Chapter 3
The Conceptualization of Legal Capacity of Older Persons in Western Law

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In Western jurisprudence, the concept of capacity is a legal presumption. It rests upon the assumption that each of us, at adulthood, is best able to decide what is in our best interest, and that we ought to be left alone to pursue our own choices (Sabatino and Basinger 2000).

Incapacity is a term that defines when a state may take actions to shatter this presumption and limit the individual's right to make decisions about his or her person or property based on disability. Guardianship or conservatorship is the process in which this determination is normally made. Conceptually, incapacity may be seen as a legal fiction. This means that it is a construct treated as a fact, whether or not it is really so, because it is recognized as having utility. Here, we are referring to legal incapacity, and not clinical or *de facto* incapacity.[1]

Taking the U.S. law as a primary reference point, this chapter will review the evolution of the concept of incapacity as a legal fiction with profound consequences to individual rights, and will offer a comprehensive yet practical framework for making judicial determinations of capacity. The chapter also will examine how capacity is conceptualized in the practice of law, in which lawyers must make assessments of client capacity to engage in legal transactions—again with practical steps lawyers can take to respond effectively to capacity concerns. Finally, we will consider the "supported decision-making" framework moving away from an "all or nothing" approach to capacity assessment and decision-making and toward a more flexible model—an approach increasingly recognized in European law and

[1] Traditionally, in the U.S., the word "incompetency" was used for legal determinations and the word "incapacity" for clinical determinations—which in turn could be primary evidence for any legal determinations. However, recently most state laws in the U.S. have discarded the term "incompetency" in favor of "incapacity" it avoids the "all or nothing" connotation of "incompetency" as well as other historical baggage of the term.

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embedded in the United Nations Convention on the Rights of Persons with Disabilities. We will conclude with reflections on next steps in the conceptualization of capacity as a trigger for a range of support mechanisms and social interventions affecting individual rights and quality of life.

Much of the content in this chapter is drawn and integrated from previous works of the authors in collaboration with others, most notably three capacity assessment handbooks—for lawyers, judges, and psychologists respectively—published jointly by the American Bar Association Commission on Law and Aging and the American Psychological Association (ABA/APA 2005, 2006, 2008).

3.1 Incapacity As a Legal Fiction

Labeling the concept of capacity and incapacity a legal fiction does not mean that the concept lacks reality, legitimacy or consequence. To the contrary, as Prof. Lon Fuller (1967) demonstrated in his classic treatise, legal fictions exist to meet sometimes very powerful social needs and values, and such fictions can have far-reaching consequences. One of the most notorious and consequential legal fictions was incorporated into the U.S. Constitution. The concept of slaves as chattels was a legal fiction with painfully real consequences until the passage of the 13th Amendment. Another largely moribund legal fiction proclaimed husband and wife to be one, the fiction that effectively restrained the independent status of women, especially with respect to property matters, for generations. Other legal fictions sometimes serve simply as "convenient shorthand." For example, the fiction of "corporate personality" serves as an abbreviation for a cluster of legal rights and obligations that would be bothersome to spell out repeatedly in discourse.

Why do we need the legal fiction of incapacity? The answer may be fairly straightforward: because we need a trigger to tell us when a state legitimately may intrude into an individual's affairs and take action to limit an individual's rights to make decisions about his or her own person or property. The action may be beneficent and supportive, but it is still an incursion of the state's authority into the individual's affairs. The underpinning of this legal fiction is the doctrine of *parens patriae*—the obligation of the sovereign to care for the vulnerable and less fortunate (Wood 2005, p. 19). Even though the roots of *parens patriae* go back centuries in our legal system, there is nothing about the doctrine that pinpoints exactly when the doctrine should "kick in" and permit state intervention into an individual's affairs.

That is where definitions of incapacity become important. They are the triggers determined by society. Recognizing incapacity as a legal fiction is important, precisely because a fiction is determined by prevailing values, knowledge, and even the economic and political spirit of the time. In other words, the criteria or elements needed to establish legal incapacity are products of society's prevailing beliefs concerning individual autonomy and social order, tempered by the restraint of legal precedent. Just as societal values and needs have evolved over time, so will the legal criteria for capacity and incapacity. Doron (2002) vividly demonstrates

this dynamic in his comparative study of guardianship in five countries. Yet, at any point in historical time, we tend to reify capacity and to make it a static "thing" to be discovered. As one keen observer notes, "Capacity is a shifting network of values and circumstances" (Margulies 1994).

3.2 The Evolution of the Concept (Legal Fiction) of Incapacity

The law of guardianship has evolved extensively from its English roots. Originally, the law required a finding that the alleged incapacitated person's status was that of an "idiot," "lunatic," "person of unsound mind," or "spendthrift." The determination of this status was made by a jury of common men and, if found, reduced the putative ward to the legal status of an infant. (Doron 2002, p. 100) By the early twentieth century, the status-based test of incapacity began a shift towards a medicalized model of "incompetency," ostensibly based on more objective, scientifically-based medical and functional criteria. However, the criteria were so broadly and vaguely enumerated in state laws that they potentially affected a much larger swath of the public. By the 1960s, a common paradigm for the definition of incapacity under guardianship laws was a two-pronged test that required: (1) a finding of some sort of a disabling condition; and (2) a finding that such condition caused a functional inability to adequately manage one's personal or financial affairs (Anderer 1990). Disabling conditions, which were described by a variety of labels used in state laws with little consistency among them, included the following (Anderer 1990, pp. 4–6):

