degree: (1) possession of a set of values and goals; (2) the ability to communicate and to understand information; and (3) the ability to reason and to deliberate about one's choices."⁵

The inclusion of a set of values and goals sets this definition apart from many other attempted articulations. Those values and goals establish a benchmark against which capacity can be assessed, for capacity must be judged according to a standard set by that person's own habitual or considered

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standards of behavior and values, rather than by conventional standards held by others.⁶ This is a principle more easily respected in theory than practice, but it is fundamental. Applying such a standard requires a more thorough knowledge of the individual than is normally feasible in a limited, one-time only encounter.

Lawyer-ethicist Nancy Dubler illustrates the importance of this knowledge in relating the quandary doctors faced when they evaluated her own mother after a fall: “[T]he doctors wondered, was she [her mother] uncooperative, cantankerous, and obstinate because her memory and mental function were impaired, or was she a woman who had spent a long lifetime being uncooperative, cantankerous, and obstinate?”⁷ As her daughter, Dubler had the knowledge to help them sort it out: “[S]he had always been obstinate, but being uncooperative and cantankerous were new characteristics, more than likely associated with her injury.”⁸ In other words, a person does not lack capacity merely because he or she

does things that other people find disagreeable or difficult to understand. Indeed, a great danger in capacity assessment is that eccentricities, aberrant character traits, or risk-taking decisions will be confused with incapacity. A capacity assessment first asks what kind of person is being assessed and what sorts of things that person has generally held to be important.⁹

In everyday legal practice, capacity issues may arise with current or former clients with whom the lawyer has great personal familiarity or with new or prospective clients who are virtual strangers in need of legal services. The familiar client offers a clear advantage of experience with the client’s values and personality. The new or prospective client poses a threshold question of whether the person even has the capacity to engage the services of the lawyer in the first place. Most cases fall somewhere in the partially familiar middle ground. In any case, the practitioner needs an ethically and clinically sound process for making a preliminary assessment of capacity, compatible with the attorney’s role and skills. The following section offers a framework and process.

Proactive Assessment

Capacity to perform most tasks is affected by countless variables: time; place; social setting; and emotional, mental, or physical state.¹⁰ Therefore, it is helpful in practice to approach capacity assessment in two stages. First, take reasonable steps to optimize capacity. Second, perform a preliminary assessment of capacity. Remember, the emphasis in the second stage is on “preliminary,” because the lawyer’s role goes only that far. If doubts remain after a preliminary assessment, then the help of a mental health professional is clearly needed for further evaluation.

Four Steps to Optimize Capacity

1. Interview the Client Alone

Family, friends, or caretakers commonly accompany older or disabled individuals to the lawyer’s office. These significant others may play an important role in providing essential background information relevant to the work to be done. However, the ethical starting point in the client-lawyer relationship remains the individual’s competent choice to retain the services of the lawyer and to decide the overall objectives of representation. Be clear from the beginning who the client is and the ethical implications of that relationship in terms of loyalty, confidentiality, and decisionmaking. The initial interview should always include a time when the lawyer and putative client meet alone. This is important not only to confirm representation and its objectives, but also to

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Elder Law Section of the Illinois State Bar Association

By Lee Beneze

The Elder Law Section of the Illinois State Bar Association was created on May 17, 1995. Prior to 1995, the elder law bar was represented by the Elder Law Committee of the General Practice Section. Before that, several members of the state bar's Young Lawyers Section created an Elder Law Committee. Today, three members of that Young Lawyers' Section committee are respectively the chair, vice-chair, and incoming secretary of the Elder Law Section Council.

Currently, the Elder Law Section has 2,225 members, making it the fourth largest section in the Illinois State Bar. The section has had steady increases in membership since the first year of its existence, when 600 members joined.

The work of the Elder Law Section is conducted by the section council, which consists of 26 members and three officers (chair, vice-chair, and secretary). The "leadership track" normally finds the secretary promoted to the vice-chairmanship, and the vice-chair promoted to the chair each June. The outgoing chair is retained on the section council as the ex-officio member. Terms of the offices are one year in each position.

In addition, two co-editors for the section newsletter, and four or five committee chairs are appointed. The current standing committees are: long-range planning, education, publications and media relations, and legislation. A Web site liaison, who will work on the bar's effort to go online, is also named. Several council members who are also members of other groups (such as the Chicago Bar Association, the American Bar Association, the National Guardianship Association, and the National Academy of Elder Law Attorneys) are appointed as reporters on the activities of those groups.

The two primary and ongoing activities of the section council are the newsletters (four published annually) and the legal education seminars (one to two seminars every year).

In 2000, the section council published and distributed a pamphlet on the role of guardians for the person and

guardians for the estate, which was an update of a 1990 publication entitled *Set Your Sites on Senior Rights*.

The section council also spends a great deal of time, both collectively and by individual members, reviewing and analyzing legislative developments during the spring legislative sessions—typically reviewing 30 to 40 bills each spring.

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In 2001, the "Guardianship Alternatives Task Force" was created to review the statutes and procedures of alternatives to guardianship, specifically powers of attorney. This effort was complementary to another wide-ranging review of guardianship statutes being conducted by a non-bar organization, which the section council was watching closely.

