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Survey of State Guardianship Laws: Statutory Provisions for Clinical Evaluations

By Michael Mayhew

We live in a rapidly aging society in which unprecedented numbers of adults are living longer lives. With such increased longevity has come an increase in the incidence of dementia and other medical disorders that can adversely affect cognitive and emotional health—and with it potential problems with the ability to care for self and estate.¹ A large number of those affected by guardianship are over the age of 65. This group of Americans, especially those over 75 years of age, is at a higher risk to have diminished capacity² to take care of themselves and to handle their affairs due to physical and/or mental impairments.³ However, guardianship is not solely an issue affecting the elderly. It also affects younger adults with mental retardation or developmental diseases, who are aging as well. The rising number of persons at risk for diminished

capacity is likely to lead to an increase in guardianship proceedings. It is important that states reevaluate their statutory framework regarding guardianship to assure that the laws effectively and fairly deal with this issue in view of modern understandings of the aging process.

Guardianship is a legal proceeding undertaken to give a person or agency (typically called a guardian or conservator) rights over another person (typically called a ward or incapacitated person) who has diminished abilities to manage some of or all of his or her personal and/or financial affairs. The particulars in how guardianships are dealt with differ from state to state, but the standard frame-

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Michael Mayhew is a third-year law student at Boston University Law School. He joined the staff of the ABA Commission as a summer intern to work on this survey.

Survey of State Guardianship Laws

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work is essentially the same. Court proceedings in guardianship cases are frequently short, unless contested.⁴ The court proceedings are mainly to afford the ward his or her due process rights, and to give the opportunity for cross-examination in any matters before the court if the proceedings are in dispute. The two major issues a judge must decide are whether a person is capable of making decisions keeping with his values, and if not, if a guardianship or less restrictive option is appropriate to safeguard the person and his assets.⁵

The notion of what it means to have diminished capacity has been discussed for years in the legal community, yet no single definition exists in the law today. Generally, the definition of incapacity (as it is referred to in most state laws), relies on some or all of the following three key concepts that

are mixed and matched by the states to form their specific statutory definition.

- **Disabling Condition.** The first concept of incapacity is that the person must have a disabling condition that results in a functional impairment with respect to one's ability to manage his or her own needs.⁶ This has been further defined by some states to be the ability to take care of "essential requirements for the person's physical health or safety."⁷
- **Functional Behavior.** Some states, such as California and Washington, have thrown out the "disabling condition" test for a simple "functional behavior" test alone, based on whether a person is able to provide for such personal needs as health, food, clothing, and safety.⁸
- **Cognitive Abilities.** Other states have chosen to supplement the disabling condition [and] functional behavior test, or throw it out altogether, in favor of a "cognitive functioning" test that evaluates whether a person has the mental ability to understand or the capacity to make responsible decisions.⁹

The 1997 Uniform Guardianship and Protective Proceedings Act (UGPPA) removes the disabling condition test entirely and states that:

"Incapacitated Person" means an individual who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions (Cognitive Test) to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care (Functional Behavior Test), even with appropriate technological assistance.¹⁰

Lastly, some states, including New York, and the District of Columbia, interpret the language of the UGPPA that assesses incapacity in light of "appropriate technological assistance" as requiring a "necessity element" before a person will be judged incapacitated.¹¹ As is evident from the different formulations that exist throughout the states, there is no global definition of incapacity that fits all situations. Where there is uncertainty in a substantive standard, it is necessary for courts to turn to procedural safeguards to protect

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BIFOCAL

BAR ASSOCIATIONS IN FOCUS ON AGING AND THE LAW
NEWSLETTER OF THE AMERICAN BAR ASSOCIATION
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New Commissioners for 2005-06

The ABA Commission on Law and Aging is composed of fifteen members who are appointed on an annual basis by the president of the association. As a multi-disciplinary group, the commissioners represent aging experts from a broad spectrum of professions, including law, health care, social work, gerontology, advocacy, and public service. The fundamental diversity of the group ensures a stimulating forum for discussion of the law-related issues facing older Americans. Cooperative efforts between the commissioners and the commission staff have produced numerous publications, as well as research and demonstration projects of considerable value to the public at large. To provide our readers with an abbreviated view into the strengths and expertise of our commission, each fall issue of *BIFOCAL* will feature brief profiles of the most recent distinguished appointees.

Larry McDevitt is chair of the ABA Commission on Law and Aging. He is the state delegate from North Carolina to the ABA House of Delegates and the president of the Van Winkle Law Firm in Asheville, North Carolina. A fellow of the American College of Trial Lawyers, he is named in both *The Best Lawyers in America* and *Business North Carolina's Legal Elite*. While the major focus of his practice is civil litigation, he also has a significant practice in the business arena. Mr. McDevitt has worked extensively in county and municipal governments, serving as the mayor of Asheville, as an Asheville



City Councilman, and as a Buncombe County Attorney. He is a permanent member of the Judicial Conference for the U.S. Fourth Circuit and was chair of the Civil Justice Reform Act Advisory Committee, which drafted the CJRA Rules effective in the U.S. District Court for the Western District of North Carolina. Following terms as president of the 28th Judicial District Bar and as vice-chair of the North Carolina State Bar's initial Board of Specialization, he was elected to serve as president of the North Carolina Bar Association. His work with the delivery of legal services to the poor extends from local to state and national levels. In that connection, he helped found the regional legal services program (Pisgah Legal Services), has served on the board of Legal Services of North Carolina, and is a former member of the ABA Standing Committee on Legal Aid and Indigent Defense.

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James Carr is a first assistant attorney general in the Colorado Attorney General's office. He supervises the Professional Boards Unit in the Business and Licensing Section and represents a number of professional licensing boards and the Division of Insurance. Within the ABA, Mr. Carr has served as chair of the Commission on Mental and Physical Disability Law, as a member of the Standing Committee on Public Education, and on the Government and Public Sector Division Council. In addition, Mr. Carr is a delegate to the ABA House of Delegates for the Tort Trial and Insurance



Practice Section and serves on the section's council. Mr. Carr recently completed a term on the Denver Bar Association's Board of Trustees and the Colorado Bar Association's Board of Governors. He has chaired the Colorado Bar Association's ADR Section, Health Law Section, and Law Education Committee. He has also chaired the Denver Bar Association's Democracy Education Committee. Mr. Carr served on the Colorado Board of Law Examiners from 1992 to 2002. He is a trained mediator and is active in volunteer mediation work. He also is involved in law-related education programs in schools, including mock trials, classroom presentations, and peer mediation. Mr. Carr received a B.S. from the U.S. Air Force Academy and a J.D. from the George Washington University Law School.

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Jennifer Moye is the director of the Geriatric Mental Health Clinic at VA Boston, an outpatient mental health clinic focusing on the needs of older veterans,



and an assistant professor of psychology in the Department of Psychiatry at Harvard Medical School. Dr. Moye's professional work focuses on how older adults adjust to medical illness and make medical decisions. She has a special interest in the assessment of decision-making capacity in older adults, focusing on increasing the accuracy and sensitivity of assess-

ments to promote autonomy in adults with neuropsychiatric illness. She is interested in how values, personal history, and ethnicity influence decision making, and how such factors impact capacity assessment. Dr. Moye has published more than 40 papers and chapters concerning capacity and related psychological issues in medically ill older adults. Dr. Moye earned a B.A. from Ohio State University and a Ph.D. from the University of Minnesota. She completed her advanced clinical training through Harvard Medical School and the VA Boston.