- Mental illness
- Mental retardation
- Developmental disability
- Chronic use of drugs or chronic intoxication
- Physical illness
- Physical disability
- Mental deficiency/ mental disability/ mental condition/ mental infirmity
- Weakness of mind
- Advanced age or infirmities of aging
- Or other cause

The breadth of these supposed disabilities was both daunting and lacking in precision. Especially noteworthy is the equating of age with pathology by the inclusion of "advanced age" as a qualifying condition. A 1990 survey of state law found 15 States had included advanced age as a disabling condition that could justify guardianship. (Anderer 1990, p. 6) Not surprisingly, such amorphous and discriminatory labels invited overly subjective and arbitrary judicial determinations. Indeed, some early reviews of guardianship in the 1970s and 1980s contained blistering critiques of state laws as "insensitive to the needs of the

elderly" and "vague and overreaching" (Regan 1972, pp. 603–604). One early study of guardianship bluntly concluded that guardianship meets the needs of the guardians and others rather than the needs of vulnerable wards and that it should simply be abolished. (Alexander and Lewin 1972) Incrementally, states sought to instill greater objectivity into their tests by refining both prongs so that they were less label-driven, more finely tuned, and more focused on how an individual functions in society. For example, most states eventually removed the pejorative term "advanced age" from the first prong of the test.[2]

Likewise, the second prong of the test—a functional inability to manage one's affairs—has been honed by many states to focus more precisely on the ability to provide for one's "essential needs" such as "inability to meet personal needs for medical care, nutrition, clothing, shelter, or safety."[3] Some states articulated essential needs in the negative, requiring a finding that the person's inability endangers their health or serious injury, illness, or disease are likely to occur. The essential needs and endangerment criteria raise the threshold for finding that the person is incapable of caring for himself or herself, but they do not eliminate the possibility of unrestrained speculation by judges.

In more recent years, advances in neurology and cognitive sciences have substantially impacted the approach of guardianship law to questions of capacity. "Cognitive functioning" tests have emerged in the majority of states to supplement or replace one or both prongs of the traditional test. Indeed, the Uniform Law Commission (1997), the most prestigious body of drafters of model state laws in the U.S., approved a revised *Uniform Guardianship and Protective Proceedings Act* in 1997 in which a cognitive functioning test entirely replaced the disabling condition language in the definition of incapacity:

> "Incapacitated person" means an individual who, for reasons other than being a minor, is *unable to receive and evaluate information or make or communicate decisions to such an extent* that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance (Section 102(5)).

These three tests—disabling condition, dysfunctional behavior, and cognitive functioning—have been used by states in a variety of ways. Some combine all three. And, since the 1980s, most states have also added one more critical threshold requirement for guardianship intervention—a finding that the guardianship is "necessary" to provide for the essential needs of the individual (i.e., there are no other feasible options) or that the imposition of a guardianship is "the least restrictive alternative" (Sabatino and Basinger 2000). This criterion is vital to distinguishing clinical incapacity, best determined by thorough clinical evaluation, from a finding of legal incapacity justifying the appointment of a guardian or

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[2] Only three states still include age in their definition of disabling condition as of 2010: Ala. Stat. Sect. 26-2A-20(8) (West 2009); Miss. Code Ann Sect. 93-13-251 (West 2009); S.C. Code Sect. 62-5-101 (2009). [CHARLIE—I checked these three statutes and this is still correct.]

[3] *See, e.g.*, Idaho Code Sect. 15-5-101(a)(1) (1999); Minn. Stat. Ann. Sect. 525.54, subd. 2 (West 1998); N.H. Rev. Stat. Ann. Sect. 464-A:2(XI) (1999).

conservator. The latter is justified only when there is no other alternative that will sufficiently meet the needs of the alleged incapacitated person.

Consider a simple example of the importance of the "necessity" criterion. Mr. Burns suffers from advanced Alzheimer's and is unquestionably totally dependent on others to manage his affairs. An adult child files a guardianship petition for purposes of financial management of his property. However, upon investigation, the court finds that Mr. Burns had appointed a financial agent under a durable power of attorney before onset of his illness. It further finds that the agent, another adult child, was properly handling his father's finances. The court would have to reject the petition and refrain from finding Mr. Burns legally incapacitated because, without more information, there is no necessity for court intervention to manage his financial affairs. A less restrictive alternative, the durable power of attorney, was in place and working adequately.

The statutory evolution of the definition of incapacity has undergone one other vitally important change in approach. Virtually all states in the last forty years have recognized that capacity is not always an all or nothing phenomenon. They have enacted language allowing for "limited guardianship" in which the guardian is assigned only those duties and powers that the individual is incapable of exercising. Thus, judges, as well as lawyers who draft proposed court orders, need to understand and identify those specific areas in which the person cannot function and requires assistance. Under the principle of the least restrictive alternative, the objective is to leave as much in the hands of the individual as possible. Though embedded soundly in statute, evidence suggests that in the U.S. actual use of limited guardianship still remains the exception rather than the norm. (Frolik 2002) Outside the U.S., particularly in selected European countries, models of "shared decision-making" that maximize autonomy are similar in concept to limited guardianship (see Sect. 3.6 below). Moreover, the 2010 Yokohama Declaration by the World Congress on Adult Guardianship Law recognizes the essence of limited guardianship in providing that "capacity is both 'issue specific' and 'time specific'" and that "measures of protection should not be all-embracing. . ."