Finally, the section council is devoting an increasing amount of time to the development of the state bar's Web site as a means of exchanging information within the profession and disseminating information to the public.

The council believes that elder law will continue to grow in importance as a speciality of the legal profession. Thus, the section is committed to provide leadership and service to its members, the bar in general, and the public in accordance with its mission statement:

To inform and advise the members of the bar whose practice involves representing older persons in such areas as estate planning, public benefits, nursing home residents' rights, elder abuse, age discrimination, real estate issues, senior housing and guardianship. To review and make recommendations regarding proposed legislation that may affect older persons. To promote the legal rights of older persons to enjoy their communities, families, and lives to the fullest extent possible and to inform older persons of these rights. To provide a forum for the exchange of views and information in furtherance of these goals.

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provide an opportunity, if needed, to assess capacity. This one-on-one meeting request may cause apprehension among family members, including the elderly client, but it is necessary to ensure that personal and environmental factors do not unduly influence the decisionmaking process.

2. Adjust the Interview Environment to Enhance Communication

Optimizing the interview environment serves all clients well. More importantly, it will optimize the partially impaired client's decisionmaking ability. Capacity deserves to be judged under the best circumstances possible. I will touch upon only a few basic parameters here and recommend that the reader use the valuable communication strategies enumerated in resources such as *Effective Counseling of Older Clients: The Attorney Client Relationship*.¹¹

Impaired vision or hearing often produces non-responsive behaviors that may be wrongly interpreted as lack of mental capacity. Speaking slowly, conducting the interview in a quiet and well-lit area, arranging furniture so as to avoid glare, and providing any necessary audio or visual amplification will facilitate communication and functioning.

Some elder clients need extra time to process the information regarding decisions at hand. Although the speed of cognitive processing may not be as fleet as that in younger persons, given more time, partially impaired elders will be able to understand the ramifications of each action under consideration.¹² Be willing to spend extra time explaining the nature and consequences of options and resist the temptation to equate the speed of the client's ability to process information with level of capacity.¹³

If possible, meet with a client more than once to acquire a stronger sense of the client's decisionmaking capacity. Greater familiarity engendered by multiple sessions may enhance the client's comfort level, confidence, and trust in the attorney—all of which enhances the client's ability to function optimally. It also enables the attorney to see temporal variations in functioning. Poor functioning due to fatigue may be avoided by scheduling shorter sessions at times when the client tends to be most alert. Keep in mind that temporary or fluctuating lucidity does not equate to total incapacity. Delaying determinations until the client is in a more lucid phase can enhance decisionmaking dramatically.¹⁴

Home visits may be especially important to optimizing decisionmaking for many clients. If, for example, the lawyer needs to know whether the client can manage personal finances, the elder may be able to demonstrate her banking skills best at her own desk with her own checks.

3. Know the Client's Value Framework

The standard against which capacity is measured is the standard set by the individual's own habitual or considered standards of behavior and values, rather than against conventional standards held by others. Without knowledge of this personal frame of reference, capacity judgements have insufficient anchor and are liable to be based on someone else's judgment of the propriety of certain behavior, clothed in the clinical language of incapacity.

For the long-time client whose functioning only recently appears to be slipping, the lawyer may already be familiar with the client's subjective frame of reference. Newer clients will require a more conscious inquiry.

4. Presume Capacity

Merely raising the issue of capacity can be hurtful and damaging to the individual and to the client-lawyer relationship. Once begun, the process could ultimately result in a major intrusion into the client's autonomy in the form of guardianship. Thus, the starting presumption should always be one of capacity. This is a first principle of assessment, as well as of due process in our western legal system.¹⁵ For a formal assessment to take place, the concerned parties must overcome this presumption by substantiating evidence of impaired decisionmaking.

Five Steps of Preliminary Assessment

If you have done everything practicable to optimize the client's opportunity to act with maximum capacity, you are ready to perform a preliminary assessment. It may involve most or all five steps below, depending upon the point at which your conclusion is clear or professional referral is needed.

1. Obtain Consent

Consent suggested here is not for the normal questions that are posed to any client to ensure that the client understands his or her options and the consequences of those options. If the lawyer proceeds to the step of utilizing a formal screening test, or taking the step of referring the client for physical or psychological testing, then client consent is ethically essential. It also conveys respect of the client's privacy and the intent to protect the client's interests.

If the client is unable to consent,¹⁶ then consider whether a legally authorized surrogate is available, pursuant to a durable power of attorney, power of attorney for health care,¹⁷ or by operation of law under a state default surrogate consent law.¹⁸ The Comment to Model Rule 1.14(b) acknowledges that the attorney may have to assume this deci-

sionmaking role as a protective action. However, if the lawyer reaches the point of taking protective action, then he or she has already come to the conclusion that the client's capacity is significantly impaired.