Mark Schickman is a lawyer with the San Francisco law firm Freeland Cooper & Foreman LLP. He has held numerous elected bar positions, including service as president of the Bar Association of San Francisco and as governor of the State Bar of California. He is the immediate past chair of California's Judicial Nominees Evaluation Commission. For the past 30 years, Mr. Schickman has concentrated on employment and labor law, litigating every type of employment matter and providing advice in avoiding liability. He is a member of the American Arbitration Association's select panel of employment arbitrators. Mr. Schickman received a B.A. and a J.D. from Columbia University, where he was a Harlan Fiske Stone Scholar and the recipient of Columbia's Whitney North Seymour Medal for Distinguished Trial Advocacy.

Ann Soden is a Montreal lawyer developing the growing field of elder law in Canada. She is the founding chair of the National Elder Law Section of the



Canadian Bar Association, a founding director of the Canadian and Quebec Networks for the Prevention of Elder Abuse, a founding member of the International Association of Law and Aging, and the Canadian representative to the Law and Aging Practice Group of the World Jurist Association. She is the first international member of ABA Commission

in its twenty-six year history. She taught the first elder law course at McGill University's Faculty of Law in the winter of 2005 and has recently developed the first course on elder law for judges in Canada with the National Judicial Institute in Ottawa.

Ms. Soden is the general editor of *Advising the Older Client*, the first national and comparative law text on law and aging in Canada. As part of her commitment to community and public service, she has acted, for more than ten years, as a consultant to the Quebec Institute of Social Gerontology on issues of abuse and exploitation.

She is also the coordinator of a national study group on powers of attorneys, bringing together the Canadian Bar Association and the Canadian Bankers Association, and acts as a consultant and legal counsel to government study groups on caregiving and end-of-life issues. As a private practitioner, since 1983, she offers legal advice, advocacy, and case management to older clients and to the people who play a role in the lives of older people. Ms. Soden earned a B.A. from the Université de Montréal, Québec, and a B.C.L and L.L.B from McGill University, Faculty of Law, Montreal, Québec.

Hon. Sandra Thompson

was appointed to the South Bay, California, Municipal Court by Gov. George Deukmejian on June 14, 1984. She was elect-



ed in 1988, 1994, and 2000, and elevated by unification to the Superior Court on January 22, 2000. She presides over misdemeanor and felony criminal trials.

During her twenty years on the bench, Judge Thompson has held virtually every assignment relating to criminal matters. Active in the area of judicial administration

during her career, Judge Thompson is a former member of the board of directors of the National Center for State Courts, former member of the Judicial Council of California, and former chair of the Municipal Court Judges Association of Los Angeles.

Judge Thompson is an active member of numerous judicial and legal organizations, including the California Judges Association, National Bar Association, American Bar Association, California Women Lawyers Association, Black Women Lawyers Association of Los Angeles, and the Langston Bar Association. She is the president of the National Association of Women Judges.

Judge Thompson is a member of the Board of Trustees of Linfield College and Marymount College, and participates on the Board of Managers of the Torrance YMCA. Judge Thompson is a graduate of the University of Michigan Law School, attended Linfield College in McMinnville, Oregon, and holds a B.A. from the University of Southern California.

Carol E. Dinkins

is the Commission's liaison from the ABA Board of Governors. Ms. Dinkins is a partner with the law firm of Vinson &



Elkins, in Houston, Texas, where she has worked since 1973, except while in government. From 1981 to 1985, Ms. Dinkins served as the Deputy Attorney General of the United States. Within the ABA, Ms. Dinkins has held numerous positions, including as a member of the Board of Governors (2005-2008); member of the House of Delegates (since 1992);

chair of the Rules & Calendar Committee (2000-2002); member of the Nominating Committee (1994-to date); *ABA Journal* Board of Editors (member since 1998, chair 2003-2006); Standing Committee on Federal Judiciary, chair (2002-2003) and member (1997-1998); chair of the Section of State and Local Government Law (1991-1992); and chair of the Section of Environment, Energy and Resources Law (1997-1998). She is a life fellow of the American Bar Foundation. Ms. Dinkins is on the board of directors of several organizations, including the Nature Conservancy (1996-2008) and the Houston Museum of Natural Science (since 1986). In 1999, Ms. Dinkins was recognized in the *National Law Journal* as one of the country's "Top 50 Women Lawyers," and in 1990, as a "Leading Practitioner of Environmental Law." Ms. Dinkins is also listed in *The Best Lawyers in America* and *The International Who's Who of Business Lawyers*. Ms. Dinkins has received numerous awards, including as an inductee to the Texas Women's Hall of Fame (2000); the ABA Commission on Women in the Profession's Margaret Brent Award for Women Lawyers of Achievement (1999); the University of Houston Law Center's Outstanding Alumnus (1984); and the 2003 Kate Stoneman Award, from Albany Law School. Ms. Dinkins received her B.S.Ed. from the University of Texas at Austin and her J.D. from the University of Houston.

Learn more about the latest resources and current activities of the ABA Commission on Law and Aging on the Web at: www.abanet.org/aging.



In Memory of Richard B. Allen

Richard B. Allen, a long-standing member and friend of the ABA Commission, died on Saturday, July 23. During his tenure with the ABA Commission, Dick served both as a member and as liaison from the ABA Senior Lawyers Division, of which he had been a founding member.

Dick's legacy with the ABA rests not only on his contributions to the Commission on Law and Aging, but also on 23 years of leadership of the *ABA Journal*, including serving as editor and publisher, until he "retired" in 1986. Following retirement, Dick went on to a second, 17-year career as managing editor of *Defense Counsel Journal*, a publication of the International Association of Defense Counsel. He retired, again, in November 2004.

Dick was a Fellow of the ABA, was elected to the ABA House of Delegates, served as chair of the ABA Senior Lawyers Division, and was on the Commission for Law and Aging for several years. He also served on various committees for the Chicago Bar Association, as well as writing the *CBA Record's* monthly column "For the Record" since 1987. Dick will be remembered not only for his contributions to the Commission and the American Bar Association, but for his ready wit and word craft, his dedication to the law profession, and his great love for his family. We will miss him.

(*BIFOCAL* thanks Mary Beth Kurzak of the International Association of Defense Counsel for the photo on the front page).

Law Day 2006 Theme

Liberty Under Law: Separate Branches, Balanced Powers

It is important that all Americans understand what this nation's founders intended and accomplished in creating a government of separate powers. The founders were very concerned that the government they established not have all its powers concentrated in the hands of a few officials. They agreed with Montesquieu that if "the right of making and of enforcing the laws is vested in one and the same man, or the same body of men . . . there can be no liberty."

The founders were also concerned that the powers granted to one branch would be balanced by powers granted to others. Congress's power to legislate, for example, is balanced by the executive's power to veto legislation and by the judiciary's power to declare legislation unconstitutional. This system of checks and balances ensures that each branch serves as a constraint on, and is constrained by, the powers of the other branches.

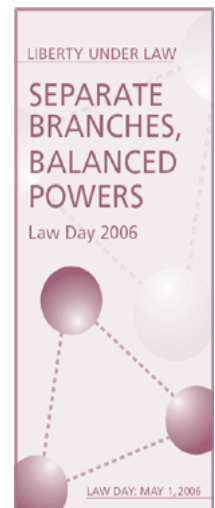
This year's theme enables Law Day planners to show how the branches have their separate spheres and separate powers, but work together for the common good. The theme also is central to building understanding of the rule of law, which has always been a primary purpose of Law Day.

The free *Law Day 2006 Planning Guide and Resource Catalog* is available on the ABA Web site at: <http://www.abanet.org/publiced/lawday/theme2006.html>.

Chapters include:

- Background, Planning—Planning tips, timeline
- Publicizing—Media tips, sample proclamations
- Teaching—Lessons, strategies for k-12 presentations
- Community Outreach and Program ideas
- Speaking on Law Day—Talking points
- Winning—Contest entry information
- Sample programs related to this year's theme.