3.3 Turning Concepts into Practice: A Framework for Courts

Given the evolution of the capacity concept in U.S. state guardianship statutes, how are courts to make a determination in practice? How are judges, guided by statute, to make that most difficult of pronouncements triggering state intervention into the private life of a vulnerable individual—whose abilities may be affected by time of day, medication, mood and environment? (Boyer 1999). There is no "bright line" dividing capacity from incapacity—no "capaci-meter" to turn to (Kapp 2003, pp. 292–294).

In 2006, the American Bar Association Commission on Law and Aging, the American Psychological Association, and the National College of Probate Judges

produced a handbook for judges on capacity assessment of older adults in guardianship proceedings (ABA/APA 2006). The Handbook aimed to offer judges practical tools for capacity assessment. It is based on "six pillars of capacity assessment" that can inform each step in the guardianship process. The "six pillars" rely on the same four factors used in most U.S. state guardianship statutes, and include two additional elements which are not criteria of diminished capacity, but rather critical considerations for determining appropriate interventions—specifically, the individual's values and preferences, and the consideration of the means to enhance the individual's capacity. The six pillars are examined below (ABA/APA 2006; Wood 2010), in the context of an example derived from a 2006 guardianship case, with facts embellished:

> Harriet at age 86 hired Anne to cook and do housework. Harriet told her son that Anne "does everything for me" and was very appreciative. Anne began to provide personal care and help with bills. On his occasional visits, Harriet's son noticed that his mother's memory was failing, and that she sometimes had difficulty expressing herself. When he learned that Harriet had met with her attorney to make changes in her will, leaving a sizable portion of her estate to Anne, he became very alarmed and filed a petition for guardianship. At the hearing, the judge heard evidence from Harriet's physician, a court visitor, and a psychologist with experience in conducting capacity evaluations.

Pillar 1. Medical Condition. One element for judicial consideration is the specific disorder causing the alleged diminished capacity—for instance stroke, traumatic brain injury, bipolar disorders, Parkinson's disease, Alzheimer's disease and more. Ideally, in addition to the diagnosis, the evidence would include a clinician's opinion on the prognosis as well as the severity of the condition. It is important that temporary, reversible conditions not become the basis for a permanent guardianship appointment. For example, the effect of medications and drug interactions, malnutrition, depression, grief or stress, transfer trauma, and delirium (such as from a urinary tract infection or dehydration) can cause confusion but may be addressed with appropriate treatment or accommodations. Moreover, it is important to note that the identification of various "medical conditions" is not always an exact science, and sometimes a diagnosis such as "Alzheimer's" can be taken in and of itself as a basis for—or synonymous with "incapacity."

In the example, Harriet's doctor reported that he had administered a brief mental examination, which showed mild to moderate cognitive impairment. Based on that, he ordered a CAT scan, which showed that Harriet had experienced a series of small strokes. He also noted that Harriet took five medications including an anti-depressant and an anti-inflammatory drug, but he did not specifically note any side effects that might bear on capacity.

Pillar 2. Cognition. Cognition concerns the functions of the brain involved in mental processes such as thinking, reasoning, remembering, and problem solving. Cognitive functioning includes "alertness or arousal, as well as memory, reasoning, language, visual-spatial ability, and insight. Neurological as well as psychiatric or mood disorders may impact information processing." (ABA/APA 2006, p. 4). The judges Handbook appendix lists a range of screening tests for evaluation of cognitive impairment (ABA/APA 2006, App. pp. 48–49; as well as "common neuropsychological domains" that clinicians might use to evaluate cognitive

capacity (such as appearance, attention, communication, understanding, executive functioning) (ABA/APA 2006 App. pp. 50–52). The often widely used "Mini-Mental Status Examination" (MMSE)—a brief test for cognitive abilities with a maximum score of 30—may be a quick mental status screen to indicate the need for further evaluation, but it is not a comprehensive test for determining decisional capacity (ABA/APA 2005, pp. 21–22). There is an unfortunate tendency for broad over-reliance on the outcomes of tests such as the MMSE, even though it may not yield information relevant to evaluating specific abilities.

In the case example, Harriet's doctor had administered the MMSE and found that Harriet had some degree of impairment. Psychologist Sands had visited Harriet and spent two hours conversing with her and conducting a formal evaluation. He observed that her speech was somewhat disjointed. In the interview he found her generally aware of her family and finances, and noted that she spontaneously expressed her positive feelings about Anne. He tested her memory and reasoning. He concluded that she had mild to moderate expressive aphasia, a difficulty in retrieving words and organizing information, as well as some degree of dementia. He also had interviewed several friends and acquaintances who did not think Harriet was cognitively impaired, as she was able to carry on a brief casual conversation.

Pillar 3. Everyday Functioning. Everyday functioning is perhaps the most critical assessment element. What can the person do or not do to function in society and take care of him or herself? Can the person benefit from assistance or adaptations if needed?

Clinicians divide everyday functioning into the "activities of daily living (ADLs—grooming, toileting, eating, transferring, dressing) and the "instrumental activities of daily living (IADLs—such as using the telephone, doing laundry and housework, shopping, taking medications, arranging transportation, preparing meals). They use both informal means, such as observation and interview, and formal testing to assess functioning (ABA/APA 2006, App. pp. 53–54).

In Harriet's case, the court visitor reported that when he came to the house, it was tidy. Anne had helped her get dressed and gave her a breakfast bar. Harriet did not give direct responses to the visitor's questions about where she grew up and about her family, but volunteered that Anne helped her with everything she needed. She knew her address and phone number. She knew she had a checking account but not the amount in the account. She knew she had gone to the attorney about her will, and said Anne had called her a taxi to get there. When the visitor asked Harriet for some tea, Harriet initially looked confused, but eventually was able to boil the water and make the tea. The visitor's report to court stated that Harriet had recognized the need for assistance in hiring Anne, and that with Anne's help, Harriet appeared able to continue living in her home. The visitor questioned whether Harriet might be vulnerable to undue influence.