2. Physical Exam

It is sometimes surprising that, in the face of signs of dementia, so little attention is given to ruling out treatable physical or mental conditions. The lawyer should provide the impetus to ensure that alternate causes of incapacity have been ruled out. Deficiencies that appear cognitive are often caused by over-medication, toxic combinations of medications, poor diet, vitamin deficiencies, depression, infectious diseases, head trauma, poor eyesight, or other treatable conditions.¹⁹ By discovering and addressing medically treatable conditions first, capacity issues may be rendered moot or at least diminished.²⁰

3. Standardized Screen

Once some familiarity with the client has been achieved, the environment optimized, and client consent obtained, consider using a brief mental status questionnaire. Keep in mind that these screening tests are not capable of dictating a firm conclusion about decision-specific capacity. They may, however, confirm the need for a formal assessment. Several brief mental status questionnaires have been developed, the most popular of which is the 30-item Mini-Mental Status Examination (MMSE), although others are widely used too.²¹

The MMSE takes about ten minutes to administer and covers a wide sampling of cognitive abilities, including: an assessment of memory (i.e., delayed recall of three items and response to questions related to temporal orientation); language (i.e., naming common objects, repeating a linguistically difficult phrase, following a three-step command, and writing a sentence); spatial ability (i.e., copying a two-dimensional figure); and set-shifting (i.e., performing serial sevens or spelling the word "world" backwards). Scores on the MMSE range from 0-30, with scores below 24 generally regarded as abnormal, although advanced age and low education are associated with lower scores in the absence of a brain disorder.²²

Another commonly used screening test is the Short Portable Status Questionnaire (SPSQ).²³ It is a 10-item test that primarily assesses orientation to time and place (i.e., date, day, place) and general and personal knowledge (i.e. president, mother's maiden name, telephone number). One question assesses concentration and set-shifting (i.e., counting backwards by threes). It is slightly shorter to administer than the MMSE and is scored by counting errors rather than correct responses.²⁴

An abundance of other screening tests populate the literature and appear in clinical practice. This genre of tests has enjoyed wide acceptance in clinical settings, mainly because of their brevity and simplicity in administering, scoring, and interpreting. However, their weaknesses are many, including insufficient sensitivity and specificity with certain clinical populations; reliance on global estimates of cognitive status; high false-positive and false-negative rates; narrow sampling of cognitive domains; lack of population-specific normative data; and confounding effects of age, education, gender, and ethnicity.²⁵ A thorough understanding of the proper administration and particular strengths and weaknesses of any mental status screening instrument is necessary. Training is essential and usually available through formal continuing education in the health disciplines or through informal training by a clinical specialist.

The greatest danger in relying on a standardized screen is relying on it too much. A poor score does not rule out the ability to perform some decisionmaking tasks. Further inquiry is still necessary to examine the client's task-specific capacity.²⁶

4. Task-Specific Assessment

The presence of some level of cognitive impairment does not tell us the degree to which individuals can still use their remaining limited abilities to act autonomously in their particular physical and social context and make decisions. Individuals adapt to limitations in countless creative ways. Therefore, the lawyer needs to consider the client's capacity related to the specific legal task at hand. Consider, for example, the different capacities needed to complete these tasks: executing a power of attorney; executing a will; executing a trust agreement; marrying or divorcing; agreeing to a property division; executing a contract; donating a substantial asset or amount of money; agreeing to a new living arrangement; agreeing to the release of medical or other confidential records; or agreeing to or refusing a medical treatment.

Baird Brown offers a useful structured questionnaire to examine a client's testamentary capacity.²⁷ Others have suggested more general guidelines for assessing capacity that may be flexibly adapted to whatever decision is in question. One paradigm of note is suggested by Peter Margulies and was adopted as a guideline in the recommendations of the Fordham Conference on Ethical Issues in Representing Older Clients.²⁸

Margulies argues that a purely functional cognitive test of capacity has serious problems and that the substance of a decision and its values context have to be factored into the assessment. We tend to over-objectify capacity—to make it into a thing to be discovered. This view misconceives capac-

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ity. Rather than being a thing, capacity is a shifting network of values and circumstances.²⁹

His foundation is a model of contextual capacity that integrates substantive and procedural concerns.³⁰ Margulies suggests that the lawyer's questioning of the client should focus on six factors, the first three of which are functional, the latter three of which are substantive in nature:

- | "Ability to Articulate Reasoning Behind Decision." The client's reasons may not be ones others would agree with, but their articulation demonstrates a level of cognitive functioning, as well as shedding light on two other factors—the client's appreciation of consequences and consistency with lifetime commitments.
- | "Variability of State of Mind." Does the client express the same wishes alone as with family members present? Are the client's wishes today the same as last week?
- | "Ability to Appreciate Consequences of Decision." Are crucial facts and likely consequences understood?
- | "Irreversibility of Decision." What exactly is at stake in the particular decision and can an error be rectified. Decisions to withhold or withdraw life-support illustrate the highest level of irreversibility.
- | "Substantive Fairness." Does the decision result in the injury or exploitation of someone?
- | "Consistency with Lifetime Commitments of Client." How does the decision stack up against the individual's own habitual or considered standards of behavior and values?³¹

The one factor above that is perhaps not self-explanatory is that of "substantive fairness." On first impression, it appears to invite the intrusion of the assessor's own value judgment of the outcome of the client's decision. However, Margulies argues that substantive unfairness is one factor that evidences whether "people are being taken advantage of or are being unduly influenced in ways that defeat their autonomy and values."³² He agrees with the criticism that courts have been overly inclined to base capacity findings solely on their judgment of a decision's outcome, but he adds emphatically that it is a mistake to go to the other extreme and ignore blatantly unfair transactions.³³

Of the six factors, substantive fairness may be thought of as one of three substantive "levers" that modulate a kind of sliding scale of capacity. The greater the concerns under the latter three substantive variables (irreversibility, fairness, consistency with commitments), the greater the level of functioning demanded under the first three variables (ability

to articulate reasoning and appreciate consequences, variability of state of mind).