How will your group use this year's theme to expand knowledge about the rights of elders and to meet their law-related needs? E-mail *Bifocal*, at Philpotj@staff.abanet.org, with your project ideas and we'll share them in upcoming issues!



Housing

Resident Rights in Assisted Living: Sources and Resources

By Stephanie Edelstein

Seniors considering assisted living or continuing care retirement communities are often drawn by offers of housing plus social and recreational opportunities, assistance with activities of daily living, and health services designed to minimize the need to move. Well-informed consumers will evaluate living arrangements, proximity to family, services available to meet current and future needs, and costs, among other issues. Yet even the well-informed are likely to overlook less tangible but crucial issues such as legal rights and protections. Lawyers must be prepared to advise clients on what they will gain, or perhaps lose, when they make the move. Unfortunately, this is not always an easy task. Legal rights and protections for residents of assisted living or the assisted living units of a continuing care retirement community (CCRC) vary considerably under state law, if they exist at all, and there are no federal standards specifically directing quality or services or promoting resident rights in these facilities. This article looks at selected sources of resident rights for assisted living facilities—state or federal laws that may offer protections against discrimination, involuntary transfers or discharges, duration-of-stay requirements, or poor quality of care and that may set forth mechanisms for notice, appeal, and enforcement.

Background

There is no universally accepted definition of assisted living, but for purposes of this article, it can be described as offering a combination of housing, personal care, and some health ser-

vices for individuals who need assistance with activities of daily living but do not require 24-hour skilled nursing care. Assisted living facilities range in size from homes with fewer than five residents to apartment-style complexes housing several hundred persons. They may be freestanding or part of a CCRC. In 2002, the National Center on Assisted Living, a provider association, estimated that approximately 900,000 people lived in more than 36,000 assisted living residences. Figures for 1999 show that the majority of residents are between the ages of 75 and 85 and more than two-thirds are female; approximately 25 percent need help with three or more activities of daily living (compared to 83 percent of nursing home residents); and 86 percent need or accept assistance with medication.¹ At least half of residents have some degree of cognitive impairment, although most do not live in specialized units.² Most assisted living residents are private pay. The federal government does not regulate assisted living, and state approaches to oversight vary widely. In 1999, following a study of 721 assisted living facilities in four states with very different systems (California, Florida, Ohio, and Oregon), the Government Accountability Office (GAO) reported that, in general, state regulation of assisted living focuses on three main areas: (1) living accommodations, (2) admission and retention criteria, and (3) the types and levels of services that may be provided. Investigators observed that, even within these three categories, states rarely address how services are to be provided, how quality is to be ensured, or what legal rights and protections should be given to residents.³ In a more recent report focused on consumer information and choice, the GAO concluded that, even in those states that have instituted regulatory requirements, facilities fail to comply.⁴

Selected Sources of Resident Rights

In the nursing home arena, advocates researching resident rights look first to federal law because nursing facilities certified to participate in the Medicare or Medicaid programs, including certified nursing home sections of a CCRC, are required to comply with the provisions of the Nursing Home Reform Amendments of OBRA '87, which include resident rights and protections.⁵ There is no Nursing Home Reform

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Stephanie Edelstein, J.D., is associate staff director of the ABA Commission on Law and Aging. She directs the Older Americans Act-funded National Legal Assistance Support Project, where her focus is on legal services delivery, housing, and economic security issues. Her housing work includes assisted living, reverse mortgages, and the rights of older persons under federal fair housing laws. She also directs the Partnerships in Law and Aging Program, which funds collaborative, community-based projects addressing the legal needs of vulnerable elders, and she manages the Elderbar listserv for the law and aging community. She is a member of the National Academy of Elder Law Attorneys and the Maryland State Bar Association Elder Law Section Council.

Resident Rights in Assisted Living

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Law equivalent for assisted living and no comparable national system of resident rights and protection. Without such a system, where does one turn?

State Licensure

Despite recent gains in rights and protections for assisted living residents in individual states, inconsistency and confusion continue to reign. There are currently more than a dozen designations for facilities that could be considered, or that are marketed as, assisted living. The National Center on Assisted Living compiles an annual list of state regulations that includes contact information for licensing agencies. While helpful for beginning research, it does not include citations or listings of resident rights (on the Web at: www.ncal.org/about/statsum.htm). Another Web site, CareScout, includes citations and contract requirements (if any) (on the Web at: www.carescout.com/resources/assisted_living/state_policies/index.html). Inconsistency in terminology reflects inconsistency in resident rights and protections. Some state laws clearly delineate rights and procedural remedies; some include rights but no mechanism for enforcement; some require disclosures to consumers but do not provide for rights with regard to the issues disclosed; and some leave this important issue to the discretion of the facility and to contract. States that license more than one kind of facility fitting the general description of assisted living, for example, assisted living and adult homes, conceivably could provide for different resident rights in different facilities. Consumers would be unlikely to realize this distinction. Resident rights may include right to freedom of choice (usually refers to daily decision making) and from abuse and restraints; the right to privacy, confidentiality, accommodation of individual needs, grievance procedures, participation in groups and other activities; the right to examine survey and inspection results and retain a unit when absent for a period of time, notification of services included in Medicare or Medicaid payment, and management of personal financial affairs. Notification may specify posting, written notice (incorporation into contract or a written copy separate from the contract), or verbal. Written acknowledgment of receipt may be required as an added protection. What mechanisms do residents have under state assisted living law to enforce their rights or to pursue complaints against providers? Some state statutes and regulations are silent; others require facilities to establish their own complaint and appeal mechanisms, which could result in nothing more than a meeting

with staff or administrator. Recently, more states have provided recourse to an outside agency (usually the agency that licenses the facility). The 2004 GAO report cites Georgia as providing assisted living residents with means for seeking redress of complaints. The avenues include an internal complaint resolution system, an administrative hearing under the Georgia Administrative Procedure Act, and the right to file in court without exhausting administrative remedies.⁶

Federal Anti-Discrimination Laws

Three major federal civil rights laws offer protection and provide legal rights to assisted living residents. Some states have equivalent laws that could be used as well. The Fair Housing Act (FHA) prohibits discrimination based on race, color, religion, sex, national origin, disability, or familial status (living with children under the age of 18) in most housing and housing-related transactions. The FHA applies to almost all housing activities or transactions, whether in the public or the private sector; to the provision of services connected with a dwelling; and to zoning, land use, or health and safety regulations.⁷ Section 504 of the Rehabilitation Act of 1973 prohibits discrimination based on disability in all programs or activities operated by recipients of federal financial assistance, including HUD-assisted housing programs and facilities that receive Medicare or Medicaid funding.⁸ The Americans with Disabilities Act (ADA) extends § 504 disability discrimination provisions to public programs, activities, and services, whether or not such programs receive federal financial assistance. Although Titles II (state and local programs) and III (public accommodations) of the ADA do not specifically cover housing, and indeed specifically exclude entities covered by the FHA, they do apply to non-housing functions of a facility, such as meeting rooms, meal sites, adult day care, and long-term care.⁹ The three statutes protect individuals who (1) have a mental or physical impairment that substantially limit some or more major life activities, such as walking, seeing, hearing, speaking, or performing manual tasks, such as personal care; or (2) have a record of having such an impairment, even if the impairment no longer exists, such as a previous diagnosis of mental illness; or (3) are regarded by others as having such an impairment, even if the perception is not accurate. They do not protect current users of illegal controlled substances, individuals convicted of illegal manufacture or distribution of a controlled substance, or those who are a direct threat to the health or safety of others. Advanced age alone does not afford protection, but older people who are frail, who have a disability, or who are perceived to have a disability because of age would be included. All three statutes include reasonable accommodation provisions. Protected persons have the right

to request reasonable accommodations—changes to rules and policies or reasonable modifications to the property to accommodate a disability, unless those changes would constitute an undue financial burden or a fundamental alteration to the program. In housing covered by the FHA, the tenant pays the costs of modifications. For example, a resident who needed a service the facility did not provide could contract with an outside provider for that service. While many issues that arise in assisted living are the same as those that arise in traditional housing, the quasi-healthcare nature of assisted living raises additional, and sometimes complex, issues.¹⁰