Pillar 4. Values and Preferences. A 1982 U.S. Presidential Commission report on bioethics maintained that having a set of values or goals and making choices consistent with these values is a key factor in decision-making capacity (President's Commission 1982). In addition, a Comment to the ABA Model Rule on "Client with Diminished Capacity" of the Association's *Model Rules of Professional Conduct* states that "consistency of a decision with known long-term commitments

and values" is an element in assessment of capacity (ABA Model Rules). Questions about values would get at what makes life meaningful for the person—what is important *to you*? (see Karel et al. 2004). The growing concept in the U.S. disability field known as "person-centered planning" takes this "important to you" concept a step further (see Sect. 3.6 below).

The psychologist asked Harriet what was most important to her, and what she likes to do. She responded, "I'm fine here." When he asked how she likes to spend her time, she said she likes to "sit here with Anne I guess." When he asked who she likes to talk with in making decisions, she named both her son and Anne. When he asked about things important in her past life, she mumbled that she didn't know.

Pillar 5. Risk of Harm and Level of Supervision. "Guardianship represents an inherent tension between protection and autonomy, between rights and needs. The risk factor will help to tilt the scales one way or another" (Wood 2010, p. 10). The degree, extent and likelihood of risk will be factors in determining the level of supervision needed. An assessment must ask: What are the physical, social, and financial risks? Does the person understand the risks and appreciate the consequences of risky behavior.

In Harriet's case, the court visitor report alluded to the risk of undue influence by Anne. Is Anne taking advantage of Harriet, and is Harriet able to understand that Anne may have mixed motives? That the change in her will affects her son? That she has become quite dependent on Anne and that there may be a risk of abuse or neglect?

Pillar 6. Means to Enhance Capacity. Instead of asking, "does the person have capacity," consider asking "does the person have capacity with support?" The Handbook recommends finding ways to augment questionable capacity through accommodations, interventions and communication techniques.

In Harriet's case, could a review of her medications, their interactions and their effect on cognition be helpful? Are there other people or activities that might broaden her experience? Could the visitor go back on a different day or at a different time to see if Harriet's functioning changes? Could questions to Anne be better phrased or broken into steps? Could information on her past interests given by her son be useful in opening the door to more communication?

3.4 Procedural Due Process and Limited Orders: Essential Safeguards

The "six pillars of capacity assessment" give judges a schema—a checklist to review with each variously-abled individual who comes before the court. But the decision sometimes is a tough one, always with drastic consequences. "In thousands of courts around the nation every week," wrote the Associated Press in its landmark 1987 review of U.S. guardianship (Associated Press 1987, p. 1), "a few minutes of routine and the stroke of a judge's pen are all that it takes to strip an old man or woman of basic rights."

Hopefully, judges will begin to factor into their "routine" a consideration of evidence in each of the six pillars, but in the end there is no simple formula to make the determination. The judges' Handbook recommends that if there are minimal or no incapacities, the judges should dismiss the petition and urge use of less restrictive alternatives such as advance directives for health care and financial powers of attorney. If there are severe diminishments of capacity in all areas, the judge could order plenary ("full") guardianship. But often the evidence will fall somewhere between these extremes, and the judge could use the observations and tests in the clinical evaluation report, based on the capacity elements, to fashion a limited guardianship order that removes rights only in those areas in which capacity clearly is lacking (see Frolik 2002).

In the real world, coming to a full or limited guardianship decision that preserves as much autonomy as possible for a person with diminished abilities is "messy" (Sabatino and Basinger 2000, p. 138). In the end, Harriet may need at least a conservator (guardian of property), but there may or may not be a way to limit the rights lost or else preserve and promote autonomy through a carefully constructed guardianship plan. Harriet's case is like many in that it presents no clear-cut capacity scenario.

What is clear, however, is that in Harriet's case before the court—as with other guardianship cases—procedural protections are critical to best examine what evidence exists and direct the courts attention toward what it means. Harriet needed not only a thorough evaluation and a careful visitor report assessing all available options, but a notice of the guardianship proceeding in language she could understand, an opportunity to be present at the hearing, legal representation to ensure her voice before the court, an opportunity to cross examine witnesses, and a standard of proof that requires clear and convincing evidence for a determination of incapacity. Indeed, while statutes may present substantive standards for capacity evaluation, "the more important protection for questionably competent individuals is procedure, not substance" and substantive standards may accomplish little "unless procedural rights are realistically recognized and enforced" (Sabatino 1996, p. 25).

3.5 Evolution of Capacity in the Context of Legal Transactions

When mental capacity is an issue in guardianship or any other litigation, the U.S. relies on an adversarial process before a trier of fact to reach a conclusion. The role of lawyers for the parties in this context is clear—to garner the best evidence and make the best case they can for their client's side. In the transactional setting in which most lawyers function—advising clients, preparing documents, completing transactions of all kinds—the role of the lawyer in assessing capacity has been less clear.

Lawyers are not trained as mental health professionals, and a law degree by itself provides no training in screening clients' capacity. Yet, lawyers have to make these judgments all the time. Taking on a new client necessitates first that the lawyer believes the client has the capacity to enter into the client-lawyer relationship, a contractual agreement. And then, the completion of any legal transaction for which the lawyer is hired presumes that the client has the level of capacity needed to complete the transaction. Fortunately, the lawyer starts with a legal and ethical presumption that any adult client has capacity, and it is only when sufficient evidence undermining that presumption comes to light that additional challenges and obligations arise.