The third factor—ability to appreciate the consequences of a decision—requires special caution in evaluating. The heart of this factor is the risk of harm posed by the likely outcome of the individual's decision. Risky conduct, as such, is not proof of incompetence, but it is the variable we worry about the most with our elder clients. Silberfeld and Fish suggest the following self-reflection on alleged risk:

- | Is the risk new or old?
- | Are there concrete instances of failure?
- | How grave is the risk?
- | Is the risk imminent or remote?
- | What is the risk of harm to others?
- | How objective is the assessment of the risk?
- | Is the risk chosen or accidental?³⁴

Silberfeld and Fish remind us: "Incompetency is the inability to make choices. A competent person chooses to run risks; an incompetent person simply happens to run them."³⁵ Our culture is risk averse in its conventional caring for older persons. The result is that much of the risk assessment we as professionals, family, or friends do easily inclines towards trumping autonomy with safety.³⁶

Consistent documentation of capacity is essential. It can be accomplished by recording of the lawyer's observations and discussion with the client using the six Margulies categories, and perhaps supplementing it with the MMSE or other standardized cognitive screen adopted by the practitioner. Though most lawyers record their conclusions in file notes or a formal memo, some firms audio or video tape interviews or document executions. Great caution should be exercised in audio or video taping. The practice of taping only questionably capable clients may invite challenge, while taping all clients is expensive and time consuming. Also, some clients may appear less lucid or capable on tape than in person. The lawyer who chooses to record the interview should be cognizant of lighting and sound techniques that may affect the quality of the tape and the impression of capacity conveyed.

5. Consultation and Referral

In borderline situations, the lawyer should seek consultation from a medical or mental health expert. Comment 5 to Model Rule 1.14 recognizes the appropriateness of such consultations in authorizing the lawyer to "seek guidance from an appropriate diagnostician" even though "disclosure of the client's disability can adversely affect the client's interest."³⁷ However, the rule gives little guidance as to the extent of disclosure permissible absent client con-

sent. Indeed, Rule 1.6(a) forbids disclosure without client consent unless it is impliedly authorized.

The ABA's Standing Committee on Ethics and Professional Responsibility in Formal Opinion 96-404, relies on the impliedly authorized language of Rule 1.6(a) to conclude that limited disclosure to the extent necessary to act in the client's best interest is impliedly authorized by the fact of representation:

Such discussion of a client's condition with a diagnostician does not violate Rule 1.6 (Confidentiality of Information), insofar as it is necessary to carry out the representation For instance, if the client is in the midst of litigation, the lawyer should be able to disclose such information as is necessary to obtain an assessment of the client's capacity in order to determine whether the representation can continue in its present fashion.³⁸

If a formal assessment is sought, whom do you use? The client's attending physician is an obvious starting point, especially if the physician and client have had a long-standing relationship. However, the attending physician's expertise may be insufficient, unless the physician is qualified by education and training credentials to do assessments of mental capacity and he or she documents the assessment thoroughly. It takes effort and experience to identify local assessment resources that are good. Give preference to multidisciplinary geriatric assessment teams and be prepared to work with them to provide a clear picture of the nature and scope of the actual task or decision for which capacity is to be assessed.

Since capacity is task-bound, it is up to the referring lawyer to educate the clinical professional regarding the tasks or tasks at issue; the kinds of information that the clients must understand; and the consequences or outcomes that the client must weigh. If you do not pose specific, well-thought-out questions to the clinician, you will get back only a general report with little or no relevant supporting data.

In making the referral, the lawyer should also inform the clinical professional about the client's living situation, family, property holdings, and life style, so that the clinician can accurately examine the client's understanding of these elements. For example, what are the names of his or her family and friends, their relationship to him or her, their place of residence, and their degree of contact?

Conclusion

Ultimately, the best strategy for dealing with the prospect of mental incapacity is a preventive one—one that helps avoid the need to take legal planning steps when the

client's capacity has already come into question. The American College of Trust and Estate Counsel (ACTEC) emphasizes this point in its Commentaries on the Model Rules of Professional Conduct:

As a matter of routine, the lawyer who represents a competent adult in estate planning matters should provide the client with information regarding the devices the client could employ to protect his or her interests in the event of disability, including ways the client could avoid the necessity of a guardianship or similar proceeding.³⁹

Of course, even this kind of preventive planning does not guarantee smooth sailing in all decisions, especially since voluntary advance planning mechanisms can be as easily revoked by a client experiencing life's turmoil. Nevertheless, whether you are planning well in advance, assessing a client's capacity to act now, or weighing the need for protective action to safeguard the client's best interests, the lawyer's guiding principles remain the same: respect the wishes and values of the client, intrude as little as possible into the client's autonomy, maximize client capacities, and maximize the client's family and social connectedness.