Public Funding

Public funding of assisted living may carry with it additional rights for residents. In at least 40 states, state Medicaid waivers provide financial coverage of health services for some assisted living facility residents who meet income guidelines and have medical conditions significant enough to warrant admission to a nursing home.¹¹ Participation in the Medicaid program is voluntary, but providers who participate must comply with program rules, including those that bar discrimination, protect beneficiaries' limited funds, and provide for certain rights and protections. While the issues have not yet been litigated, Medicaid law arguably could be used to challenge duration-of-stay requirements or attempts to discharge a resident who spends down savings and becomes Medicaid-eligible, or other attempts to transfer or discharge a resident without good cause or due process protections.¹² The U.S. Department of Housing and Urban Development offers limited federal funding to support mortgage loans, conversion, or rehabilitation of assisted living for low-income persons. These programs include § 202 supportive housing, 42 U.S.C. § 1701q, and §§ 232 and 223(f) new construction and substantial rehabilitation, and 12 U.S.C. § 1715(w). A recent Internal Revenue Service Ruling appears to confirm that projects receiving this financial assistance cannot terminate tenancies without good cause. While the number of assisted living programs using such funds is low, the ruling gives rights to residents in states without such protections in assisted living laws.¹³

Contracts and Disclosures

Are contracts a source of resident rights? The industry has argued that the relationship between provider and resident should be determined by contract rather than by regulation. There are several problems with this approach. Not all states require a written contract. Contracts can range from single, sparsely worded pages that commit a facility to providing nothing more than a roof over the resident's head and per-

Web Resources for Assisted Living Facility Resident Rights

American Bar Association Commission on Law and Aging, <http://www.abanet.org/aging>

Bazelon Center for Mental Health Law, <http://www.bazelon.org>

CareScout, <http://www.carescout.com>

Center for Excellence in Assisted Living, <http://www.theceal.org>

National Academy for State Health Policy, <http://www.nashp.org>

National Citizens' Coalition on Nursing Home Reform, <http://www.nccnhr.org>

National Long-Term Care Ombudsman Resource Center, <http://www.ltombudsman.org>

National Senior Citizens Law Center, <http://www.nslc.org>

haps some basic housekeeping to multi-page documents packed with detailed, often confusing, information that may be inconsistent with marketing materials or internally inconsistent. Contracts frequently fail to provide legal rights or procedural protections to residents, and because they vary from one facility to the next, they are of little use in comparing facilities. Contracts also may include duration-of-stay, third-party guarantor, mandatory arbitration, or waiver of liability clauses that are unlawful, unconscionable, or simply not in the resident's interest. No states have mandatory contracts, but some have models, as do the large provider groups. In Washington state, advocates, providers, regulators, and others developed a model agreement.¹⁴ Is disclosure an adequate protection for residents? The 2004 GAO report highlights a Texas requirement that facilities provide prospective residents with a standardized disclosure statement in a checklist format that describes services, costs, discharge policies, staff training, and other issues and is worth considering as one tool.¹⁵ However, while disclosures can be effective tools for informing consumers, they are not a substitute for resident rights or agency oversight.

Consumer Protection Law

All states and the District of Columbia have some form of statute protecting consumers' rights in the marketplace. Unfair and Deceptive Acts and Practices (UDAP) laws give consumers a private right of action, authorize the state to pur-

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sue claims, and provide special remedies such as attorneys' fees and some individual damages. Consumer law also could be used to challenge as unlawful or unconscionable false or misleading statements by a facility, discrepancies between what is advertised and what is actually provided, other misrepresentations regarding services or costs, or clauses covering duration of stay, third-party guarantor, mandatory arbitration, or waiver of liability.¹⁶ While consumer laws have not been as widely used in assisted living as they have in the nursing home arena, much of the consumer protection law that has developed to challenge nursing home abuses could be applicable.¹⁷

Private Right of Action

Does an individual resident have a legal right to challenge quality of care? In general, quality standards are enforced by state licensing agencies, but AARP in 2000 identified 16 states and the District of Columbia as offering a private right of action to assisted living residents. The report compares strengths and weaknesses of a range of causes of action and concludes that in some circumstances a private right of action may be more effective than actions based in contract, tort, landlord-tenant, or consumer protection law and may enable residents to attain the higher level of civil and social rights promised by assisted living.¹⁸

Other Issues

Negotiated Risk Agreements

Negotiated risk (shared risk, shared responsibility) agreements release a facility from liability arising from its failure to meet at least one aspect of a resident's needs. Such agreements purport to offer assisted living residents additional rights in the form of choice in daily decisions, when in reality they may be used by providers to waive resident rights. The common rationales for these agreements involve allowing a resident the freedom to eat foods that could adversely impact a medical condition or to leave the facility unescorted although unsteady of gait. However, these agreements also have been touted as a way to retain a resident whose service needs exceed those provided by the facility. Advocates argue that providers use these agreements to avoid liability for harm to the resident, that they offer no legal benefit to the resident, and that they are unconscionable. There appears to be no good reason for such agreements; good care planning can

achieve the results a resident needs without waiving any rights a resident might have.¹⁹ Some states, including Washington and Oregon, now prohibit such agreements.

Involuntary Transfer or Discharge

Almost all states require assisted living facilities to give residents notice of transfer or discharge. Not all states, however, specify what that notice should contain, how it is to be provided, or to whom it should be given. States that regulate the content of the notice also may require the facility to set forth the reason for the action, effective date of the proposed action, where the resident is to be moved, appeal rights, and a contact for the long-term care ombudsman. Some states have established, or require facilities to establish, guidelines and procedures by which residents can object to the action. Some require facilities to establish appeal mechanisms, which could result in nothing more than a meeting with the very staff member or administrator who made initial decision being challenged. Others have guidelines for internal procedures, or recourse to an outside agency (usually the agency that licenses the facility), or both. In a handful of states, including Massachusetts, New Hampshire, and Minnesota, assisted living discharges are considered evictions under state landlord-tenant law and residents have access to the courts. Argument has been made that assisted living residents may have a common law right to a court hearing to challenge an eviction on the grounds that the relationship between a boarding home provider and a resident has all the indicia of a tenancy.²⁰

Conclusion

While state assisted living regulations may establish minimum guidelines and parameters within which facilities are to operate, those laws vary and few establish comprehensive mechanisms for resident rights. Other federal and state laws can provide valuable support to elder law attorneys and others advocating on behalf of assisted living residents.

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Notes

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7. 42 U.S.C. §3601, 24 C.F.R. pt. 100, *et seq.*
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9. 42 U.S.C. §§ 12101, *et seq.*, *see* 28 C.F.R. pt. 35.
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20. *See* Jeff Crollard, *Boarding Home Residents' Right to a Discharge/Eviction Hearing*, in conference materials 2004 National Citizens' Coalition for Nursing Home Reform (NCC-NHR) Annual Conference (Jan. 6, 2004).