The challenges include knowing what signs of incapacity might justify consultation with a mental health professional, or even full evaluation of the client if the client consents. In the end, the decision to proceed with a legal transaction desired by the client is on the lawyer's shoulders. And if the transaction is challenged later based on the lack of capacity, the lawyer may need to account for his or her counseling processes and facts known at the time of the transaction. To flesh out the dimensions of the lawyer's role, it is useful first to examine the ethical parameters in which U.S. lawyers must operate with respect to diminished capacity of clients, and second, to consider the range of transaction-specific definitions of capacity in American law.

3.5.1 Professional/Ethical Obligations of Lawyers

The American Bar Association Center for Professional Responsibility (2002) promulgates the Model Rules of Professional Conduct (MRPC) as a model for state bars. As revised in 2002, the Model Rules acknowledge lawyers' assessment functions for the first time, and indeed, suggest a duty to make informal capacity judgments in certain cases. Specifically, MRPC Rule 1.14, titled *Clients with Diminished Capacity*, quoted in full below, addresses three aspects of the lawyer's role. The first part of the rule states the imperative of maintaining a normal client-lawyer relationship to the extent reasonably possible. The second part confers discretion to take protective action if the lawyer reasonably believes three criteria are met: (1) the client has diminished capacity; (2) the client is at risk of substantial harm unless action is taken; and (3) the client cannot adequately act in the client's own interest. The third part provides limited discretion to reveal confidential information to the extent necessary to protect the client's interests when protective action is merited.

3.5.1.1 MRPC 1.14: Client with Diminished Capacity

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental

impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian *ad litem*, conservator or guardian.

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

Prior to 2002, the rule referred to a "client under a disability" rather than "client with diminished capacity" and the term "capacity" appeared nowhere in the rule. With the acknowledgement that lawyers do indeed have a role in screening for diminished capacity, the need for guidance in how to carry out this role became vital, because the presence of diminished capacity is one of the essential triggers that can lead to a decision to take protective action. Even though taking protective action is permissive and not mandatory under the rule, the stakes of taking protective action versus inaction can be high financially, emotionally, and legally.

Comment 6 to new Rule 1.14 attempts to gives at least some guidance in assessing capacity, although the rule itself does not define capacity or incapacity.

> In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision; variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.

These factors were first elucidated by Margulies (1994) in a values-based ethical analysis of representing seniors with diminished capacity. The factors also serve as natural targets of discussion for lawyers in client counseling. Even when capacity is not in question, the client's reasoning behind a decision is important to understand. As guidance for identifying diminished capacity, the factors do have some clinical clinically relevance, but they do not amount to a capacity screening test by themselves.

Other lawyer resources have emerged in direct response to the revisions in the ethical rules. Prominent among them is a handbook for lawyers jointly published by the American Bar Association and the American Psychological Association Commission on Law and Aging (ABA/APA 2005), *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*. Lawyer resources such as the handbook help to fill in the conceptual background and to offer systematic steps—including a worksheet for systematically recording clinically relevant observations—in making assessments of capacity. Lawyers cannot be expected to

take on the role of clinicians. But they can systematically screen for capacity at least at a preliminary level.

3.5.2 Legal Attempts to Define Transactional Capacities

Outside the more global assessments of capacity in guardianship proceedings, American law has always recognized situation-specific standards of capacity, depending on the particular event or transaction—such as the capacity to make a will, marry, enter into a contract, vote, drive a car, stand trial in a criminal prosecution, and so on. A finding of incapacity in any of these matters could nullify or prevent a given legal act.

Law in U.S. states also presumes that adults possess the capacity to undertake any legal task unless they have been adjudicated as incapacitated in the context of guardianship or conservatorship, or the party challenging their capacity puts forward sufficient evidence of incapacity to meet a requisite burden of proof. Depending on the specific transaction or decision at issue, as well as the jurisdiction in which one is located, legal capacity may have multiple definitions, set out in either state statutory and/or case law. (Frolik and Radford 2006) Lawyers must be familiar with the specific state-based standards.

The following descriptions represent commonly articulated capacity standards for particular kinds of transactions:

Testamentary Capacity. To execute a valid will, one must have sufficient mental capacity (1) to know the "natural objects of one's bounty," (2) to generally comprehend the kind and character of one's property, (3) to understand the nature and effect of the act, and (4) to make a disposition of one's property according to some plan formed in his or her mind (American Jurisprudence 2d 2011C, Sect. 63). The legal catchphrase "natural objects of one's bounty" simply refers to those who naturally have a legal or moral claim to benefit from the property left by the testator.

The archaic terminology that the testator must be of "sound mind" is still commonly used, too, but serves merely as a shorthand phrase for more detailed criteria. A testator who generally possesses the elements of testamentary capacity may also have that capacity negated by the existence of an "insane delusion" (i.e., irrational perceptions of particular person or events") if the delusion materially affects the will (American Jurisprudence 2d 2011C, Sect. 76).