Notes

1. Model Rules of Professional Conduct Rule 1.14(b) (1998) [hereinafter Model Rules].
2. Model Rule 1.14, Cmt. [5]. The Model Code of Professional Conduct does not address impaired capacity in the disciplinary rules. Ethical Consideration 7-11 and 7-12 simply recognize that the lawyer may have additional responsibilities, depending upon the client's mental condition.
3. Stephen J. Anderer et al. *Determining Competency in Guardianship Proceedings* 4 (American Bar Association, Division for Public Services, Public Service Monograph Series, Number 1) (1990).
4. *Id.* See also Charles P. Sabatino, "Competency: Refining Our Legal Fictions," in *Older Adults' Decisionmaking and the Law* 1, 4 (Michael Smyer, K. Warner Schaie and Marshall B. Kapp, eds., 1996).
5. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Vol. 1, Report: Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* 57 (1982).
6. Michel Silberfeld and Arthur Fish, *When the Mind Fails: A Guide to Dealing with Incompetency* 47-48 (1994).
7. Nancy Dubler and David Nimmons, *Ethics on Call* 209 (1992).
8. *Id.*
9. Silberfeld and Fish, *supra* note 16, at 47.
10. William M. Altman, et. al, "Autonomy, Competence, and Informed Consent in Long-term Care: Legal and Psychological Perspectives," *Villanova Law Review*, 1671 (1992).

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Now Available

State Courts and the Federal Representative Payment Program

Four new publications aimed at helping state courts better serve the needs of incapacitated adults and minor children who are receiving some form of Social Security benefit payment through a representative payee are now available (see “Helping Seniors Who Cannot Manage Monies,” in *BIFOCAL*, Vol. 22, No. 2, Winter 2001).

The publications include:

- 1. *State Guardianship and Representative Payment: Briefing/Best Practices Pamphlet for Judges and Staffs of Courts Exercising Guardianship Jurisdiction*
- 2. *State Guardianship and Representative Payment: Model Curriculum for Judges and Staffs of Courts Exercising Guardianship Jurisdiction*
- 3. *Representative Payment and Kids: Briefing /Best Practices Pamphlet for Judges and Staffs of Juvenile and Family Courts*
- 4. *Representative Payment and Kids: Model Curriculum for Judges and Staffs of Juvenile and Family Courts*

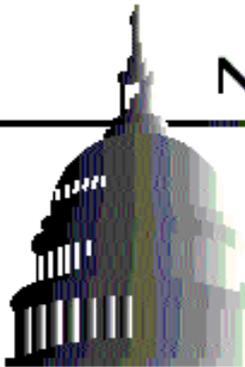
Single copies can be requested, free of charge, from the ABA Commission on Legal Problems of the Elderly, ph (202) 662-8690. The full text of the “Representative Payment and Kids” briefing/best practices pamphlet can also be accessed on the Web site of the Center for Children and the Law at www.abanet.org/child.

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11. American Bar Association Commission on Legal Problems of the Elderly and Legal Counsel for the Elderly, *Effective Counseling of Older Clients: The Attorney-Client Relationship* 15 (1995).
12. Marshall B. Kapp, “Decision Making by and for Nursing Home Residents: A Legal View,” *Clinics in Geriatric Medicine* 667, 671(1988).
13. *Id.*
14. See Daniel L. Bray and Michael D. Ensley, “Dealing with the Mentally Incapacitated Client: The Ethical Issues Facing the Attorney,” 33 *Fam. L. J.* 329, 336 (1999) (describing “windows of lucidity”); see also *Lane v. Candura*, 376 N.E. 2d 1232 (Mass. App. Ct. 1978).
15. The presumption of capacity has been incorporated into the Uniform Health Care Decisions Act (1993), §11 (“An individual is presumed to have capacity to make a health-care decision, to give or revoke an advance health-care directive, and to designate or disqualify a surrogate”). The Uniform Guardianship and Protective Proceedings Act (1977) §310 also reinforces a presumption of capacity by requiring “clear and convincing evidence” of incapacity and need before a guardian may be judicially appointed.
16. Capacity to consent to a medical evaluation, like many other capacities, has no universal definition. However, most states have a statutory standard of capacity for medical decisions fairly similar to that found in the Uniform Health Care Decisions Act (1993) §1(3): “‘Capacity’ means an individual’s ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.”
17. All states recognize some form of durable power of attorney for health care. See Myra G. Gilfix and Charles P. Sabatino, “Health Care Decision Making in an Elder Law Practice,” Portfolio 16, at 16-95 to -108, in *The ElderLaw Portfolio Series* (Harry S. Margolis, ed., 1997).
18. See Colleen M. O’Connor, “Statutory Surrogate Consent Provisions: An Overview and Analysis,” 20 *Mental & Physical Disability L. Rep.* 128-138 (1996).
19. Rabins et al., *supra* note 5, at 49-78; University HealthSystem Consortium, *supra* note 3, at 6-10; U.S. Congress, Office of Technology Assessment, *Losing a Million Minds: Confronting the Tragedy of Alzheimer’s Disease and Other Dementias* 8-13, OTA-BA-323 (Washington, DC: US Government Printing Office, April 1987).
20. *Id.*
21. Marilyn S. Albert, “Focus on Assessment Techniques,” in 14 *Annual Review of Gerontology and Geriatrics*, 93-106 (M. Powell Lawton and Jeanne A. Teresi eds. 1994).
22. *Id.* at 94-95; M. Folstein, S. Folstein, and P. McHugh, “Mini-Mental State: A Practical Method for Grading Cognitive State of Patients for the Clinician,” 12 *J. Psychiatric Res.* 189-198 (1975).
23. Marilyn S. Albert *supra* note 33, at 97-98; E. Pfeiffer, “SPMSQ: Short Portable Mental Status Questionnaire,” 23 *J. Am. Geriatrics Society* 433-441 (1975).
24. *Id.*
25. University HealthSystems Consortium, *supra* note 3, at 4. See also Thomas Grisso and Paul S. Appelbaum, “A Comparison of