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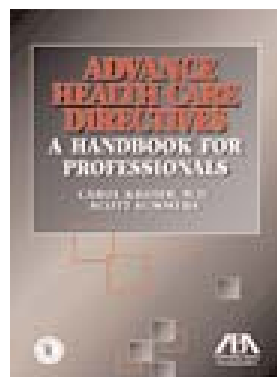
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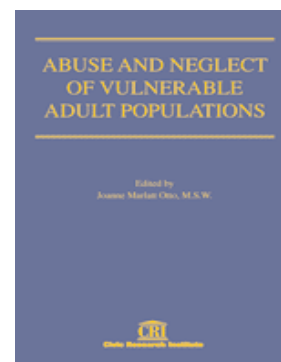


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the rights of those subject to guardianship proceedings.¹² Clinical¹³ evaluations play a necessary and important role in protecting autonomy by providing the information necessary for a clear and accurate determination of an individual's functional strengths and weaknesses.

This paper surveys current state guardianship statutes, with a focus on 1) how clinical evaluations are conducted in a guardianship proceeding and 2) what information these evaluations contain. The need for clinical evaluations in guardianship proceedings is paramount, as they provide a key objective and scientific component of the data needed by the court to make an appropriate determination of the need for capacity. Good evaluations also provide parameters that enable the court to create limited guardianship orders tailored to the specific cognitive and functional limitations of the ward. While most states require some sort of assessment conducted by a physician, mental health professional, or both, there is a lack of direction in the state statutes as to what information these assessments should contain. It is important that state statutes provide direction as to the type of information that these evaluations produce. It would provide guidance to physicians on what to evaluate and to judges on what to consider. It would also prevent the incidence of short conclusory evaluations done without the interests of the ward in mind. Encouraging clinical evaluations in guardianship proceedings, while focusing the approach and information provided, are two easily attainable reforms of state laws that are of great importance as the population of incapacitated adults increases.

What Is a Clinical Evaluation?

An Associated Press article in the late 80s found that about one-third of all wards had guardians appointed for them even without a doctor's opinion prepared or presented to the court, the guardian, or the ward. Incredibly, 25 percent of cases did not involve a hearing. When there was a hearing, the person alleged to be incapacitated attended only eight percent of the time.¹⁴ The introduction of the National Probate Court Standards on Guardianship in 1993 and the Uniform Guardianship Proceedings Act in 1997 were meant to remedy these problems. However, there is still more that needs to be done on the state level to ensure that the proposed ward's rights are properly respected and that they receive the care and consideration they need. Many state statutes now require that a clinical evaluation—an evaluation of the proposed ward by a physician, psychiatrist or psychologist, or multi-

disciplinary team—take place in the course of a guardianship proceeding. In other states, a clinical evaluation is not required, but may be submitted by the petitioner or respondent to provide evidence of the need for a guardianship, or ordered by the judge to gather more information about the respondent's medical or mental health conditions, skills, and areas of capacity.

National Standards for Clinical Evaluation

The discretion to produce and the practice of clinical evaluations differs greatly among the states and various model codes. The National Probate Court Standards, a set of recommended practices for judges, have set out that the court should avail itself of professional evaluations of the proposed ward's abilities.¹⁵ These standards advocate for the use of other professionals, in addition to a physician, to help create a more accurate picture of the capacity of the proposed ward. Among the factors to be addressed in the report are:

- Respondent's diagnosis;
- Respondent's limitations and prognoses, current condition, and level of functioning;
- Recommendations regarding the degree of personal care the respondent can manage alone or manage alone with some assistance, and decisions requiring supervision of a guardian;
- Respondent's current abilities and how it affects his or her ability to provide for personal needs; and
- Whether current medication affects the respondent's demeanor or ability to participate in proceedings.¹⁶

Though widely recognized, the National Probate Court Standards are not universally followed and practices differ significantly by state, court, and judge.

The Uniform Guardianship and Protective Proceedings Act, originally part of the Uniform Probate Code, revised in 1982 and again in 1997, serves as a model for conducting guardianship proceedings. In practice, adoption of the UGPPA in many states has been piecemeal.¹⁷ There are major differences that exist between the model act and how most states conduct guardianship proceedings. The UGPPA states that "The court *may* order a professional evaluation but

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shall order the evaluation *only* if the respondent demands it.”¹⁸ The UGPPA requires that a professional evaluation report include: a description of the cognitive and functional limitations, an evaluation of the medical condition, identification of strengths and abilities, a prognosis, and any recommendations for care.¹⁹ The act provides substantial guidance to the states regarding how clinical evaluations should be conducted and what evidence should be produced. With more widespread acceptance of the UGPPA, states would be able to conduct clinical evaluations that are more focused and efficient in serving both the court and the persons involved.

The upcoming publication *Determining Capacity of Older Adults in Guardianship Proceedings: A Benchbook for Judges*, produced jointly by the American Psychological Association and the ABA Commission on Law and Aging,²⁰ provides many helpful ideas regarding how judges can handle the clinical evaluation process. The benchbook advocates for the use of comprehensive clinical evaluations that provide detailed information on functional strengths and weaknesses to support limited guardianships where appropriate.²¹ According to the benchbook, the key elements of a clinical evaluation include: diagnosis with severity and prognosis, cognitive and decisional strengths and weaknesses, everyday functional strengths and weaknesses, consistency of choices with lifetime values and preferences, and risk of harm and level of supervision needed.²² The benchbook states that judges, in crafting their guardianship orders, should make written findings on capacity to establish the basis for the order and any plan implemented, and should match their judgment to the most appropriate intervention (least restrictive, limited, or total guardianship).²³ By looking at the possible considerations a judge might have in regards to clinical evaluations, it is possible to see areas in which the state statutes are lacking or in need of improvement.

Methodology Used for This Study

This paper will describe the ABA Commission’s review of guardianship statutes in the United States in terms of the provisions for clinical evaluations. Statutes from 50 states and the District of Columbia were reviewed and considered based upon the following variables:

Guardianship Clinical Assessment:
Procedure Categories Used

1. Is a Clinical Evaluation Required?

2. At What Point Does the Evaluation Take Place?
3. What Documentation Is Required?
4. What Professionals Are Involved in the Evaluation?

Guardianship Clinical Assessment: Information
Required in the Evaluation Categories Considered:

1. The Medical Condition
2. The Functional Strengths and Weaknesses
3. The Cognitive Strengths and Weaknesses
4. The Risk of Harm and Necessity of Appointment
5. Strengths and Abilities of the Person
6. Prognosis for Improvement
7. Recommendations for Care/
Least Restrictive Alternative
8. Medication-History/Effect
9. Other Information

These variables were chosen based upon their general acceptance as standards in the UGPPA,²⁴ the National Probate Court Standards,²⁵ and the ABA/APA benchbook for judges on capacity assessment.²⁶ All three of these sources use these variables when determining how clinical evaluations should be conducted, and what information evaluations should ultimately produce for the court. This study also includes an analysis of a small sample of standardized forms for clinical evaluations used by some courts to give examples of how clinical evaluations are handled on the local or district level. The results of this study are discussed in the sections below.

Survey of State Statutes on Clinical Evaluations in Guardianship Proceedings²⁷

Are Clinical Evaluations Required by Statute?

One issue in looking at the role clinical evaluations play in state guardianship proceedings is whether they are required by state statute. As it stands today, thirty states and the District of Columbia explicitly require in their statutes that a clinical evaluation take place during a guardianship proceeding.²⁸ Fifteen states leave this decision to the discretion of the court, though most require that a capacity evaluation be ordered if the respondent (proposed ward) wants one.²⁹ Currently there are five states that have no statutory direction on whether a capacity evaluation should or should not be conducted.³⁰

The procedural aspects used by these states for clinical evaluations in guardianship proceedings are very similar

from state to state. Most states require that the clinical evaluation take the form of a written report to be presented to the court if an evaluation is required or ordered. The possible contents of the clinical evaluation delivered by the physician or mental health professional are discussed in the next section of this paper.³¹ Some states, like Pennsylvania, Mississippi, and Utah, explicitly require the evaluator to be available for cross-examination during the proceedings, though there is not much support for that requirement in the statutes of other states.³² It is a debatable issue whether clinical evaluations submitted in states that don't require that physicians be present for testimony are subject to hearsay objections.