Donative Capacity. Capacity to make a gift has been defined to require that a donor have "the mental capacity necessary to make or revoke a will and must also be capable of understanding the effect that the gift may have on the future financial security of the donor and of anyone who may be dependent on the donor." (Restatement 3rd of Property 2003, Sect. 8.1)

Contractual Capacity. In determining an individual's capacity to execute a contract, courts generally assess whether the party has sufficient mental capacity to understand the nature and consequences of the transaction and agree to its provisions. (American Jurisprudence 2d 2011A, Sect. 28) Since subject matter

and complexity of a contract can vary dramatically, the test for capacity must be scalable to the complexity of the transaction. In other words, a contract to engage in a leveraged buyout of a major corporation requires a higher level of mental capacity than a contract to clean your home's windows.

Capacity to Convey Real Property. To execute a deed, a grantor typically must have "sufficient mental capacity to retain in his memory. . .the extent and condition of his property, and to comprehend how he is disposing of it, and to whom, and upon what consideration." (American Jurisprudence 2d 2011B, Sect. 23)

Capacity to Execute a Durable Power of Attorney. The standard of capacity for creating a power of attorney has typically been equated with the capacity to contract, even though a power of attorney is not technically a contract. (Frolik and Radford 2006)

Decisional Capacity in Health Care. Capacity to make a health care decision is defined by statute in most states under their health care advance directives laws. Typical of these legal definitions is the following from the Uniform Health Care Decisions Act (Uniform Law Commission 1993):

> "Capacity" means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision. (Section 1)

State health decisions laws generally delegate to clinicians the task of determining a patient's capacity to make medical treatment decisions. Lawyers are more commonly faced with the question of whether a client has the capacity to execute an advance directive for health care or to establish a client's capacity to make a particular health care decision when a dispute over the issue arises. The capacity needed to appoint a health care agent is not the same as that needed to make a particular health care decision, for it does not require an understanding and appreciation of the significant benefits, risks, and alternatives to a proposed health care treatment in light of the person's current health care condition. The capacity needed is more general.

One state, Utah, has articulated a standard in statute, requiring that: "the adult understands the consequences of appointing a particular person as agent" (Utah Code Ann. §75-2a-103 West (2011). The definition is supplemented by factors that should be considered when determining whether an adult has the capacity to appoint a health care agent:

(a) Whether the adult has expressed over time an intent to appoint the same person as agent;
(b) Whether the choice of agent is consistent with past relationships and patterns of behavior between the adult and the prospective agent, or, if inconsistent, whether there is a reasonable justification for the change; and
(c) Whether the adult's expression of the intent to appoint the agent occurs at times when, or in settings where, the adult has the greatest ability to make and communicate decisions (Utah Code Ann. §75-2a-105 West (2011).

Financial Capacity. Financial capacity can be describe as the ability to manage one's financial affairs in a manner consistent with personal self-interest and values (Marson and Hebert 2008). It is generally assessed in the legal context by examining the nature of the particular transaction that is being challenged or scrutinized, whether it be contractual, donative, or otherwise. A broader notion of financial capacity as a day-to-day component of independent living—for example, paying for groceries or paying one's rent—generally receives scrutiny only as a basis for guardianship or conservatorship proceedings and is thus subject to the variety of guardianship criteria described earlier.

Capacity to Consent to Sexual Relations. The mental capacity necessary to consent to sexual relations lacks a universally accepted standard. State law is quite variable and has evolved primarily in criminal prosecutions of mentally capable individuals who have had sexual relations with someone intellectually challenged. According to Reed (1997), the majority of cases interpret "mental incapacity" to mean that the person cannot understand the nature of sexual conduct—that is, the person does not know either the physiological aspects of sex, or the possible consequences of sexual activity, such as pregnancy and the contraction of sexually transmitted diseases. A handful of states require that, in addition to understanding the nature of the sexual act involved and its consequences, the person must also appreciate the moral dimensions of the decision to engage in sexual conduct, although the individual is free to act inconsistently with these notions of morality.

Other Legal Capacities. Any legal act that becomes the subject of a legal dispute over mental capacity inevitably spurs courts to articulate, to some extent, criteria for the specific capacity, often based on clinical expert testimony, but often not. Courts deal with these issues only when a specific dispute comes before them. Examples of other capacities include capacity to drive, to marry, to stand trial, to sue and be sued, to engage in mediation, or to vote. Lawyers who provide counsel to families and individuals face these issues with difficulty and often without much guidance. The ABA/APA capacity assessment handbook series (ABA/APA 2005, 2006, 2008) grew out of the recognition that practical guidance was lacking not only for lawyers, but also for judges, and for mental health professionals who become involved in legal determinations of capacity in connection with specific transactions as well as in guardianship proceedings.

3.5.3 Differences Between Legal and Clinical Approaches

Historically, legal and clinical notions of capacity were essentially one and the same. The law simply used a medical model, defining capacity in clinical terms or relying on clinicians to make determinations. Over time, clinical and legal concepts of capacity were recognized as separate. However, considerable confusion often arises concerning the difference between the two approaches. Originally, a threshold distinction was made in terminology, with the law empowered to make findings

of "incompetency" while clinicians made findings of "incapacity." That distinction in terminology no longer holds true as most states have discarded the term "incompetency" in statute and have replaced it with task-specific terminology of incapacity. But even with the merging of terminology, there are significant differences in concept between the legal and clinical, so in discussing capacity, it is important to be clear whether one is addressing *legal* incapacity or *clinical* incapacity. The ABA/APA handbooks describe three characteristic differences between legal and clinical approaches to incapacity:

> One is that the focus on particular "transactions" in the law is parallel in many respects to what psychologists would characterize as functional "domains," although clinical domains are much more finely articulated.
>
> Two, the law tends to ask about capacity for specific transactions in a binary fashion—i.e., is capacity present or lacking—somewhat like an on/off switch. Clinicians are more oriented toward understanding capacities as variable continuums in which there may be no bright line between the presence or absence of capacity. While the law is warming up to the variable continuum notion, the transactional focus of the legal question still pushes for a binary yes or no answer.
>
> Third, legal definitions of transactional capacity tend to follow a fairly simple conceptual template: can the individual understand the nature and effect of (fill in the task) and perform whatever the essential function is necessary to implement the task? Thus, they tend to articulate tests that are sound in principle but not necessarily helpful in parsing the operational cognitive, behavioral, or emotional abilities necessary to meet the standard. Clinical assessment fills in that detail but must be clearly linked to the relevant legal standard. (ABA/APA 2008, p. 22)

Suppose, for example, that a jurisdiction's test for capacity to enter a contract is that the individual possesses sufficient mental capacity to understand the nature and consequences of the transaction and agree to its provisions. Conceptually, the definition is understandable by both legal and clinical professionals. However, for clinicians, the test necessitates examination through clinical interview and data collection of multi-dimensional cognitive and emotional domains, including comprehension ability, short-term and long-term memory, reasoning ability (i.e., contrasting risks and benefits and relating them to personal values and preferences), executive function, auditory comprehension, as well as psychiatric, emotional, and social factors that many impact capacity to enter into a contractual agreement (ABA/APA 2008, p. 53). Lawyers and the courts need sufficient knowledge and skills to make sense of the clinical input and to use it as an aid to making the ultimate determination of legal capacity.

3.5.4 Working with Clinical Experts

In representing clients in legal transactions, lawyers may need to turn to clinicians for help in capacity assessment if the lawyer's preliminary screening raises material questions about capacity. Indeed, the Comment to the ABA ethics Rule 1.14 on Clients with Diminished Capacity states: "In determining the client's diminished capacity … the lawyer may seek guidance from an appropriate diagnostician" (ABA Model Rules 2002). The key is in knowing when to seek clinical help, and how to make a referral and best communicate with a clinician about the case (see ABA/APA 2005, pp. 31–36).

Certainly not all clients should be referred for clinical evaluation. Not only is it costly, time consuming, and frequently unnecessary, but it can also damage the trust in the lawyer-client relationship. However, if the lawyer's preliminary screening finds more than mild or substantial problems with capacity, a professional consultation or referral is advisable. Additionally, if family conflict is in the picture, the lawyer may seek a professional assessment in anticipation of future litigation such as a will contest.

Clinical experts can be valuable resources. They can clarify the possible causes, particular areas and severity of diminished capacity. They can offer suggestions for support and accommodation for identified weaknesses, and can highlight the need for protective action; or, they may simply affirm the client's capacity, which is critical to going forward with the legal transaction. Ultimately, though, the judgment about the client's capacity for the particular transaction is *for the lawyer to make*. The lawyer can use the clinical assessment as key and sometimes critical evidence "but still needs to 'look behind' the [clinical] report and make an independent judgment taking all factors into account" (ABA/APA 2005, p. 34).

Lawyers may seek help from a range of clinicians including physicians, geriatricians, psychologists, psychiatrists, neurologists, or geriatric assessment teams. The most important qualification is experience and knowledge in capacity assessment—which not all clinical professionals have. Lawyers may look to clinicians for two levels of assistance. First, an informal consultation is a discussion with a clinical expert about a case without the need for client identification, consent, or referral. Second, a formal referral for evaluation requires client consent if possible for the referral and the evaluation—or at the very least, assent.

Careful lawyer attention to making a full and informed referral will bear the best results. The lawyer's referral must clearly state the reason the evaluation is needed, the nature of the legal transaction at hand, information on the client's background and condition and on the client's values and preferences if known (see ABA/APA 2005, p. 36). On receiving the clinician's report, additional communication with the expert may help to highlight key points. The lawyer can then use the report to substantiate the validity of a legal transaction, as evidence in a court proceeding, or as advice to improve the client's functioning.

3.6 Growing International Perspective on Reframing Incapacity: From Supplanting Decisions to Supporting Decisions

The foregoing discussion of capacity rests on certain Western jurisprudential assumptions: First, that each of us, at adulthood, can make decisions for ourselves. Second, an individual's capacity may be diminished, causing difficulties with decision-making about self-care, medical treatment, property, and about legal transactions. Third, the legal-judicial system can determine whether someone has sufficient capacity for a specific legal task or for overall self care. And fourth, if the legal-judicial system determines capacity is lacking, the right to make decisions can be transferred to a surrogate. The surrogate then becomes empowered with the legal right and duty to make specified decisions—while the individual becomes "unpowered" or "unpersoned" (Bayles and McCartney 1987). The system envisions that there is a trigger point, defined by the legal fiction of incapacity, at which the state steps in—in the form of a guardian—and the fundamental rights of the individual are lost.

These jurisprudential concepts on capacity have been challenged in a growing number of countries (see below) and most notably in 2006 by a landmark international legal document: the United Nations Convention on the Rights of Persons with Disabilities. The Convention is based on the principle that all persons with disabilities have a right to "full and effective participation and inclusion in society" (U.N. Convention 2006, Article 3 (c)). Article 12.1 of the Convention states that "persons with disabilities have the right to recognition everywhere as persons before the law;" and Article 12.2 provides that "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." To activate these concepts, Article 12.3 requires "States Parties [to] take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."

