VII. Understanding and Using the Capacity Assessment Report

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

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

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

A. Understanding the Elements of the Capacity Report

1. Demographic Information
The report should provide basic information concerning the age, race, gender, education, marital status, and vocational status of the patient. Such basic information provides a general context for the report’s findings and conclusions.

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

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

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

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

5. **Informed Consent**

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

6. **Behavioral Observations**

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

7. **Tests Administered**

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

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

8. **Validity Statement**

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

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

10. Diagnostic and Clinical Interpretation

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

The next section can detail the clinician’s opinion of the client’s psychosocial capacities. This opinion reflects not merely a scoring and reporting of test results, but a process of clinical inquiry and interpretation. It is important to keep in mind that the cognitive and emotional/personality findings and diagnostic assignments will not be determinative, by themselves, of the capacity outcomes in a particular matter. The capacity outcomes depend primarily on the fit, as judged by the examiner, between the individual patient’s current functional abilities and the demands of the capacity in question within the patient’s life context. Thus, as an example, a patient diagnosed with mild Alzheimer’s disease and mild to moderate memory impairment may still be quite capable of consenting to medical treatment, if he or she demonstrates sufficient treatment consent abilities such as appreciation, reasoning, and understanding in discussing a medical intervention with a physician.

B. Clinical Capacity Opinions Versus Legal Capacity Outcomes

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

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

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

C. Using the Capacity Report

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

Follow-up with Examiner

Upon receiving a capacity evaluation, an attorney should allocate time to read and digest the report as thoroughly as possible. This will permit an informed
follow-up with the examiner to identify, for example, other issues needing attention or, on occasion, factual inaccuracies needing correction. Also, the attorney may need to clarify the meaning of technical language or abbreviations used in the report.

**Use of the Report As Evidence**

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

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

**Limited Guardianship and the Least Restrictive Alternative**

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

**Protective Actions Under Model Rule 1.14**

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

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

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

**Clinical Interventions**

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

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

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