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Second Annual National Aging and Law Conference

You are invited to attend the **NATIONAL AGING AND LAW CONFERENCE (NALC): *Strengthening Protections and Building Bridges to Enhance Elder Rights***, October 10-13, 2001, Crystal Gateway Marriott, 1700 Jefferson Davis Highway, Arlington, VA 22202.

Because of the overwhelming success of the 2000 NALC, the AARP Foundation's National Training Project, together with the ABA Commission on Legal Problems of the Elderly, the National Senior Citizens Law Center, The Center for Social Gerontology, the Center for Medicare Advocacy, Inc., and the National Academy of Elder Law Attorneys is proud to sponsor the second annual National Aging and Law Conference.

This year's NALC will afford advocates an exciting opportunity to identify creative approaches to the emerging legal needs of older persons and serve as a catalyst for many exciting and valuable collaborative cross-disciplinary advocacy initiatives.

Registration Fees

The **Pre-Conference "Nuts & Bolts"** on Wednesday, October 10, costs \$75 and includes admission to a full day of workshops covering basic issues in Medicare, Medicaid, Social Security, SSI, the ADA and more. Also included are a continental breakfast and lunch at the hotel.

The **Conference** from October 11-13 offers over 70 workshops and roundtables dealing with cutting edge issues in protective services, advanced substantive law, consumer issues, ethics, the Americans with Disabilities Act, delivery systems, nursing home law and more. Cost for the conference is \$275 for legal services or aging advocates, or \$325 for private bar, and includes admission to all workshops and roundtables, daily continental breakfast and lunch, and the Thursday evening welcoming reception.

Hotel Accommodations

The NALC has reserved a block of rooms for our conference attendees at the Crystal Gateway Marriott, 1700 Jefferson Davis Highway, Arlington, Virginia, at a group rate of \$159 for single occupancy, and \$179 for double. Please be sure to make your reservation early, as the number of available rooms is limited. To reserve your room, call 800-228-9290 or 703-920-3230 and state that you are reserving under the "AARP/National Aging and Law Conference" rate.

Airline Reservations

The American Bar Association is one of the cosponsoring organizations for this conference. In planning your air travel, you can take advantage of the ABA Discounted Meeting Airfares. Three airlines offer ABA discounted fares:

- ➔ American Airlines - 800-433-1790 - Discount Code #S13266
- ➔ US Airways - 877-874-7687 - Discount Code #21900057
- ➔ Delta Air Lines - 800-241-6760 - Discount Code #170346A

Contact the airline directly or your travel agent and mention the ABA discount code to get a reduced airfare.

CLE Credits

The ABA Commission on Legal Problems of the Elderly has applied for CLE credits.

For a list of planned workshops and a registration form, please visit our web site:
<http://www.aarp.org/ntltrpro> or contact:

Ada B. Albright, 202-434-2197 E-mail: aalbright@aarp.org OR:
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Model for Reform: Oklahoma Law Establishes, Defines Role of Legal Services Developer

By Richard Ingham

Woody Allen once said, “Eighty percent of success is just showing up.” I believe this also applies to advocacy. Showing up at the state capitol—just being there—is the key to legislative advocacy for older Americans.

Roy Keen, the Director of the Aging Services Division of the Oklahoma Department of Human Services, has known this for more than twenty years. He has allowed, first, his ombudsman, and, for the past seven years, his legal services developer, the freedom to develop needed laws and shepherd them through the Oklahoma legislature.

As the long-time treasurer and a respected member of the board of directors of the National Association of State Units on Aging, Roy Keen will tell you that this is simply good management. Each state aging agency is directed by Chapter 4 of Title VII of the Older Americans Act—even in its reauthorized form—to hire a legal services developer to secure and maintain the legal rights of older individuals. The Older Americans Act assigns the legal services developer twelve services to be provided to seven groups or classes of recipients. One of the services is “supportive functions,” as appropriate—and I do not think it is a stretch to call “legislative advocacy” a supportive function.