The Convention's provisions on capacity represent a sharp break with existing guardianship law in many nations. Instead of focusing on the lack of capacity and the appointment of a surrogate, the Convention focuses on how to support individuals in exercising their right to make decisions. Under the Convention, there is no "incapacity" —rather, some persons with disabilities need support in decision-making, and some need more support than others. It is the duty of States to "do what they can to support those individuals and introduce safeguards against abuse of such support. Support could take the form of one trusted person or a network of people; it might be necessary on one occasion or always" (Kanter 2009, p. 563; also see Lawson 2007, pp. 595–597).

The Convention's call for a "supported decision-making" model is in line with a recent article on surrogate decision-making and the Americans with Disabilities Act (Salzman 2010). In the article Salzman argues that "we generally accept the notion of supplanting, rather than assisting, the decision-making process" (Salzman 2010, p. 165). She points out that if an individual has a surrogate decision-maker, the

person is less likely to interact with others, and that over time this becomes isolating, and results in a self-perception of helplessness and loss of control. She asserts that such "state-sanctioned isolation" could violate the ADA mandate of integration that requires public entities "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (28C.F.R. 35.130(d)). Salzman attempts to "re-conceptualize" guardianships as "a violation of the integration mandate because they fail to provide assistance with decision making in the least restrictive 'setting'" (Salzman 2010, p. 194). The article asserts that supported decision-making models should be seen as a less restrictive form of assistance with personal and property management than current guardianship law—even with recent guardianship reforms that seek to maximize autonomy through limited orders and through recognition of the person's values and preferences.

Formal supported decision-making models have been developed in a growing number of nations. Such models must provide procedures for appointing a support person, designating who could serve in such a role, identifying who would qualify for such assistance, and circumstances under which the support person could make decisions without the person's consent if necessary (Salzman 2010, p. 234). These models move away from the traditional Western jurisprudential concepts of "incapacity" and "surrogate decision-making" toward shared decision-making approaches.

For example, in Germany traditional adult guardianship law recently has been replaced by a system of "care and assistance." Under this schema, a caretaker is appointed when a court finds a person unable to take care of some or all of his or her affairs. A court is to tailor the order to set out the specific responsibilities of the caretaker. "A significant element of this reform is the fact that the person does not lose his or her legal status or any other legal rights. Even though it is the duty of the caretaker to represent the person... or if the court so order, to provide consent for a legal action to be valid, the person retains the legal capacity to enter into contracts or manage his or her own legal affairs" (Doron 2002, p. 379). Sweden has a two-tiered system of decision-making assistance—a "god-man" appointed by a local court with the consent of the individual, who requires the person's consent for transactions; and an "administrator" who acts as a surrogate decision-maker similar to a guardian (Doron 1999, p. 384; Salzman 2010, p. 33). Finally, British Colombia, Canada, enacted a "Representation Agreement Act" under which "an adult can enter into a 'representation agreement' with a trusted person (or support network) who is empowered either to assist that individual in making and communicating [decisions] or to make decisions for him or her" (Salzman 2010, p. 237 citing R.S.B.C., ch. 405, pt. 3, Sec 26 (1996)). The idea is something like a power of attorney, but without strict requirements for "capacity," and including the requirement that the representative consult with the person to the extent possible.

Such models are still emergent, and may require further scrutiny, as they continue to be operationalized, to prevent abuse. But clearly a shift is underway internationally in guardianship law toward the supported decision-making end of

the spectrum. This trend is in accord with the related idea of "person-centered planning" that arose from the disability field in the U.S. and Canada—in which support persons "think about the quality of life from the perspective of the person [who is being supported]" (Smull 2010). It is a process for continual listening and focusing on what is important to a person. It aims to make "the person's activities, services and supports … based on his or her dreams, interests, preferences, strengths and capacities" (Schwartz et al. 2000, p. 238). It puts the person rather than the service system at the center, offering support to act on the person's own priorities to the extent possible.

3.7 Conceptualizing Legal Capacity: Looking Ahead

The concept of "capacity" in the guardianship context first evolved from the outmoded "status based incompetency" model through several stages to a broader construct encompassing cognitive and functional abilities as well as risk and values. At the same time, lawyers faced with issues of a client's diminished capacity in the context of specific legal transactions now have some guidance on factors to consider and ways to work with clinical professionals in assessment.

In the United States, the capacity trigger for state intervention as well as the nature of the intervention still rest primarily on a model of supplanting autonomy rather than supporting it. The six pillars of capacity promoted by the ABA/APA (2008) suggests that the U.S. model may be transitioning toward the supportive model, because two of the pillars call for examination of the individual's values and preferences as well as strategies for enhancing the individual's capacities. In comparison, certain European countries and Canada have made more definitive gains in that direction.

The reality is that the socio-legal models we create for the benefit of those members of society with diminished capacities and special needs are not easy to craft theoretically or practically, and they will never stop evolving. As Terry Carney (2012) describes in his companion article, it is a balancing act "between philosophical values of autonomy and paternalism, the respective roles of state and civil society, respect for cultural values and pluralism, and tolerance of reasonable degrees of personal risk." Yesterday's formulations of the right balance will not work today, nor will today's necessarily work for tomorrow, nor will it work for every culture. Today's new gold standard—supported decision-making, aimed at maximal social participation—is still in a formative stage and, as with any model, is dependent on the availability of adequate resources for its implementation. While it dramatically changes the way we conceptualize state intervention into the lives of vulnerable individuals, it still requires a trigger for activating state-sponsored support in whatever form it takes. The evolving "fiction" of diminished capacity is likely to provide the theoretical base for that trigger for some time to come.

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