When Does the Clinical Evaluation Take Place?

There are three general courses established in the state statutory framework for when a clinical evaluation should take place. Some states require that the clinical evaluation be done before the petition is filed, with the assessment results attached to the petition as key evidence of why a guardianship is needed and should be established.³³ The advantage to this process is that there is initial medical documentation to back up the guardianship claim. The process becomes more streamlined, since the medical evaluation has already taken place and there is less of a need for additional information before the judge can rule. The downside is that there could be problems obtaining consent to a medical evaluation beforehand, if the proposed ward is contesting the guardianship proceeding. Also there is a significant cost in clinical evaluations that cannot be borne by some petitioners. Other states require that the clinical evaluation be done between the time the petition is filed and before the court proceeding takes place.³⁴ This process brings the information to the judge before the proceeding and would be useful in supplementing and comparing the claims made in the petition. The downside is that the process becomes more cumbersome, as a clinical evaluation may lengthen the proceedings. Lastly, some states will order that the capacity evaluation be done after the court proceedings.³⁵ This framework allows the judge to measure all information given throughout the process against the results of a capacity evaluation, before coming to a final decision. If the clinical evaluation is at odds with the other information previously supplied to the court, a more searching review may be required.

What Professionals Are Involved in the Evaluation?

One of the main issues in the debate over clinical evaluations is what professionals should be involved so that a clear picture of the capacity of the proposed ward is produced. The

involvement of a physician is the primary focus of most state laws. Thirty-six states mention the involvement of a physician in clinical evaluations.³⁶ However, 23 state statutes say that the court can involve a mental health professional, such as a psychologist or psychiatrist, in the clinical evaluation process, either in lieu of a physician or to supplement the evaluation.³⁷ There seems to be recognition on the part of these states that there is a growing need and usefulness for a mental health professional's expertise in diagnosing and offering prognoses relating to mental health issues, areas in which a physician may not have sufficient expertise to offer a qualified opinion. There are a few states that require a multidisciplinary evaluation that combines a team of physicians, social workers, psychologists, or others (nurses, gerontologists, etc.)³⁸ The benefit of including such a large group of professionals in the clinical evaluation process is that it provides the most complete picture of the (physical and cognitive) strengths and limitations of the proposed ward. The results of such an evaluation would enable the judge to tailor a specific order that helps the ward in areas where needed, but limits the power of the guardian to authority over only the areas where diminished capacity exists. The main drawback to multidisciplinary evaluations is the cost, as the appointment of a range of professionals undoubtedly raises costs to a level that would be difficult for proposed wards to pay.

Information Required in Clinical Evaluations³⁹

While most states either require or normally use a clinical evaluation in determining guardianship cases, there are substantial differences between the states as to what information the clinical evaluation should produce. There are currently 23 states⁴⁰ that specifically detail in their statutes the information that is required to be included in any clinical evaluation. With the goals of the evaluation spelled out beforehand, physicians and/or practitioners will have an easier time conducting the evaluation. It will also save time and effort by focusing their evaluation on the key areas of concern to the court. The entire process will be streamlined so that the information given to the judge is precisely what is required.

Medical Condition—Functional Abilities —Cognitive Abilities

There are three main areas of concentration that must be included in any clinical evaluation. Traditional state definitions of incapacity concentrate on a two- or three-prong test that identifies incapacity according to whether there is a disabling condition, a functional limitation, and/or a cognitive

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limitation. Therefore, most states that have laid out the information that is required from a clinical evaluation have specified that the clinical evaluation should include a diagnosis of the medical condition of the proposed ward, the functional strengths and weaknesses of the proposed ward, and the cognitive strengths and weaknesses of the proposed ward. There are nine states that require all three of these elements to be included in any capacity assessment.⁴¹ Currently 24 states⁴² require that any clinical evaluation include information regarding a medical diagnosis of the proposed ward's current condition. With knowledge of the current medical condition, the court can assess the ability of the ward to be present for the hearing (a due process concern), while also gaining information as to the ward's immediate needs. In a few state statutes⁴³ there is also the mention of the severity of the medical condition, which is important for clinicians to comment upon because it may bear directly on the nature of the cognitive impairment. There are 16 states⁴⁴ that require information regarding the functional strengths and weaknesses of the proposed ward. There are 11 states⁴⁵ that require information regarding the cognitive strengths and weaknesses of the proposed ward. This information is of use to the court because it helps shape a guardianship order by establishing limits to the powers given to the guardian based on the abilities and decision-making capacity that the ward retains to function independently and to assess his or her own rights and needs.

Prognosis

There is a wealth of other information that clinical evaluations could provide that would be of use to judges in tailoring specific limited guardianship orders. Specifically, there are 13 states that require that the clinical evaluation provide a prognosis of the future condition of the ward.⁴⁶ This is an important consideration, as it provides the judge with guidance over how to craft the extent of the powers of the guardian (for example, if the prognosis was "significantly deteriorating health," more extensive powers may be necessary), as well as the length of the guardianship (if, for example, the prognosis was for improvement, a temporary guardianship may be more in order).

Recommendations for Care/ Least Restrictive Alternative

Another piece of information that could be required in clinical evaluations, and is in 16 states' statutes currently, is a rec-

ommendation by the physician and/or mental health professional regarding recommendations for care and the least restrictive alternatives available.⁴⁷ The judge has the power to craft a guardianship order that would establish certain types of care for the ward and to provide for the amount of care needed and no more than that. With the recommendations of professionals who have expertise in the area of incapacity that the proposed ward has, the judge would have an invaluable resource for consideration of care options and effectiveness.

Medication History

Another area that some states address in capacity evaluations is the medication a proposed ward is taking. In our health care system, the medications that people take are central to their continued health and well being. Currently, ten states have a requirement that any clinical evaluation identify the medications a proposed ward is taking and what medications they may need in the future.⁴⁸ An important rationale for including information regarding medications is the effect that medications may have on capacity, as is the case with psychotropic drugs. A ward's medication history and needs touches upon recommendations for care and current medical condition considerations, for instance whether the ward is able to attend a hearing. It also deals significantly with cost and health care decision-making issues that a judge will have to address when crafting guardianship order.

Strengths and Abilities of the Proposed Ward

Lastly, the UGPPA addresses the need to assess the "educational potential, adaptive behavior, and social skills," of any proposed ward before deciding on a guardianship petition.⁴⁹ It is important that the abilities of the proposed ward be recognized, as the ward should be encouraged to maximize his or her autonomy. There are only seven states that have adopted the language of the UGPPA and require that any clinical evaluation identify the "educational potential, adaptive behavior, and social skills" of the proposed ward.⁵⁰ While guardianships are an important protection in society, it is also important that the autonomy and abilities of any person be recognized and respected.