Given the significance and breadth of the responsibilities of state legal services developers, state agency directors shouldn’t risk this assignment by hiring a part-time developer, giving him or her extraneous duties not mentioned in the

Older Americans Act, or dissuade the developer from going to the state capitol. The returns to a state director in letting the developer exercise the full responsibilities of the job are indisputable. For the past seven years, aging advocacy groups in Oklahoma, working with the legal services developer, have produced additional funding for legal aid, a community do-not-resuscitate form, and millions of dollars of tobacco money dedicated to the health and well being of senior adults.

The returns to the state legal community are significant as well. The legal services developer can work with elder law attorneys to establish or develop elder law sections of the bar or work with probate judges and Adult Protective Services workers to draft or increase funding for public guardianship programs.

No one is better suited, among Older Americans Act employees, to do these things than the legal services developer. I urge all state directors to review a recently passed law in Oklahoma (*see next page*), to see if this law might be a model for reform. This new law establishes, within Chapter 4 of Title VII, a full-time developer position and protects the developer in advocating for the elderly, the same way ombudsmen have been protected for years.

Richard Ingham is the legal services developer for Oklahoma. He may be reached by email at richard.ingham@okdhs.org.

New Online Resource for National Health Care Data

The Kaiser Family Foundation has produced a new Internet resource that offers comprehensive and current health information for all 50 states, the District of Columbia, and U.S. territories.

State Health Facts Online, at www.statehealthfacts.kff.org, provides health policy information on a wide range of issues including managed care, health insurance coverage and the uninsured, Medicaid, Medicare, women’s health, minority health, and HIV/AIDS.

This free online resource is intended for journalists, policymakers, researchers, and others to easily view information for a single state or compare and rank data across all 50 states and compare it to U.S. totals. Information on more than 200 topics is displayed in easy-to-read tables and color-coded maps. State Health Facts Online can be accessed at www.statehealthfacts.kff.org or through the Kaiser Foundation’s primary web site at www.kff.org.

Oklahoma Act Establishing “An Office of Elder Rights and Legal Assistance Services Development”

Bill No. 789, Signed by Governor Keating on April 16, 2001. An Act relating to poor persons; requiring the Aging Services Division of the Department of Human Services to establish specified program; requiring specified coordination and assistance by the Aging Services Division; requiring establishment of an Office of Elder Rights and Legal Assistance Services Development; specifying parameters of Office; providing for designation of person to administer program; stating criteria to determine sufficiency of staffing; requiring development of statewide standard; requiring provision of specified technical assistance; requiring consultation to ensure coordination of activities with specified services provided under state and federal programs; requiring specified education and training; requiring promotion and provision of education and training and stating contents thereof; requiring promotion of the development of specified legal aid and rights of older individuals; requiring the provision of periodic assessments and stating parameters thereof; requiring working agreements with specified entities; defining term; providing for codification; and providing an effective date.

Be It Enacted by the People of Oklahoma:

Section 1. New Law. A new section of law to be codified in the Oklahoma Statutes as Section 3100 of Title 56, unless there is created a duplication in numbering, reads as follows:

- A. 1. The Aging Services Division of the Department of Human Services shall, in accordance with the provisions of this section and in consultation with area agencies on aging, establish a program to provide leadership for improving the quality and quantity of legal and advocacy assistance as a means of ensuring a comprehensive elder rights system for Oklahoma’s vulnerable elderly.
2. In carrying out the program established in paragraph 1 of this subsection, the Aging Services Division shall coordinate and provide assistance to area agencies on aging and other entities in Oklahoma that assist older individuals in:
- understanding the rights of older individuals,
 - exercising choice,
 - benefiting from services and opportunities authorized by law,
 - maintaining the rights of the older individual and, in particular, of the older individual with reduced capacity, and
 - resolving disputes.
- B. In carrying out the provisions of this section, the Aging Services Division shall:
1. Establish an Office of Elder Rights and Legal Assistance Services Development as the focal point for leadership on elder rights policy review, analysis, and advocacy at the state level, including, but not limited to, such elder rights issues as guardianship, age discrimination, pension and

health benefits, insurance, consumer protection, surrogate decisionmaking, protective services, public benefits, and dispute resolution;

2. Designate a person to administer the program, who shall be known as the State Legal Services Developer and who shall serve on a full-time basis, and other personnel, sufficient to ensure:
 - a. leadership in securing and maintaining legal rights for the older individual,
 - b. capacity for coordinating the provision of legal assistance,
 - c. capacity to provide technical assistance, training and other supportive functions to area agencies on aging, legal assistance providers, ombudsmen, and other persons as appropriate,
 - d. capacity to promote financial management services for older individuals at risk of guardianship,
 - e. capacity to analyze, comment on, monitor, develop, and promote federal, state, and local laws, rules and regulations, and other governmental policies and actions that pertain to the issues listed in paragraph 1 of this subsection, and
 - f. capacity to provide information as necessary to public and private agencies, legislators, and other persons regarding issues listed in paragraph 1 of this subsection;
3. Develop, in conjunction with area agencies on aging and legal assistance providers, statewide standards for the delivery of legal assistance to older individuals;
4. Provide technical assistance to area agencies on aging and legal assistance providers to enhance and monitor the quality and quantity of legal assistance to older individuals, including technical assistance in developing plans for targeting services to reach the older individual with greatest economic need and the older individual with greatest social need, with particular attention to low-income minority individuals;
5. Provide consultation to area aging agencies to ensure coordination of their activities with:
 - a. the legal assistance initiatives provided under the Older Americans Act,
 - b. services provided by the Legal Services Corporation, and
 - c. services provided under other state or federal programs, administered at the state and local level, that address the legal assistance needs of older individuals;
6. Provide for the education and training of professionals, volunteers, and older individuals concerning elder rights, the requirements and benefits of specific laws, and methods for enhancing the coordination of services;
7. Promote and provide, as appropriate, education and training for individuals who are or who might

become guardians or representative payees of older individuals, including information on:

- a. the powers and duties of guardians or representative payees, and
 - b. alternatives to guardianship;
8. Promote the development of, and provide technical assistance concerning:
 - a. pro bono legal assistance programs,
 - b. state and local bar committees on aging,
 - c. legal hot lines,
 - d. alternative dispute resolution,
 - e. programs and curricula, and
 - f. other issues related to the rights and benefits of older individuals; in law schools and other institutions of higher education, and promote other methods to expand access by older individuals to legal assistance and advocacy and vulnerable elder rights protection activities;
 9. Provide for periodic assessment of the status of elder rights in Oklahoma, including analysis of:
 - a. (1) the unmet need for assistance in resolving legal problems and benefits-related problems,
 - (2) methods for expanding advocacy services,
 - (3) the status of substitute decisionmaking systems and services, including, but not limited to, systems and services regarding guardianship, representative payeeship, and advance directives,
 - (4) access to courts and justice system, and
 - (5) the implementation of civil rights and age discrimination laws in Oklahoma, and
 - b. problems and unmet needs identified in programs established under the Older Americans Act; and
 10. For the purpose of identifying vulnerable elder rights protection activities provided by entities under this act and coordinating activities with programs established under the Older Americans Act, develop working agreements with:
 - a. state entities, including the state consumer protection agency, court system, Attorney General, the state agency responsible for equal employment opportunity initiatives, and other state agencies, and
 - b. federal entities, including Social Security Administration, Health Care Financing Administration, the Dept. of Veterans’ Affairs, and other federal agencies.
 - c. As used in this section, the term “representative payee” means the person who enters into a contractual relationship with the U.S. Social Security Administration to receive a Social Security recipient’s check and to disburse funds to meet the needs of the recipient.

Section 2. This act shall become effective November 1, 2001.

Assessing Clients with Diminished Capacity

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Standards for Assessing Patients' Capacities to Make Treatment Decisions," 152 *Am J. Psychiatry* 1033 (1995).

26. Robert P. Roca, "Determining Decisional Capacity: A Medical Perspective," *Fordham L. Rev.* 1177, 1182-83 (1994). Roca elaborates on one of the shortcomings of the MMSE: It tests orientation, memory, attention and concentration, as well as language use, aptitude for serial subtraction, and the ability to copy a complex figure. Perfect performance earns 30 points. Scores below 24 are the rule in persons with dementia, and few demented persons score 24 or above. Persons with scores of 24 or above rarely are judged to have inadequate cognitive function for decisionmaking purposes. But many persons with scores below 24 are neither demented nor seriously impaired in their decisionmaking capacity. This is because dementia is not the only factor affecting scores on the MMSE. The greatest number of "false positives" occur in persons who have limited formal education, particularly those whose schooling ended at or before the eighth grade. Over reliance on the usual "cut-off point" for the MMSE, thus, can lead to overestimation of the prevalence of dementia and of the severity of disability. In fact, no cut-off point perfectly distinguishes persons with or without decisional capacity. For this reason, the results of standardized tests are best regarded as simply one source of information about capacity. The final judgment must integrate data from many sources.
See also Marshall B. Kapp and Douglas Massmar, "Measuring Decisional Capacity: Cautions on the Construction of a 'Capacimeter,'" 2 *Psychol. Pub. Pol'y & L.* 73 (1996).
27. Baird B. Brown, "Assessment of Capacity," §§5.01 - 5.06, in *Mental Capacity: Legal and Medical Aspects of Assessment and Treatment* (A.C. Walsh et al., 1994).
28. Peter Margulies, "Access, Connection, and Voice: A Contextual Approach to Representing Seniors Citizens of Questionable Capacity," 62 *Fordham L. Rev.* 1073 (1994).
29. *Id.* at 1083.
30. *Id.* at 1085.
31. Margulies, *supra* note 40, at 1085-1090.
32. *Id.* at 1088.
33. Margulies, *supra* note 40, at 1088.
34. Silberfeld and Fish, *supra* note 16, at 61-65.
35. *Id.* at 65 (emphasis added).
36. *See, e.g.,* Jan Ellen Rein, "Ethics and the Questionably Competent Client: What the Model Rules Say and Don't Say," 9 *Stan. L. & Pol'y Rev.* 241 (1998).
37. Model Rules, *supra* note 10, Rule 1.14 Cmt. 5 (1998).
38. ABA Formal Op. 96-404 (1996).
39. ACTEC Commentary on the Model Rules of Professional Conduct 1.14 at 216-217.

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