Standardized Forms Used by Courts for Clinical Evaluations: An Informal Survey⁵¹

As part of this article, the ABA Commission conducted an informal survey of the clinical evaluation forms used by courts in states that were willing to participate. In all, the Commission collected nine different forms from six different

states, with four responses from states that did not use any standardized form in any clinical evaluation that is done. With the exception of Rhode Island, which includes a standardized “decision-making assessment tool” in its statute,⁵² the forms that the Commission received were forms used either by local judges or forms used in particular counties. Most of the forms highlighted the necessary basic information regarding medical diagnoses, cognitive assessment, and functional ability assessment. Highlights of particular forms include:

- **Rhode Island** has a standardized form for clinical evaluations, called a “decision making assessment tool,” written directly into their state guardianship statutes. The form must be filled out and attached to the petition for the court to even consider the guardianship. The form consists of two parts: a clinical evaluation followed by a summary of findings. The form can be filled out either by a physician or other professional with expertise in the incapacity.
- The form used by probate courts in Harris and Galveston counties in **Texas** requires a doctor to conduct the clinical evaluation and fill out the form. At the end of the form the physician is asked to decide whether the proposed ward is totally incapacitated, partially incapacitated, or not incapacitated at all. This form raises the question of whether the clinician should be asked to make what is ultimately a legal judgment.
- **Florida** provides separate forms for the physician and the other professionals (psychologists, social workers, etc.) working on the clinical evaluation, with each form highlighting the particular professionals expertise. For example, the physician’s form deals with diagnoses and cognitive abilities, while the other forms deal with functional abilities and the capabilities to exercise certain rights.
- In Montgomery County, **Maryland**, the petition requires the physician to give an opinion as to the cause, nature, extent, and probable duration of the disability; whether institutional care is recommended; and whether the proposed ward has sufficient capacity to consent to the appointment of a guardian.
- Although there is no statutory requirement in **Indiana** to have a clinical evaluation, a doctor’s evaluation is required in the case of an adult. Some individual courts use a standardized form for this

statement, which asks for the physician’s opinion, based on past examinations or an evaluation of the medical records, on the current medical and physical condition of the proposed ward, whether the ward is capable of making personal and financial decisions, whether he or she needs to remain in a nursing facility or can function in society without the help of a guardian, and whether the proposed ward can appear in court without injury to health.

- In Cuyahoga County, **Ohio**, a physician, social worker, psychologist, or mental retardation specialist can fill out the standardized form.

Conclusion

A guardianship proceeding is a complex legal action where some of the most basic individual rights are at stake. When a guardianship is ordered, there must be no doubt that it is a truly necessary step taken with the interests of the ward at heart, and that the guardianship that has been established goes no further than necessary. As the law moves in the direction of advocating for limited guardianship tailored around the specific functional and cognitive capabilities and limitations of the person, the importance and usefulness of clinical evaluations in guardianship proceedings is readily apparent.

Clinical evaluations act as a procedural safeguard for individuals, in a sense protecting them from the arbitrary application of substantive standards of incapacity that still differ from state to state. Most states now include clinical evaluations in their statutory framework dealing with guardianship, with more than 60 percent of states requiring an assessment at some point during the proceedings. Clinical evaluations in most states are produced by either a physician, mental health professional, or other medical professional, with some states requiring a multidisciplinary evaluation in order to get the most complete picture of the capacity of the proposed ward.

Less than 50 percent of state guardianship statutes in the U.S. stipulate the information that should be produced by a clinical evaluation. Without statutory direction it is hard to imagine that effective and efficient clinical evaluations will be consistently carried out. The states that lay out in their statutes the capacity information required in an assessment generally include three main prongs when considering incapacity: the medical condition of the proposed ward, their functional abilities, and their cognitive strengths and weaknesses. However, there are other pieces of information, set out most prominently in the UGPPA, that clinical evaluations

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could inform the court about. In terms of the future needs and condition of the individual, only 13 states currently require a prognosis to be included in the clinical evaluation. Only 16 states require any recommendation by the evaluator regarding recommendations for care. Lastly, there is a surprising lack of states (less than 20 percent) that require information relating to the medication history of the proposed ward, which is important not only in regards to the individual's current medical condition, but also as to fitness to attend and to participate in any hearing for the guardianship petition.

As is evidenced by the state forms reviewed by the ABA Commission, standardized forms for clinical evaluations are one way in which to further streamline and strengthen the clinical evaluation process. As it stands today, however, few states spell out in their guardianship statutes the needed information that a clinical evaluation should include. With an accurate and complete statutory description of whether a clinical evaluation should take place, who could be involved, and what information would be required as a result of such an assessment, guardianship proceedings could hone more directly on the specific capabilities of the proposed ward. As the population of the United States ages and the incidence of dementia and other medical disorders increase, it is necessary to look at state law to see what changes must be made to accommodate a large influx of guardianship petitions while still respecting the individual rights of those involved.

Notes

1. ABA Commn. on L. & Aging & Am. Psychological Assn., *Determining Capacity of Older Adults in Guardianship Proceedings: A Benchbook for Judges* (2005) (unpublished manuscript, on file with the ABA Commission on Law and Aging).
2. The term "diminished capacity" will be used in this paper when possible, instead of "incapacitated," to adhere to the recommendations of the Wingspan National Guardianship Conference Recommendations. See *Wingspan—The Second National Guardianship Conference, Recommendations*, 31 Stet. L. Rev. 595 (2002).
3. Mary Joy Quinn, *Guardianship of Adults* 9 (2005).
4. *Id.* at 154.
5. See ABA Commn., *supra* n.1 at 28 (discussing how a judge should craft a guardianship order and the considerations they should take into account.) See also Quinn, *supra* n.2 at 229-235.
6. Charles P. Sabatino & Susanna L. Basinger, *Competency: Reforming Our Legal Fictions*, 6 J. Mental Health and Aging, 119, 119-123 (2000).
7. *Id.* at 119.
8. *Id.* at 126.
9. *Id.*
10. Uniform Guardianship and Protective Proceedings Act § 102(5) (1997).

11. *Id.* at 29-132; See D.C. Code Ann. § 21-2011(11)(1999); N.Y. Mental Hyg. Law, §81.02(a) (McKinney 1999).
12. *Id.* at 137.
13. The term "clinical" as used in this paper refers to doctors or other health care professionals, such as psychologists and psychiatrists, who work with patients.
14. Fred Bayles & Scott McCartney, *Guardianship of the Elderly: An Ailing System* 1 (Associated Press Special Report, Sept. 1987).
15. Commission on Nat'l Probate Court Standards, National College of Probate Judges & National Ctr. for State Courts, *National Probate Courts Standards* (1993).
16. *Id.* § 3.39 (commentary).
17. AL, CO, HI, MN, and MT are the only states that have fully adopted the UGPPA.
18. Uniform Guardianship and Protective Proceedings Act § 306 (1997).
19. *Id.*
20. See ABA Commn., *supra* n.1.
21. See ABA Commn., *supra* n.1 at 25.
22. *Id.* at 28-30.
23. *Id.* at 31.
24. Uniform Guardianship and Protective Proceedings Act § 306 (1997).
25. Commission on Nat'l Probate Court Standards, National College of Probate Judges & National Ctr. for State Courts, *National Probate Courts Standards* § 3.39 (commentary) (1993).
26. ABA Commn. on L. & Aging & Am. Psychological Assn., *Determining Capacity of Older Adults in Guardianship Proceedings: A Benchbook for Judges*, 40 (2005) (unpublished manuscript, on file with the ABA Commission on Law and Aging).
27. For charts detailing how each state treats the issues discussed in this section, see <http://www.abanet.org/aging/guardianship.html>.
28. States that **require** that a court order a clinical evaluation in a guardianship proceeding include: AL, AK, AZ, AR, CA, CT, D.C., FL, GA, ID, IL, KS, KY, ME, MD, MS, MO, NJ, NM, NY, ND, RI, SD, SC, TN, TX, VT, VA, WA, WV, and WI (30 states and D.C.).
29. States that leave to the **discretion** of the court or as a result of motion by the respondent whether a clinical evaluation take place or not include: CO, HI, IA, LA, MA, MI, MO, NE, NV, NC, OH, OK, OR, PA, and UT (15 states).
30. States that have **no statutory direction** on whether a clinical evaluation should take place in a guardianship proceeding include: DE, IN, MN, NH, and WY (5 states).
31. See *infra*. Section III.
32. States that require the professional/s who conduct the evaluation **be present** at the hearing and subject to cross-examination include: PA, MS, and UT (3 states).
33. States that require a capacity evaluation **attached to the guardianship petition** include: MD, NV, NJ, OH, RI, SD, and WV. (KS, TN, and TX give the option of filing the clinical evaluation with the petition or having it take place after the filing of the petition.)
34. States that require that the clinical evaluation take place **between** the filing of the petition and the hearing include: AK, AZ, AR, CT, DC, FL, GA, HI, ID, , KY, LA, ME, MA, MI, MS, MT, NE, NM, NY, NC, NC, OK, OR, UT, VT, and VA. (KS, TN, and TX give the option of filing the clinical evaluation with the petition or having it take place after the filing of the petition.)
35. States that 1) don't require that the clinical evaluation take place before the hearing, or 2) do not give any statutory direction on when the clinical evaluation should be handed over to the court include: 1) CA, CO, IL, and WA, and 2) AL, IN, DE, IA, MN, MO, NH, PA, WI, and WY.

36. States that **use physicians** include: AL, AK, AZ, CA, CO, CT, FL, GA, HI, ID, KS, KY, ME, MD, MA, MI, MS, MO, MT, NE, NJ, NY, ND, OH, OK, OR, RI, SC, SD, TN, UT, VA, WA, WV, and WI. (36 states).
37. States that use **mental health professionals** in clinical evaluations include: AZ, CA, CO, FL, GA, HI, ID, KS, KY, ME, MA, MI, MS, MO, ND, OK, OR, SD, VA, VT, WA, WV, and WI. (23 states).
38. States that use or advocate for the use of (by including “may use” language in the statute) **multi disciplinary** evaluations include: FL, KY, MD, MS, NC, RI, SC, and WI (8 states).
39. For charts detailing what information each state requires in their capacity evaluations, see <http://www.abanet.org/aging/guardianship.html>.
40. States that **detail in their statutes the information that is required** in their capacity evaluations include: AZ, AR, CA, CO, FL, GA, HI, KS, KY, LA, ME, MD, MI, NM, NY, ND, OH, OK, TN, TX, VA, VT, WA, and WV (24 states).
41. States that **require all three**, medical condition, functional, and cognitive assessment, include: AZ, AK, CO, HI, KS, KY, ME, NM, and WV.
42. States that require information regarding the current **medical condition** of the proposed ward include: AZ, AR, CA, CO, FL, GA, HI, KS, KY, LA, ME, MD, MI, NM, NY, ND, OH, OK, TN, TX, VA, WA, and WV.
43. States that mention assessment of the severity of the condition, or impliedly mention it (through terms such as “extent” of the injury) include: CO, FL, HI, KS, KY, ND, TX, OK, and WV.
44. States that require information regarding the **functional** strengths and weaknesses of the proposed ward include: AZ, AR, CA, CO, FL, GA, HI, KS, KY, ME, NM, NY, ND, OK, VA, and WV.
45. States that require information regarding the **cognitive** strengths and weaknesses of the proposed ward include: AZ, AR, CO, HI, KS, KY, ME, NM, NY, TX, and WV.
46. The states that require that a **prognosis** be given in any clinical evaluation given the court include: AZ, CO, FL, HI, KA, KY, ME, MI, NY, ND, OK, TX and VA.
47. The states that require that **recommendation for care/ least restrictive alternatives** be given to the court in any clinical evaluation include” AZ, AR, CO, FL, GA, HI, KS, KY, LA, MI, NY, OK, TN, VT, WA, and WV.
48. The states that require that a **medication history** be given in any clinical evaluation include; AZ, GA, KY, MI, NY, ND, TX, VA, WA, and WV.
49. Uniform Guardianship and Protective Proceedings Act § 306 (1997).
50. The states that require that the **strengths and abilities** of a proposed ward be identified in any clinical evaluation given the court include: AZ, CO, HI, KS, KY, OK, and WV.
51. Copies of the standardized forms analyzed in this section are included in this report are on file with the authors at the ABA Commission on Law and Aging, 740 15th St. N.W., Washington, D.C. 20005.
52. See R.I. Gen. Laws § 33-15-47 (2004).

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

ABA Commission on Law and Aging
and American Psychological Association
80 pp. \$25
ABA Product Code: 4280025
ISBN: 1-59031-497-2

With the coming demographic avalanche as the Boomers reach their 60s and the over-80 population swells, lawyers face a growing challenge: older clients with problems in decision-making capacity.

While most older adults will not have impaired capacity, some will. Obvious dementias impair decision-making capacity—but what about older adults with an early stage of dementia or with mild central nervous system damage? Such clients may have subtle decisional problems and questionable judgments troubling to a lawyer.

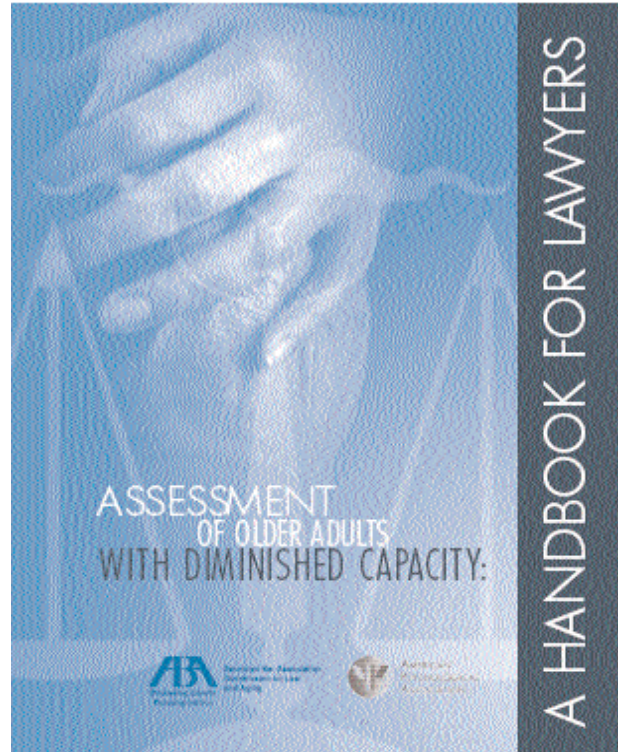
Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers offers elder law attorneys, trusts and estates lawyers, family lawyers, and general practitioners a conceptual framework and a practical system for addressing problems of client capacity, in some cases with help from a clinician.

Lawyers are increasingly faced with capacity issues in a rising number of cases involving specific legal transactions and, in some instances, guardianship. Whether they intend to or not, lawyers are making judgments about capacity. Even the notion that “something about the client has changed” or a decision to refer a client for a formal professional evaluation represents a preliminary assessment of capacity.

This handbook represents a unique collaboration of lawyers and psychologists. It offers ideas for effective practices and makes suggestions for attorneys who wish to balance the competing goals of autonomy and protection as they confront the difficult challenges of working with older adults with diminished capacity.

Questions that this handbook answers include:

1. What are legal standards of diminished capacity?
2. What are clinical models of capacity?



3. What signs of diminished capacity should a lawyer be observing?
4. What mitigating factors should a lawyer take into account?
5. What legal elements should a lawyer consider?
6. What factors from ethical rules should a lawyer consider?
7. How might a lawyer categorize judgments about client capacity?
8. Should a lawyer use formal clinical assessment instruments?
9. What techniques can lawyers use to enhance client capacity?
10. What are the pros and cons of seeking an opinion of a clinician and how can a lawyer identify an appropriate clinician to make a capacity assessment?

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